MEDICAL SAVINGS ACCOUNTS [MSAs] IN THE FEHBP

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON
GOVERNMENT REFORM
AND OVERSIGHT
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

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MEDICAL SAVINGS ACCOUNTS [MSAs] IN THE FEHBP

MONDAY, MARCH 9, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Fort Monmouth, NJ.

The subcommittee met, pursuant to notice, at 10:13 a.m., in Building 1206, Fort Monmouth, NJ, Hon. John Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica and Pappas.

Staff present: George Nesterczuk, staff director; Caroline Fiel, clerk; and Cedric Hendricks, minority counsel.

Mr. MICA. We're going to call this meeting of the House Civil Service Subcommittee to order. I chair the subcommittee.

First of all, I want to take just a moment to thank those involved in hosting us today, particularly the base commander, General Dwyer Brom, for the wonderful support that people at Fort Monmouth have provided to our subcommittee in organizing this field hearing.

We do much of our work in Washington, but dealing with the workforce issues makes it very sensible to go into the workplace whenever our subcommittee is able. I want to also mention the point that the Defense Department employs nearly half of their Federal workforce in this area. I am pleased to have been able to receive the recommendation of the vice chairman of our subcommittee, Congressman Pappas, to host and also convene this field hearing of our subcommittee.

I might announce also that the ranking member, Mr. Elijah Cummings, is not going to be able to be with us today. I think we're all fortunate, given the circumstances of the weather, that any of us that made it coming in last night and this morning. We do have Cedric Hendricks, who is the counsel for the minority and the liaison to the ranking member of our subcommittee with us, and George Nesterczuk, who is the staff director for the subcommittee, also here on the podium with us here today.

The manner in which we'll proceed, first I'll make an opening statement. Then I will yield to Mr. Pappas for his opening statement. Then we will hear from our witnesses. Today we have two panels. At the conclusion of that time, if we can, we will be glad to allow others to make brief statements.

I might also say that it is the practice and custom of our subcommittee to invite written comments, and I will leave the record

open for at least 1 week so that your comments or recommendations become part of the record of this congressional hearing.

Today, we will look at a very important issue and program, the Federal Employees Health Benefits Program or FEHBP, as many of us call it. Specifically, we are here to gather information about Medical Savings Accounts or MSAs. As we consider adding MSAs as a health insurance option in the Federal employee benefit program, it is important that we hear from those who have been involved with this type of health care service and hear first hand from those individuals. So that is why our subcommittee came into the field today.

The growing cost of healthcare is of great concern to many of us. Last year, Federal employees experienced, on average, an increase of more than 15 percent in their share of healthcare premiums. Now, if you have a 15 percent increase in healthcare insurance premiums on average, and our average Federal employee received a 2.8 percent pay increase, and our average Federal retiree received an average increase of 2.7 percent, that can have quite an impact on their pocketbook.

Our committee is responsible for finding alternatives that will help control costs, but hopefully do not interfere with the doctor/patient relationship. I personally believe that MSAs should be explored as such an alternative.

Federal employees who participate in the Federal Employees Health Benefits Program know that it is, in fact, a well-managed system. But to provide our employees and retirees with the best choices available, we must be flexible and adapt to changing circumstances. In the 1980's when HMOs first came on the scene, the FEHBP program was expanded to include HMOs as an option. Now many Federal employees are, in fact, happy in their HMOs. But if Congress had listened to the naysayers, the same naysayers who oppose MSAs today, Federal employees would have been denied that option. As times change, our Federal programs and our Federal options change. That is again one reason why we are here today.

Of course I would be the first to acknowledge that many Federal employees are concerned about the practices of some HMOs and other managed care providers. In a meeting just before this, we discussed it. I commented that the law has not kept up with the new service delivery system such as HMOs. That is one of the important questions before Congress as we return this week as a matter of fact.

Some Federal employees and retirees fear that healthcare rationing by HMO and insurance company so-called bean counters, that we have that. They want to choose their own doctors. They believe that healthcare decisions should be made by the individual employer, retiree, and their doctors. I support their opinion on those issues.

Some say more Government regulation is the only way to deal with these problems. But Government regulators can be just as incentive and inflexible as private sector bureaucrats. We need alternatives that return control to the consumer.

Economists across the political spectrum have concluded that an important factor driving the cost of healthcare coverage is our third

party payment system. Patients are often insulated from the cost of their medical services by the fact that someone else, perhaps insurance, Medicare or Medicaid, will pay the cost. MSAs provide one method of dealing with some of these problems. They allow more choice in medical services available to consumers. At the same time, they give people greater control over healthcare spending.

MSAs combine a savings account to cover out-of-pocket medical expenses, with a higher deductible insurance plan to cover major medical expenses. MSAs also have the additional benefit of being completely portable. In contrast to standard employer health paid insurance, MSAs will follow the individual regardless of changes in their employment status. Funds in MSA accounts can be used to purchase medical insurance during lapses in employment.

Congress has allowed individuals in the private sector to take advantage of the MSAs. Federal employees, too, are vitally concerned about both the quality and cost of healthcare for themselves and for their families. They work hard to serve the public. They should not be denied, in fact, the same freedom of choice now available to our private sector employees.

We have invited today two panels of expert witnesses to our hearing. But this is not a congressional hearing where Washington brings experts to New Jersey to sell you another Government program. No, in fact, our witnesses are from your community here in New Jersey. They provide expertise based on their experience. Hopefully we can learn from their expertise, and that expertise will be a benefit to us and in national interest.

We will be listening carefully to each of our witnesses today, and to their testimony and their recommendations to our panel. I will go into the list of the witnesses after we hear from our vice chairman. If he has an opening statement, he is recognized.

Mr. PAPPAS. Thank you, Mr. Chairman. Ladies and gentlemen, thank you for attending and thank you especially to the folks here at Fort Monmouth for their cooperation.

Mr. Chairman, let me begin by thanking you for holding this hearing at Fort Monmouth, and welcome those of you, certainly from the committee and staff and others through the 12th district, the heart of the Garden State. I hope all of you that traveled here today take some time to look around and explore what we are very proud of here in this part of the State, a very historic area and very beautiful county of Monmouth. If the weather were a little bit better, we might be able to hold the hearing on the beach or the Jersey Shore, as those of us from New Jersey call it. It's only a few miles from here. But if the weather doesn't improve, Mr. Chairman, we may want to hold the next hearing in your district in Florida.

We are truly honored today to have such——

Mr. MICA. Excuse me. Are you inviting the audience to come with us? We might have a deal here. [Laughter.]

Mr. PAPPAS. We are truly honored today to have such a prestigious panel of witnesses, who are themselves in some instances practitioners, policymakers and others from the private as well as the public sector. Once again, thank you very much for the trouble that you have taken to be here.

Mr. Chairman, I can't think of a better place to hold this hearing today than Fort Monmouth. Just over 6,000 Federal employees, Fort Monmouth owes its success to the hard work of its civilian and defense employees. Fort Monmouth is at the forefront of cutting edge technology and communications that's providing our Nation with the army of the future today. Just as Fort Monmouth is at the cutting edge of technology, many argue Medical Savings Accounts or MSAs are at the forefront of the healthcare industry.

Medical Savings Accounts are currently available in the private market to employees who work for small businesses and the self-employed. Beginning in January 1999, Medicare beneficiaries will also have the opportunity to enroll in MSAs. I am grateful that we are going to examine whether Federal workers should have the same option that is or will soon be available to other Americans.

By offering MSAs as another option in the Federal Employees Health Benefits Program or FEHB, Federal employees and their families may well have the opportunity to take control of their own health care decisions, including choosing their own doctors rather than Government, insurance companies, or providers, employees will be able to choose their own health care.

Under current legislation being considered by the Congress, Federal employees will be able to choose an MSA option combined with a high deductible catastrophic policy. The annual deductible limits are identical to those currently permitted for private market MSAs, $1,500 to $2,250 for individual coverage, and annual out-of-pocket cap on expenses of not more than $3,000, and $3,000 to $4,500 for family coverage, an annual out-of-pocket cap on expenses of no more than $5,500.

Contributions made to the MSA and any interest on the account will accumulate tax free. Should the worker retire prior to age 65, he or she can continue coverage through the high deductible health insurance plan and continue to make contributions through his or her MSA.

I am looking forward to hearing the testimony of our panel of witnesses on whether the Government should expand choice to Federal workers, thereby helping improve their healthcare coverage and reduce healthcare costs.

Specifically, I am interested in determining if the Medical Savings Account option will further strengthen and improve the FEHB Program by expanding the array of choices in the program. Again, I want to extend a welcome to everyone here, and thank the chairman for making this hearing possible.

Mr. MICA. Again, I want to thank you, Mr. Pappas, for hosting our congressional subcommittee this morning. Mr. Pappas asked unanimous consent that we enter into the record a statement from our ranking member, Mr. Elijah Cummings, the gentleman from Maryland. Without objection, it is so ordered.

[The prepared statement of Hon. Elijah E. Cummings follows:]

OPENING STATEMENT OF THE HON. ELIJAH CUMMINGS
RANKING MEMBER
SUBCOMMITTEE ON CIVIL SERVICE
HEARING MEDICAL SAVINGS ACCOUNTS AS AN OPTION UNDER UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

March 9, 1998

Mr. Chairman, the Federal Employees Health Benefits Program (FEHBP) is a proven, competitive health benefits plan which has served Federal employees and their families since 1960. Just a few years ago, during Congressional consideration of health care reform legislation, FEHBP was roundly hailed as a model for the nation because of the wide array of health plans offered, and effective cost containment.

As successful as FEHBP has been, I have no doubt that it can be improved. Studies done during the 102nd and 103rd Congresses by consultants to the House Post Office and Civil Service Committee recommended many changes that were never implemented as that Committee's work on FEHBP was eclipsed by the national broader health care reform effort. In 1994, the Committee reported a bill that would have opened enrollment in the existing program to nonfederal employees. That proposal went no further. No further action has been

taken on legislation that would change the nature or scope of the program.

Last month, legislation was introduced that would allow for high deductible health plans and medical savings accounts to be made available as an option under FEHBP. The bill, H.R. 3166, the Federal Employees Health Care Freedom of Choice Act, is not specifically the focus of today's hearing. Its subject matter, however, clearly is.

This is not the first time that the Civil Service Subcommittee has examined the MSA issue. A previous hearing was held in December 1995. Testimony was received from local government officials from two different jurisdictions about MSA plans they had established for their public employees. At the time, however, these programs -- in Jersey City, New Jersey, and Ada County, Idaho -- had only been underway a few months and its was too early to evaluate the level of participant satisfaction and the overall impact on health insurance costs.

It is my understanding that since that hearing, both jurisdictions have terminated their MSA plans as the result of sky rocketing costs. I am pleased that the Mayor of Jersey City is back before the Subcommittee today to update us on his experience with MSAs. I want to know why Jersey City's program failed? I also want to know if, in light of the failures in Jersey City and Ada County, he still believes, as he did in December 1995, that it would be a good idea to make MSAs a part of FEHBP?

Whether or not providing the option to participate in medical savings accounts would improve FEHBP or ruin it is the issue before the Subcommittee today. There are many more questions that I would like to have answered by the other witnesses who will appear in order to help me form a judgement about this. I would like to know:

* What is the nature and extent of favorable tax treatment necessary to make MSAs viable and attractive?

* What minimum and maximum limits should be placed

on the dollar amounts to be deposited into the accounts?

* What types and what percentage of employees would likely be attracted to MSAs?

* What rules might be needed to forestall adverse selection? and

* What would the effect be on overall FEHBP premium rates?

Mr. Chairman, MSAs are controversial and the issues surrounding them are complex. I hope that today's hearing will enable us to determine their true merits.

Thank you Mr. Chairman.

Mr. MICA. Our first panel this morning consists of four individuals. Our first witness is Mayor Bret Schundler of Jersey City, who testified at one of our hearings some time ago in Washington. We'll be getting an update from the mayor on some new and interesting information he has to provide, and also share with us the experience they have had with MSAs in Jersey City, NJ.

He will be joined by Alieta Eck, whose family opted out of traditional insurance that became prohibitively expensive. We'll also hear from Dr. Joseph Cauda, and another doctor, Dr. Sidney Goldfarb, both New Jersey physicians, who believe that the interest in MSAs on the part of doctors hopefully will be a prescription that could benefit all of our Federal employees and retirees.

I would like to invite our first panel to come forward. As they do, I might indicate for those in attendance, and also our witnesses, that this an investigations and oversight subcommittee of Congress, part of the Government Reform and Oversight Committee, which is the chief investigative and oversight audit arm of the House of Representatives. In that capacity, we do swear in all of our private citizen witnesses. So if you will please raise your right hands.

[Witnesses sworn.]

Mr. MICA. We'll let the record reflect that the witnesses answered in the affirmative.

Will you please be seated? I would like to welcome you again. I will also set the ground rules for our hearing this morning. Mayor Schundler has been before us before. What we do is we allow 5 minutes. We have a little timer over here. We would be glad if you would give a 5-minute presentation. We do give a little bit of leeway on the oral presentation, however, you are permitted to enter and provide for the subcommittee any lengthy statements or documents. They will be, upon request, made a part of the official record of this hearing.

So with those opening comments, again, I would like to welcome our panelists. I will recognize, first, the mayor. Welcome back to our panel. We are anxious to hear your statement and the experience with MSAs. Welcome. You are recognized, sir.

STATEMENTS OF BRET SCHUNDLER, MAYOR OF JERSEY CITY; ALIETA ECK, M.D., PHYSICIAN; JOSEPH CAUDA, M.D., SURGEON; AND SIDNEY GOLDFARB, M.D.

Mr. SCHUNDLER. Thank you and good morning, Chairman Mica and members of the subcommittee. It's a great pleasure to be with you. I am appearing before you today again to encourage you to include Medical Savings Accounts as part of your Federal Employees Health Benefits Program.

My last testimony, you will remember——

Mr. MICA. Mayor, could you pull—I don't know if that mic has a cord——

Mr. SCHUNDLER. What I'll do is I'll try to get closer to it.

Mr. MICA. As close as you can get. I think it will pick you up better. That's it. Thank you.

Mr. SCHUNDLER. As you recall, my last testimony before you on this issue was in December 1995. For those who were not Members

at this time, I'll briefly explain our experience in Jersey City with Medical Savings Accounts.

In 1994, Jersey City became the first governmental entity in the United States to offer Medical Savings Accounts to its employees. We wanted to conduct an experiment with MSAs, so we obtained permission to withdraw temporarily our management employees from the New Jersey State Health Benefits Plan to enroll them with Blue Cross/Blue Shield of New Jersey, who was in fact the manager of the State Health Benefits Plan at the time. So we didn't even have to change people that the city was working with.

Our management employees were allowed to choose either from the three options that were constructed to exactly mirror the State Health Benefits Plan, which are a low deductible, fee-for-service indemnity option; an HMO option; and a Preferred Provider Option. Or a fourth new option, Medical Savings Accounts.

Fifty-six percent of our management employees chose the Medical Savings Account option, including all of those who had previously opted for the standard indemnity option. Under our Medical Savings Account plan, the city purchased the catastrophic insurance policy that covered 100 percent of a family's medical costs above a $2,000 deductible. The city then placed an additional $1,800 in a Medical Savings Account that an employee could draw down to pay for most of that deductible for his family. There was a $1,400 amount for individual policies. Putting these elements together meant that a family of four would at most have to pay $200 in out-of-pocket deductible expenses for medical care in any given year. That $200 contribution came in the form of a back-end deductible. In other words, an employee would not have to reach into his pocket for the first $200 of medical costs until the $1,800 in the Medical Savings Account had already been expended. If a family's total healthcare costs fell below $1,800 in a given year, the money remaining in a Medical Savings Account was refunded to the employee at year's end. The employee was free to use that money as he or she saw fit.

Employee satisfaction with Medical Savings Accounts was extremely high. The vast majority of new city employees choosing healthcare options opted for the Medical Savings Account plan. Even initial foes to this experiment among the city's civil service management employees, soon came to praise the plan. This shouldn't come as a surprise. In comparison with the standard indemnity plan, a Medical Savings Account reduced out-of-pocket healthcare expenses for major healthcare users, gave money back for minor healthcare users. In fact, the average employee family received $1,100 back at the end of the year, and it preserved absolute freedom of choice for all.

What we set out to prove in Jersey City was that Medical Savings Accounts would prove less expensive than traditional low-deductible indemnity plans, and would provide superior health coverage for employees. Four years later, we are confident that our experience has proved successful. With final renewal pricing based on several years of real claims experience, the renewal cost to the city for families choosing the Medical Savings Account option, including both the catastrophic premium and the Medical Savings Account

contribution costs, was $997 a year less than the renewal cost for a family choosing the traditional low deductible indemnity option.

The HMO option also continued to be priced cheaper than the indemnity plan. But the HMO option achieved this cost efficiency through third party rationing of medical care. Our MSA option, in contrast, achieved this cost saving while preserving full employee choice relative to healthcare providers and services.

The ability of individuals to control their own healthcare decisions is growing more and more endangered in our current national healthcare environment. With our MSAs, patients were able to choose the doctors they wanted to see and the procedures they wanted to receive. I think this is an extremely significant healthcare advantage of the MSA option compared to the HMO option.

We were ultimately forced to return our management employees to the State Health Benefits Plan. Our city employees tend to be older than the State average. Many have disabilities and illnesses. Some take part-time jobs with the city just for health insurance to pay their ailments. By switching back to the State plan, Jersey City employees will now be grouped with a much larger and healthier pool of individuals.

We are now endeavoring to have the State plan offer an MSA option. We will be pushing hard for the State to implement such an alternative. As we showed in Jersey City, the MSAs would quickly become the most popular healthcare option for New Jersey State and local employees, would save employers, in this case taxpayers, money, and would accomplish this while granting freedom of choice over medical care to participants, a freedom that all Americans cherish.

You will see from my comments that I have written out that I think this would have tremendous benefits, not only for employees and for the Federal taxpayer, but I think you would accrue a significant appreciation for our congressional representatives who had the foresight to introduce this option for Federal employees.

[The prepared statement of Mr. Schundler follows:]

Testimony of the Honorable Bret Schundler
Mayor, Jersey City, New Jersey
Before the House Civil Service Subcommittee
Hearing on Medical Savings Accounts in the
Federal Employees Health Benefits Program
Ft. Monmouth, New Jersey
March 9, 1998

Chairman Mica and Members of the Subcommittee on Civil Service

Good morning. I am appearing before you today to again encourage you to include Medical Savings Accounts (MSAs) as an option in the Federal Employees Health Benefits Program. My last testimony on this issue in front of your committee was in December 1995. For those of you who were not members at that time, let me briefly explain our experience in Jersey City with MSAs.

In 1994, Jersey City became the first governmental entity to offer MSAs to its employees. In order to conduct an experiment with MSAs, we obtained permission to withdraw temporarily our management employees from the State Health Benefits Plan to enroll them with Blue Cross/Blue Shield of New Jersey.

Our management employees were allowed to choose either from three options that exactly mirrored the State Health Benefit Plan--a low-deductible, fee-for-service indemnity option; an HMO option; a Preferred Provider Option--or a fourth, new option: MSAs. Fifty-six percent of our management employees chose the MSA option, including almost all of those who had previously opted for the standard indemnity option.

Under our MSA plan, the city purchased a catastrophic insurance policy that covered 100 percent of a family's medical costs above a $2,000 deductible. The city then placed an additional $1,800 in a medical savings account that the employee could draw down to pay most of that deductible. Putting these elements together meant that a family of four would, at most, have to pay $200 in out-of-pocket deductible expenses for medical care in any given year. That $200 came in the form of a "back end" deductible. In other words, the employee would not have to reach into his pocket for the first $200 of family medical costs until the $1,800 in the MSA had been expended. If a family's total health-care costs fell below $1,800 in a given year, the money remaining in the MSA account was refunded to the employee at year's end. The employee was free to use that money as he or she saw fit.

Employee satisfaction with MSAs was extremely high. The vast majority of new city employees choosing health-care options opted for the MSA plan. Even initial foes of this experiment among the city's civil-service management employees soon came to praise the plan. This should come as a no surprise. In comparison with the standard indemnity plan, our MSA option reduced out-of-pocket health-care expenses for major health-care users, gave money back to minor health-care users (the average employee family received $1,100 back at the end of the year), and preserved absolute freedom of choice for all.

What we set out to prove in Jersey City was that MSAs would prove less expensive than traditional low-deductible indemnity plans and provide superior health-care coverage for our employees. Four years later, we are confident our experiment has proved successful. With final renewal pricing based on several years of real claims experience, the renewal cost to the city for families choosing the MSA option (including both the catastrophic premium and the medical savings account contribution costs) was $997 a year less than the renewal cost for a family choosing the traditional, low-deductible indemnity option. The HMO option also continued to be priced cheaper than the indemnity plan. But the HMO option achieved its cost efficiency through third-party rationing of medical care. Our MSA option, in contrast, achieved this cost saving while preserving full employee choice relative to health-care providers and services.

The ability of individuals to control their own health-care decisions is growing more and more endangered in the current national health-care environment. With our MSAs, patients were able to choose the doctors they wanted to see and the procedures they wanted to receive. I think this is an extremely significant health-care advantage of the MSA option compared to the HMO option.

We were ultimately forced to return our management employees to the State Health Benefits Plan. Our city employees tend to be older than the state average; many have disabilities and illnesses. Some take part-time jobs with the city just for the health insurance to pay for their ailments. By switching back to the State plan, Jersey City employees will now be grouped with a much larger and healthier pool of individuals.

We are now endeavoring to have the State Plan offer an MSA option. We will be pushing hard for the state to implement such an alternative. As we showed in Jersey City, MSAs would quickly become the most popular health-care option for New Jersey state and local employees, would save employers (in this case the taxpayers) money, and would accomplish this while granting freedom of choice over medical care to participants--a freedom that all Americans cherish.

You, too, should offer medical savings accounts to your employees. As members of Congress, you could take the lead in national health-care reform by starting it in your own backyard. Also, as candidates for reelection, imagine how happy federal employees will be with you if the average employee family is able to save, as was the case with our experience, $1,100 each year, or at worst (if their health care usage is high) are enabled to reduce their out-of-pocket expenses.

Also imagine how happy taxpayers will be with you for the tax savings you provide. Imagine, too, how happy doctors and pharmacists will be with you for helping to move America away from the darkening nightmare of having to deal with arbitrary HMO rules.

Your example could move huge numbers of private employers to follow suit. The anti-inflationary impact of the MSA approach, which creates first-party incentives to obtain value for every health-care dollar, could even help preserve the solvency of Medicare and help to keep health care affordable for all.

We in Jersey City had a tremendously positive experience with MSAs. By providing MSAs on a large scale to federal employees, you could send the nation a message about the benefits of MSAs. I strongly encourage you to implement an MSA option for federal workers to show the nation how to provide quality care at lower costs, while at the same time returning freedom of choice in health care to the consumer.

Thank you!

The Honorable Bret Schundler
Mayor, Jersey City, New Jersey

Supplementary Statement to Testimony Delivered at
Ft. Monmouth, New Jersey
March 11, 1998

A question has been raised as to why Jersey City has re-enrolled its management employees in the State Health Benefits Plan, given the success of its experiment with medical savings accounts. This amendment to my earlier testimony seeks to respond to that question.

When purchasing health care for its employees, any organization has to answer two questions for itself. First, does it want to stand alone when purchasing health insurance, or be part of a larger group? Second, what kind of health care options does it want its employees to receive?

Relative to the first question, Jersey City does NOT want to stand alone. On average, our employees use more health care than other members of the State Health Benefits Plan. By becoming part of the State pool, we essentially receive a partial subsidy, resulting in lower premiums for the City, whether we are talking about the cost of providing HMO, PPO, standard indemnity, or MSA coverage for our employees.

Relative to the second question, we do want the State plan to offer an MSA option. We want our employees to have lower out-of-pocket expenses when their health care usage is high. We want them to receive money back when their health care usage is low. And we like the fact that offering an MSA option will save the State money, compared to its cost for offering the standard indemnity option.

HMOs are fine for employees who are willing to give up control of their health service buying decisions to a third-party rationer, but most of our employees reject that option. That is why the standard indemnity option was the most popular option among our managers before Jersey City left the State Health Benefits Plan.

Given the fact that all City employees who had previously chosen the standard indemnity option opted for the medical savings account option once it was offered, it is clear that the State, if it is going to continue to offer a standard indemnity plan at all, should offer an MSA option as well. It will cost state taxpayers less to offer and make state and municipal employees much happier than they are today with their current three coverage options.

In conclusion, we here in Jersey City do want to be part of the State Health Benefits Plan and we also want to see the State add an MSA average to its current menu.

Mr. MICA. Thank you, Mayor Schundler.

We'll withhold the questions until we finish the panel. I would like to recognize Dr. Eck now, please.

Dr. ECK. I come before you today as a physician as well as a healthcare consumer. I have studied the history of our healthcare system from the development of penicillin to the inception of the huge Government programs, Medicare and Medicaid in 1965, to the phenomenal healthcare inflation that has ensued. I am convinced that every time the Government has intervened to "help" it has made things a little bit worse. The Government cannot and should not be making medical decisions, yet it cannot help but do so when it has decided it is going to pay the bills. Now I realize the Government as an employer is different from the Government as the provider of healthcare to people who are not under their employment. So I want to make a distinction there. So Medicare and Medicaid are different from the Government employees.

But let me just continue. The question before us is whether Medical Savings Accounts should be offered to Federal employees. But the broader question is whether or not they are good policy at all. If so, what should they look like? It is clear that we can't provide an infinite amount of healthcare to every American. Now I know that is an unpopular thing to say, but it is just like saying we can't say every American deserves a Cadillac and so let's just buy one for everyone, or everyone deserves to live in a 10-room mansion. Obviously economics would say that we cannot do that.

So someone has to decide in healthcare where to draw the line. The question is who. Should it be an HMO executive? Should it be the Government? Should it be the physician? Or should it be the individual patient? I believe that there are great pitfalls with a disinterested third party or the Government making rationing decisions. Physicians when unrestrained will do as much as possible for every patient. This leaves the individual patient and his family being the best ones to decide, provided that they care what the care costs, and thus will not overuse it.

Medical Savings Accounts pay for the routine and preventative care, coupled with high deductible indemnity insurance, leaves the patient with the most control over his own destiny. This is why they are an excellent idea.

If I had my way, there would be two requests I would have of our Government that would do the most to solve the healthcare cost crisis. Once the cost crisis is taken care of, it will be much easier for us to take care of the poor.

First, move the tax break for healthcare from employers to individuals. This would cause the insurance companies to have to compete for individual consumers rather than employers, and would allow people to choose the best priced plan for the value provided.

Second, we have to stop piling new laws on top of bad laws to fix the problems that the Government has caused. A great example would be the new Patient Protection Act that's currently being promoted. Patients are being forced into HMOs that they hate because their employers put them there. HMOs exist largely because the Government has mandated that large employers offer them. But they exist for the purpose of concealing the fact that they are rationing medicine. Now the Government has to micromanage the

HMOs to keep them from hurting the very patients that they are pretending to help. I realize I am rather negative about HMOs, but I have just had so much experience with them that I can't help but be so.

I happen to live in a State that has essentially enacted the Kassebaum-Kennedy legislation 3 years before the Federal Government did. It is so bad that the rest of the country is being told to look at New Jersey to see what will happen to them if they don't fix things quickly. Since 1992, New Jersey has had guaranteed issue and community rating, two provisions which mean that people can wait until they are sick to buy insurance, and that insurance companies cannot ask any health questions. It means that 20-year olds have to pay the same rate as 64-year olds. Every principle of insurance is violated, similar to our being able to rush out and buy fire insurance while the fire fighters are already putting out the fire in our house.

As in every new program, it seemed to work well at first. But now, the fallout is occurring. Predictably, the young and healthy people are dropping out, leaving older and sicker people to pay higher and higher rates.

Another feature of New Jersey insurance is that they mandate coverage of $300 per person for preventative care, such as immunizations, blood work, mammograms, routine physicals. These are the type of things that ought not to be covered by insurance at all, but should be paid out of MSAs. They are not insurable events. They are events that we know we are going to need. They simply drive up the cost of insurance.

Personally, our family rates were going from $585 per month up to $870 per month for $1,000 deductible policy. Therefore, we dropped our own personal health insurance in June 1997. A friend just informed us that he received notice that his rates are about to double this coming April. He is about to drop out as well. As we might expect, many people are begging the Government to do something. But I suggest that they have done enough damage already.

Since starting our medical practice in 1988, my husband and I have been outspoken proponents of Medical Savings Accounts. It makes perfect sense that the best way to eliminate administrative costs would be to eliminate the administrators. MSAs do exactly that. People would only access the health care that is worth their hard-earned cash. They would not need to submit claim forms to be scrutinized and reviewed and denied. Then they would get high deductible insurance only for unforeseen medical catastrophes. Several years back when Congress was debating it, I was right there trying to promote Medical Savings Accounts, and when they had that law that said that 750,000 new accounts could be started, you would have thought that we would have been the first ones there to get one. But we found out that the insurance industry and the mandates on insurance made them so expensive that they were not worth the money that they would cost. It would have cost us $545 a month for a $4,500 deductible policy. We turned it down.

If I have just another minute, I could tell you what we actually did. We have been fortunate. We found a program that the Government hasn't been able to mess up, frankly. Our family has enrolled

in something called a Christian Brotherhood Newsletter, a system that allows us to give a gift to some family in the United States that will help them pay their healthcare bills. Amazingly, this system only asks us to give $300 a month. If we have a medical event that exceeds $200, we can obtain help from other Christian Brotherhood families. It's not insurance. A voluntary system instead that has worked for the past 15 years. It covers 80,000 people. It has been instrumental in the paying of $4.3 million in healthcare bills per month.

We started this last June. We have been putting the same $585 we were spending on insurance away in our Medical Savings Account, giving $300 to a Christian Brotherhood family. To date, we have $3,000 that's now sitting in our Medical Savings Account, which we can use for routine healthcare.

We can't claim a deduction under Kennedy-Kassebaum. We don't fall under their guidelines, but we are still way ahead. So, thank you very much. We're doing fine with our Medical Savings Account.

Healthcare inflation began when the Government got involved. If the Government stays involved, rationing will become the only solution. The only other alternative is freedom. Medical Savings Accounts are the best way to provide that freedom. Thank you.

[The prepared statement of Dr. Eck follows:]

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Testimony before the Committee on Government Reform and Oversight
Civil Service Subcommittee—March 9, 1998
Fort Monmouth, NJ

I come before you today as a physician as well as a health care consumer. I have studied the history of our health care system, from the development of penicillin to the inception of the huge government programs, Medicare and Medicaid in 1965, and to the phenomenal health care inflation that has ensued. I am convinced that every time the government has intervened to "help," it has made things a little bit worse. The government cannot and should not make medical decisions—yet it cannot help but do so, when it has decided to pay the bills. The question before us is whether Medical Savings Accounts should be offered to federal employees. The broader question is whether or not they are good policy at all—and if so, what should they look like?

It is clear that we cannot provide an infinite amount of health care to every American. Someone has to decide where to draw the line. The question is "Who?" Should it be an HMO executive, the government, the physician or the individual patient? I believe there are great pitfalls with a disinterested third party or the government making rationing decisions. And physicians, when unrestrained, will do as much as possible for every patient. This leaves the individual patient and his family being the best ones to decide—provided that they care what the care costs and thus will not overuse it. Medical Savings Accounts to pay for the routine and preventative care, coupled with high deductible indemnity insurance, leaves the patient with the most control over his own destiny. This is why they are an excellent idea.

If I had my way, there would be two requests I would have of our government that would do the most to solve the health care cost crisis. And once the cost crisis is taken care of, it will be much easier to care for the poor:

1) First--move the tax break for health care from employers to individuals. This would cause the insurance companies to compete for individual

consumers rather than employers, and would allow people to choose the best priced plan for the value provided.

2) Second—stop piling new laws on top of bad laws to fix the problems that government has caused. A great example would be the new "Patient Protection Act" that is currently being promoted. Patients are forced into HMO's that they hate because their employers put them there. HMO's exist largely because the government has mandated that large employers offer them. But they exist for the purpose of concealing the fact that they are rationing medicine. And now the government needs to micromanage the HMO's to keep them from hurting the very patients they are pretending to help.

I happen to live in a state that essentially enacted the Kassebaum-Kennedy legislation three years before the federal government did. It is so bad that the rest of the country is being told to look at New Jersey to see what will happen to them if they don't fix things quickly. Since 1992, New Jersey has had "guaranteed issue" and "community rating," two provisions which mean that people can wait until they are sick to buy insurance, that the insurance company cannot ask any health questions, and that 20-year-olds must pay the same rate as 64-year-olds. Every principle of insurance is violated, similar to our being able to rush out and buy fire insurance even as the firefighters are trying to put out the fire. As in every new program, it seemed to work well at first, but now the fall-out is occurring. Predictably, the young healthy people are dropping out, leaving the older, sicker people to pay higher and higher rates. Another feature of NJ insurance is that they mandate coverage of $300 per person for preventative care such as immunizations, blood work, mammograms, routine physical and EKG's. These are the type of things that ought to be paid for out of the MSA's—they are not "insurable events." They simply drive up the insurance rates unnecessarily. Our family rates were going from $585 per month to $870, for a $1000 deductible policy. We dropped our personal family coverage in June of last year. A friend just informed us that he received notice that his rates are about to double this coming April, so he is dropping his coverage as well. As we might expect, many people are begging for the government to "do something," but I would suggest that it has done enough damage already. How about getting out of the way?

Since starting our medical practice in 1988, my husband and I have been outspoken proponents of Medical Savings Accounts. It makes perfect sense that the best way to eliminate administrative costs would be to eliminate the administrators, and MSA's would do just that. People would only access health care that was worth their hard-earned cash, they would

not need to submit claim forms to be scrutinized and reviewed and denied. And they would only need high deductible insurance for the unforeseen medical catastrophes. Several years back, when the Congress was debating the MSA concept, I was right there, arguing on their behalf and pushing for their enactment. I valued freedom and was not willing to be told by the government or an HMO what I could and could not get. My patients were being increasingly herded into HMO's against their will, and I was fighting for their freedom to choose. When the law finally passed, allowing for the 750,000 new MSA's as a trial, you would have expected our family to be the first to sign up. The trouble came when we searched for the policy that we could purchase to meet the requirements of the new law. To my dismay, a $4500 deductible family policy, the only one offered in NJ, cost a phenomenal $545 per month. I turned it down. It was not worth our hard-earned money.

We have been fortunate though. We have found a program that the government has not been able to mess up. Our family has enrolled in the Christian Brotherhood Newsletter, a system that allows us to give a gift to some family in the United States each month that will help them pay their health care bills. Amazingly, this system only asks us to give $300 per month, and if we have a medical event that exceeds $200, Christian Brotherhood families will help us. This is not insurance, but a voluntary giving system that has worked for the past 15 years, covers 80,000 people, and has been instrumental in the paying of $4.3 million in health care bills per month. We started this last June, and have systematically put the $585 we were paying for insurance, into our own Medical Savings Account. From that account, we are paying the $300 per month to a real family with a real need. We have managed to save $3000 in premiums and that is building with interest in our MSA, waiting for the time when we will need it. It is OUR money—not insurance company profits. We cannot claim a tax deduction under Kassebaum-Kennedy, because we do not have the mandated health insurance policy required, but we are still way ahead.

My last request to my government would be this. If we could help people to understand that health insurance is just another way that they are compensated for their work, they might value the cash instead. If federal employees could have medical savings accounts from which they would purchase their own health care and catastrophic insurance, they would be on their way to being able to obtain the best health care with the fewest strings attached. They would be able to join and develop voluntary cost-sharing programs such as the Christian Brotherhood Newsletter. Federal employees should not have better or worse health care than the taxpayers who pay their salaries. They just should have the same freedom that we have personally found.

Health care inflation began when the government got involved. If the government stays involved, rationing will become the only solution. The only other alternative is freedom, and Medical Savings Accounts are the best way to provide that freedom.

Mr. MICA. Thank you for your testimony. I'll recognize Dr. Cauda next.

Dr. CAUDA. Thank you. It's an honor to be here this morning as an ordinary citizen who practices surgery only a stone's throw from Fort Monmouth. My name is Joseph Cauda. I graduated from medical school in 1980.

Mr. MICA. Just a second. I'm not sure if you are being picked up.

Dr. CAUDA. Yes. My name is Joseph Cauda. I graduated from medical school in 1980. I had 6 years of post-graduate training. I started practice as a general surgeon in 1986. Over that period of time, I have witnessed the steady erosion in the quality of our healthcare system, both from the doctor's and patient's point of view.

Escalating costs were inevitable with the technological explosion. Twenty years ago, CAT scanners were just coming on the scene. MRIs were practically science fiction. The equipment necessary to remove a gall bladder could be reused literally thousands of times. Today, CAT scans and MRIs can be found in almost every small town hospital throughout the United States. A gall bladder operation is done with four puncture wounds, which enables a patient to leave the hospital within 24 hours out of surgery. But this requires the use of expensive high tech equipment, sometimes discarded after only one use.

These are only some minor examples of how medicine has changed, but each one has made your life better. One thing that has not made either the patient's or the doctor's life better is the current insurance system. As the cost of low deductible, traditional indemnity insurance has climbed, HMOs have taken its place. They provide managed care. One wonders who is managing what kind of care.

I will give you an example of how managed care has affected my patients. One night I received a phone call from the emergency room. I was awakened from my sleep and I was asked if I accept a certain HMO. I frankly wasn't sure. The emergency room doctor stated that he had a very sick patient who likely needed surgery, but could not find a surgeon who participated in the plan.

Now let me ask everyone here, is this the conversation that two physicians should be having in the middle of the night concerning an emergency? Or should they be discussing the vital signs and other information pertinent to the patient's health?

I went in and took care of the patient. The patient did fine. But these types of delays are so common with the routine treatment of patients in emergency room, it's obscene. This is not an unusual story.

The average duration of time a person remains in a given HMO is about 20 months. Most people do not like the fact that an insurance company limits them to certain doctors or hospitals. As they change plans, they have to change the doctors and hospitals. They also resent the fact that a clerk in the insurance company may decide on whether a test or a procedure deemed necessary by the doctor is truly needed. It's about time that the consumer of medical care, the patient, once again have the right to make decisions about his health.

People are asked to make dozens of decisions each day that affect their lives. Suddenly we are told that we need a big brother to make choices that directly impact our lives and our health.

The doctor-patient relationship is vital to this decisionmaking process, but it is eliminated in managed care. This trusting relationship is developed over the years as a result of a physician's skill in the science and art of medicine. Because of this bond, the physician becomes the patient's advocate, unlike the clerk in an insurance company.

A well-informed patient is not only equipped to seek proper medical care, but the most economical care if allowed. Rand Corporation studies show that the medical consumer, when faced with out-of-pocket costs, that is to say with higher deductible policies, they make more responsible choices than those in low deductible plans. Medical Savings Accounts will help return medical care to the patient and the doctor. They will eliminate the mindset of rationed care and replace it with responsible care.

Since most people, up to 90 percent, do not utilize $3,000 per year, the amount of paperwork can be drastically reduced. Some estimates have MSAs reducing administrative costs by $33 billion a year by eliminating all these low dollar claims as patients come in with their sore throats or whatever low dollar problem they have. This all generates paperwork. The increased manpower necessary to process these claims and obtain clearance for procedures has greatly increased my office payroll as well.

I will leave it to other speakers to discuss the benefits economically of the MSAs. We have heard some from Mayor Schundler and from Dr. Eck. The present system of tax-free employer provided health insurance benefits highway journeyers. MSAs help lower income families to gain access to better and more complete health care. For example, the person that paints your house, I recently had a wallpaperer come in. He told me he didn't have health insurance because he couldn't afford it. He is self-employed. This is not tax deductible for him. If he was employed by somebody else, it would be tax deductible to the employer. This should stop.

Hopefully, with increasing support, Congress will expand the availability of MSAs to all who will choose them. Also, legislation is needed that would support MSA surpluses to be rolled over to IRAs. This could help low income families provide future medical expenses or retirement. The excess may even some day help supplement the present Social Security or Medicare method of pay as you go funding.

In closing, I would like to emphasize that we must take back control of our healthcare. We must have the liberty to choose our own doctors and course of therapy, unrestrained by a third party that only looks at the bottom line. Thank you.

[The prepared statement of Dr. Cauda follows:]

My name is Joseph Cauda. I graduated from medical school in 1980 and had 6 years of post graduate training. I started practice as a general surgeon in 1986. Over that period of time I have witnessed a steady erosion in the quality of our health care system, from both the doctor and the patient's point of view. Escalating costs were inevitable with the technological explosion. Twenty years ago CAT scanners were just coming on the scene. MRIs were practically science fiction. The equipment necessary to remove a gall bladder could be reused literally thousands of times. Today, CAT scans and MRIs can be found in almost every small town hospital throughout the USA. A gallbladder operation is done with 4 puncture wounds but requires the use of expensive high tech equipment sometimes discarded after one use.

These are only some minor examples of how medicine has changed, but each one has made your life better. One thing that has not made either the patients' or the doctors' life better is the current insurance system. As the cost of low deductible traditional indemnity insurance has climbed HMOs have taken it's place. They provide managed care. One wonders who is managing what care!

I will give you an example of how managed care has affected my patients. One night I received a phone call from the emergency room. As I was awakened from my sleep, I was asked if I accept HMO X. I frankly wasn't sure. The ER doctor stated that he had a very sick patient who likely needed surgery but could not find a surgeon who participated in the plan. I saw the patient, performed the emergency surgery and the patient recovered quickly. It took over 6 months for the patient to have his bills to the hospital and doctor paid.

This is not an unusual story. The average duration of time a person remains in a given HMO is 20 months. Most people do not like the fact that

an insurance company limits them to certain doctors or hospitals. They also resent the fact that a clerk in the insurance co. may decide whether a test or procedure is needed.

It is about time that the consumer of medical care, the patient, once again have the right to make decisions about his health. People are asked to make dozens of decisions each day that affect their lives. Suddenly, we are told that we need a big brother to make choices that directly impact our lives and health. The doctor patient relationship is vital to this decision making process, but is eliminated in managed care. This trusting relationship is developed over the years as a result of the physician's skill in the art and science of medicine. Because of the bond the physician becomes the patient advocate.

A well informed patient is not only equipped to seek proper medical care but the most economical care if allowed. Rand Corporation studies show that the medical consumer, when faced with out of pocket costs (higher deductibles) make more responsible choices than those in low deductible plans.

Medical savings accounts will help return medical care to the patient and the doctor. They will eliminate the mindset of rationed care and replace it with responsible care.

Since most people, 90%, do not utilize $3000. per year, the amount of paperwork can be drastically reduced. Some estimates have MSAs reducing administrative costs by $33 billion per year, by eliminating low dollar claims. The increased manpower necessary to process these claims and obtain clearance for procedures has greatly increased my office payroll as well.

I will leave it to another speaker to discuss the benefits of MSAs to everyone. The present system of tax free employer provided health insurance

benefits high wage earners. MSAs help lower income families gain access to better and more complete health care. Hopefully with increasing support, Congress will expand the availability of MSAs to all who would choose them. Also legislation is needed that would support MSA surpluses to be rolled over to IRAs. This could help low income families provide future medical expenses or retirement. The excess may even someday replace the present Social Security or Medicare method of pay as you go funding. In closing, I would like to emphasize that we must take back control of our health care, We must have the liberty to choose our own doctors and course of therapy unrestrained by a third party that only looks at the bottom line. Thank you.

Mr. MICA. Thank you.

I would like to recognize Dr. Goldfarb. You are recognized, sir.

Dr. GOLDFARB. Hi. My name is Dr. Sidney Goldfarb. I am a urologist in private practice in Princeton. I would like to thank the committee for inviting me to speak today on Medical Savings Accounts and my perspectives on them. Our medical system I feel is deteriorating quickly under managed care as practiced today. Care basically is not being managed, rather profits are. Large insurance companies have a need to report larger and larger profits each fiscal quarter or else Wall Street groans or their chief executive moans. The Federal Government, unfortunately, is looking primarily at it's budget numbers, while giving more lip service to the quality of care. Medicine is therefore financially besieged by the Government as well as the insurance companies. The Clinton health care initiative gave greater impetus to this as well.

I became a candidate for Congress in 1994, for the 12th Congressional District advocating Medical Savings Accounts. A local township office in 1995, saying Medical Savings Accounts would save millions of dollars locally, as well as keep local municipal workers and teachers out of managed care. This would give them their choice of doctor and hospital, and give them more of a hand in choosing their own care.

In 1997, I ran for the New Jersey State Assembly, where I invented the concept of auto insurance savings accounts, using the same idea behind Medical Savings Accounts, which I felt would cut car insurance costs in New Jersey by 50 percent, and begin to cut down on needless lawsuits by allowing sort of a deductible for law suits. I still may have this issue to run on next year, and hopefully Congress can push this particular idea nationwide.

I chose a Medical Savings Account for my own family's personal health care insurance because I was able to save a net of 75 percent of my health insurance premium. As a surgeon, I thought I would get cheap rates, but my rates were $8,000 a year going to $9,000 a year. The Medical Savings Account, which is available through Blue Cross/Blue Shield, was only $6,000 a year, which is going down, by the way, this year to $5,500. Of the $6,000, $3,750 was in my Medical Savings Account. If I don't use it, I get to keep it and roll it forward to next year.

If you are healthy, as most people are when they start working in their 20's, by the time they are in their mid-40's or 50's and they needed to have some major healthcare situation corrected, either surgically or with a hospitalization, you might have at least $75,000, maybe $100,000 in your Medical Savings Account. You could pay for your own bypass, your own transplant, and your deductibles would be very very high at the same time, saving you even more money.

If someone is ill and needs coverage, he would unfortunately lose the Medical Savings Account building up, but still you have been saving the 33 percent a year in lower premiums all along. Plus, you are not in managed care where you have somebody else telling you what you can and can't do. This is becoming worse. You read the newspapers, Aetna Insurance is losing their profitability. They have to raise their premiums by 10 or 15 or 20 percent. You will be reading more of this as time goes on.

I feel the MSA, from a patient's point of view, needs to be combined with a fee structure like I have with Blue Cross/Blue Shield. Otherwise, I might be charged exorbitant fees. With the Blue Cross/Blue Shield MSA, I am not. I have heard many times patients tell me as a physician, "Gee, doctor, do anything you need. Cost is no object." Indeed, cost is no object because the patients generally nowadays have pre-paid healthcare. They pay their premiums and they don't have to pay another dime. They want to have everything done. This is also raising the cost of healthcare.

Medical Savings Accounts shift the emphasis to prevention and early detection, where greater impact can be made on healthcare. All the money in the world can't put a cancer back in the originating organ where cure rates would be much higher.

Medical Savings Accounts differ from the current spending accounts that many corporations have. With spending accounts, a worker puts aside a certain amount of money. But if he doesn't spend it by the end of the year, he loses it. This money would be rolled forward with MSAs.

Mr. Schundler and I believe at Forbes magazine, they have done this. They are shining examples of this. A huge problem with getting MSAs accepted is publicity. No one knows what these things are. I tried to talk to my local mayor. She had no idea what a Medical Savings Account was. I told her it would save her $1 million in her budget. She said, well, come on over and we'll talk about it. I have talked to the local school board president, I have talked to legislators, I have tried to get this pushed for car insurance. There is a lot of reluctance because people just don't understand how these things work.

If we had MSAs, we could lower expenses 33 to 75 percent. Then we could afford to keep our full benefits, which is what people want. Otherwise, without the full benefits, we lose things as consumers, as taxpayers.

An example of lost benefits is what is happening in the psychiatric field. My wife is a psychiatrist. They are closing psychiatric hospitals. If you have a depressed patient, you could give them a drug, you could get them good medical care and they would be back at work being productive. On the other hand, now they are not.

I also feel that there is a lot of waste in other areas in medicine which would save the Government and the insurance companies money, such as on disability where some people come in and they are perfectly functional. I feel the Veterans Administration system could probably be merged in with the general healthcare system so a veteran would be able to get the benefits that they are entitled to at any hospital. The veterans hospitals seem to be about half full. They really should be a quarter full. They are being over-utilized. There is a lot of money wasted. Medicare has many restrictive rules. People can't go home for IV antibiotic therapy. They have to stay in the hospital for 4 to 6 weeks. For some reason, these are the rules that are in existence.

I have talked about Medical Savings Accounts and the power behind how they work. It is a return to taking personal responsibility for your health. You will be more interested in staying healthy, for car insurance you will have an incentive to be a better driver and to sue less. I urge you to apply Medical Savings Accounts to Fed-

eral workers, but also to take the message to every mayor, school board member, and public citizen, to let them know that Medical Savings Accounts are available and they are better than our current insurance products.

It's a question of economics 101 and politics 101. Economics 101 says give the person an incentive and they will respond. I hope politics 101 in this case will be to be brave and to offer this new product to everybody.

[The prepared statement of Dr. Goldfarb follows:]

Testimony on Medical Savings Accounts for Civil Service Committee

Sidney J. Goldfarb, M.D.
3/9/98

I would like to thank the committee for inviting me to speak today on Medical Savings Accounts and my perspectives on them. Our medical system is deteriorating under managed care as practiced today. Care is not being managed , rather profits are The large insurance companies have a need to report larger and larger profits each fiscal quarter or else Wall Street moans or the chief executive groans. The federal government, as well, looks primarily at it's budget numbers while giving more lip service to the quality of care. Medicine is therefore financially besieged by the government and the insurance companies. The Clinton health care plan gave greater impetus to this trend.

I became a candidate for congress in 1994 for the 12th congressional district advocating MSAs, local township office in 1995 saying MSAs would save millions of dollars locally and keep local municipal workers and teachers out of managed care. This would give them their choice of doctor or hospital and give them more of a hand in their care. In 1997, I ran for state assembly in New Jersey where I invented the concept of auto Insurance Saving Accounts{ISA}, which I felt would save 50% a year in premiums and begin to cut down on needless lawsuits and allow benefits to remain at full levels.

I may still have this issue to run on in 1999. Possibly, Congress can push this concept nationwide.

I chose a MSA for my families personal health insurance because I was able to save a net of 75% of my health insurance premium. My premium was going to go from $8000 a year to $9000. My MSA was $6000 a year going down to $5500 this year, by the way. $3750 of my $6000 is in the MSA, to be used for my first $3750 of medical expenses. If not used, the $3750 rolls forward each year as well as being tax deductible. If I had started this at age 23, when I began to work twenty years ago, I would have had $75,000 in my MSA plus interest. This would total possibly $150,000 to $200,000 today. I would be able to pay for most major illnesses by myself. This would include surgeries, transplants, or a long hospitalization. This could be a supplemental retirement plan, as it is under the Kennedy-Kassebaum law, or people might be able to increase their deductible to save even more, or simply keep their money for something else. The AMA offered me a health policy last year with a $20,000 deductible for a total premium of $500 for the year. I would get to keep my other $5,000 and use it for college costs or savings.

If someone is ill and needs coverage, he or she would lose the MSA building up but would still have been saving 33% a year in lower premiums all along. Plus he would not be in managed care. The HMO contract I was able to get last year were still more than the cost of the MSA.

The MSA needs to be combined with a fee structure like I have with Blue Shield of New Jersey, otherwise patients will be asked sometimes for exorbitant fees.

I've heard patients say, many times, that price is no object in a loved one's case. This is generally true, because people now don't pay for their health care beyond the yearly

premium. If they did, the system would be more normalized, but now their insurance companies provide them with pre-paid care. They don't want to pay one dollar more.

MSAs shift the emphasis to prevention and early detection, where a greater impact can be made. All the money in the world can't put a cancer back in the originating organ where cure rates are much higher.

MSAs differ from the current spending accounts that many corporations have. With spending accounts, a worker puts aside a certain amount of money, but loses it at the end of the year if it is not spent. Therefore, come the year's end, people get services, or glasses, or other products that they might not really need. With an MSA, people would not rush to spend for these possibly marginal needs. This is a further money-saver. The experience of Forbes magazine is a shining example in this.

A huge problem with getting MSAs accepted is publicity. We need a prominent spokesperson to lead in spreading the concept of MSAs. Mr. Forbes strongly advocates these, but has many other issues to deal with. Insurance companies and brokers make less money per policy under MSAs, but an informed populace would love them.

People always ask how an MSA works to cut costs, and can't quite grasp the concept. My Mayor, School Board President, and legislators all just don't get the full impact of the benefit of giving the consumer a choice, along with increasing their personal responsibility.

If we had MSAs, and could lower expenses 33% to 75%, we could afford to keep full benefit packages with health and car insurance. We don't want insurance companies and the government to cut benefits.

An example of lost benefits is the loss of psychiatric benefits due to costs. We have to save money someplace. If someone becomes mentally ill, insurance benefits are much lower, run out much faster, and are of a lesser quality than other medical benefits. It would be more effective to cover these problems and have a functioning person back at work than to pinch pennies. The government participates in this by closing psychiatric hospitals, such as North Princeton Developmental Center in New Jersey. As a result, they don't give full benefits to their citizens for psychiatric citizens. These psychiatric hospitals are being closed at a rapid rate. This has resulted in people being cut off from their supports, and we have seen increasing homelessness, disease, more cases of HIV and drug addiction, and a general cheapening of life and our society's level of morality.

On the other hand, we spend far too much money on "disability." We are too soft on some people, too hard on others. I see people who come to see me professionally who are termed "disabled" when they are actually able to work and contribute to society. Then I walk to a local store and see a woman in a wheelchair with obvious lower extremity problems who is working behind the cash register. If this person can work, so can these minimally impaired people.

I feel that the Veterans Administration System should be reexamined and possibly phased out as a separate system. Many VA hospitals are half-full and really should be only one-quarter full, and are not effective cost-wise or resource-wise. I would suggest integrating these hospitals into the total system. A veteran could have a card allowing him full veterans' benefits in any hospital in the country, not only if he or she goes to a VA. Tens of billions could be saved with no benefit reduction.

Medicare has many restrictive rules that waste money also. People with severe infection have to stay in the hospital for four to six weeks of antibiotic treatment, which is much more expensive than home care, when all other more enlightened plans allow home IV therapy. Other patients much be admitted to the hospital for treatments to be covered.

There are hundreds of such money-wasting problems, and hundreds of money-saving ideas that should be implemented.

MSAs should be extended to car insurance and to the Social Security system. If applied to the Social Security system, and if the system were "privatized," a retiree would have one million dollars of cash in his account upon retirement, instead of five hundred thousand dollars in IOU's. What would any of us prefer?

I've talked about MSAs and the power behind how they work. It's a return to taking personal responsibility for your health. You'll be more interested in staying healthy. For car insurance, you will have incentive to become a better driver and to sue less.

I urge you to apply Medical Savings Accounts to federal workers, but also to take the message to every Mayor, School Board Member, and public citizen, to let them know that MSAs are available, that they are better than our current insurance products, and that they save money. We'll all be patients someday, myself included. I want the choice of a free and vigorous health care system to be there for me, my children, and my children's children when the time comes. I feel the government and the insurance companies must get out of our lives and out of managing health care.

It's a question of Economics 101 and Politics 101. Economics 101 teaches that if citizens are given an incentive to save, they will. Politics 101, however, says that it is hard to change the system and think "out of the box." I hope we can get beyond base politics and help correct our medical system.

Economics 101 applies also to the problem of cigarettes. I would urge Congress to pass a tax equivalent to any proposed settlement with the tobacco companies. This would mean we could have money coming in immediately to pay for health care benefits. It would also cut out lawyers' contingency fees that may approach $100 billion dollars. I can't see wasting $100 billion dollars of money by having a settlement. Also, the tax should be passed in one fell swoop, not in small increments. Economics 101 says that with a huge price increase, our teenagers would be less likely to smoke. If you raise prices slowly, with a settlement, very few people with stop smoking. In Europe, a pack of cigarettes costs $4.00 a pack, and 50% of the population still smokes.

Thank you.

Sidney Goldfarb

Mr. MICA. Thank you, Dr. Goldfarb. Thank you to our other witnesses this morning. I will lead off the questioning. I'll start first with Mayor Schundler.

First, Mayor, I am surprised to see you back in public office. Given the circumstances of your first testimony—I think you told our subcommittee you inherited a pretty dismal financial scene from Jersey City and some opposition to some of the tough prescription which you had recommended. One of those changes I think you said was brought about by, as I recall, looking at the budget like we look at the Federal budget: how much it costs us for providing health care for our employees and retirees. I think you told us, as I recall, that it was one of the most significant budget items. Is that correct?

Mr. SCHUNDLER. It definitely created savings for us. At the time that we went into this plan, the State Health Benefits Plan was preparing a very significant health premium increase. I would have liked to have taken our union employees with us out of the State plan as well. My council members were not willing to go along with me on that, given the union's opposition.

The union's opposition was easy to understand. They had what they thought was a nice plan. They didn't want to risk anything on something new. So they wanted to stay where they were. As a result, we were able to make some nice savings on covering our management employees. We were not able to get the full savings we would have liked to have gotten out of all of our employees.

Mr. MICA. What percentage of your employees were eligible for MSAs?

Mr. SCHUNDLER. It was about 200 employees out of about 3,000 employees at a time. Now we are at about 2,600 employees full-time.

Mr. MICA. And based on your experience with a smaller group, were there or weren't there savings?

Mr. SCHUNDLER. There were definite savings. Among other things, we avoided the entire State Health Benefits Plan premium increase. Again, I would point out that we not only achieved savings, but these savings become more substantial as time goes forward because you just continually have this inflation in the price of the standard indemnity plan. So the savings started at about $500 for those taking a standard indemnity plan. Now it is up to $997.

Mr. MICA. Now the other thing besides the cost is the element of coverage. What about the satisfaction of the 200 or so folks that enrolled?

Mr. SCHUNDLER. They are usually happy. I mentioned that some people who opposed it originally simply because they are the believers that doing anything that hasn't been done before ever is not good.

Mr. MICA. You had lower premiums for the city.

Mr. SCHUNDLER. Right.

Mr. MICA. And lower cost for the employees. And you are testifying back with us today that they felt they had adequate coverage.

Mr. SCHUNDLER. Again, even those who never want to try something new and were originally opposed to it, became tremendous proponents of the plan once they had a chance to experience it.

Mr. MICA. Then I think you also spoke to the question of consumer choice under MSAs versus the rationing under HMOs. Maybe you could explain that better; what the options are that these folks——

Mr. SCHUNDLER. Some people continue—almost everyone who was in a standard indemnity plan, I shouldn't say almost everyone. Everyone who is in a standard indemnity plan left it because their costs were high. This gave them less out of pocket expense. If their costs were low, they got money back.

Some of those who were in the HMO stayed in the HMO because of its cost to them, because there was only a $5 office visit charge. This gave them the guarantee of the lowest out-of-pocket expenses. So what happens is you have some people staying with the HMO, but everyone who wanted to be able to have the choice of their own doctors and to be in the driver's seat relative to the procedures they receive, every single one of those individuals who valued that ability to make their own healthcare decisions, every single one of them went into the MSA plan.

Mr. MICA. You also said that about 56 percent of the managers chose an MSA. I would imagine that your managers would probably be a little bit further up in age than the average employee. Was there any evidence of what has been termed "cherry picking" or folks——

Mr. SCHUNDLER. With this plan, because it decreased costs, if you had high healthcare usage relative to the standard indemnity plan, you did not have any of that adverse selection problem. You had again, just to put it in perspective, the way the standard indemnity plan worked, it was a $200 front-end deductible, whereas this was a back-end deductible. So it's better to know you are not going to pay any dollars out of your own pocket until you have expended the $1,800, than to know the first dollar of health coverage you get in a year is going to come out of your pocket.

Second, the standard indemnity plan had a 20 percent co-pay, up to a $400 expense per family member. So that could become a very big cost out of pocket. This eliminated that. Our MSA eliminated that altogether. So there was no cherry picking. You had people who were very ill still opt for the MSA. The only people who didn't opt for the MSA again, were people who felt comfortable with their HMO relationships and the fact that they only have to pay $5 co-pay. If they felt comfortable giving up their choice, then they typically felt comfortable with the HMO.

Mr. MICA. I think in your testimony you also said that the renewal costs for the MSA option was almost $1,000 lower than the renewal cost for the more traditional, low deductible indemnity plan.

Mr. SCHUNDLER. Exactly.

Mr. MICA. Is there anything specifically you could attribute the reduced costs to?

Mr. SCHUNDLER. Again, it grew from $500 to $997. I think it is because there is an incentive created to get value for your dollars. People don't waste money when they know at the end of the year that if they don't waste it, they can get it back. So because there is an incentive for people to seek value in health care, you begin to see lower claims growth, which results in lower premium growth

on the catastrophic policy than what you are getting in the standard indemnity plan premium.

Mr. MICA. Thank you, Mayor.

Dr. Eck, you had some pretty harsh comments for what New Jersey is doing with their guaranteed issue, and also the $300 mandated preventative per person care cost. Many times we're asked in Congress to take a similar approach, mandated coverage in particular. That, in fact, we held hearings on the reason that we have averaged 15 percent increase in costs for our FEHBP program in the last year. A great deal of the attributed cost is to mandated coverage.

I guess you are seeing the same experience in New Jersey. How long has this been in effect? Is that the case?

Dr. ECK. 1992 was when New Jersey began mandated community rating and guaranteed issue. In the past year, the insurance costs for individuals that want to just buy insurance has doubled. It has gotten out of hand. So what is happening is the people who were on the fringe; who were already paying too much for their health insurance, suddenly when it doubled, they dropped out. Those are generally the healthy people.

People who are very sick buy their health insurance no matter what it costs because it's cheaper than paying cash for healthcare. It is the healthy, 20 year olds that just say forget it, I'm not going to pay that for insurance. They drop out. Then you have a death spiral. As the healthy people drop out and you are left with sicker and sicker older people, the insurance rates just become exorbitant.

Mr. MICA. One of the accusations against MSAs is that you will see the same pattern developing; that people will not participate, especially the younger people, and you'll get this adverse selection or cherry picking. I questioned the mayor about this. Now you tell me you switched into a different plan.

Dr. ECK. Something totally different.

Mr. MICA. It's not even official——

Dr. ECK. Not officially insurance, right.

Mr. MICA. You couldn't really speak to this point.

Dr. ECK. In favor of Medical Savings Accounts, let me think. If you take a woman, say a single mother making $12,000 a year, on January 2, her child wakes up with a fever. She knows she has got to go to work and she doesn't have a lot of time to spend. Put her in a traditional insurance policy and she's got a $500 deductible. She's only making $12,000 a year. That $500 is a lot of money she has got to come up with. So she is going to hesitate getting that child healthcare.

If she is in an HMO, now it might only cost her $5 for a visit. But she gets on the phone. She calls a secretary. She tries to get into the office. They say we can't see you for 3 days. It's very hard to get care when time is of the essence.

If she had a Medical Savings Account and worked in Jersey City, she would have gotten $1,800 placed in her Medical Savings Account on day one, January 1. There would be nothing to stop her from calling the doctor that she has known for the past 20 years. He would say sure, come right in. He would take care of her. She would pay out of her Medical Savings Account. There would be no claim forms. She would be only making $12,000 a year, so she

would be very, very well served by having a Medical Savings Account.

In no other program is there such flexibility. You can't say this is for the wealthy and just for the healthy. The other alternative is if this is a diabetic or somebody who has more ongoing healthcare needs, that person wants to be able to go to the endocrinologist. HMOs say you can only go to an endocrinologist once, and then their family doctor has to take care of all your insulin pump and all these very complicated things. These people value the choice of being able to go to their own doctor. It sounds to me like in Mayor Schundler's program, it would cost them only $200 out of pocket, compared to say $500 or $1,000 deductible. These people would benefit greatly.

We had an example in our office. Everybody in our office has a Medical Savings Account. One of our workers needed a thyroid scan. She called up one hospital and it was going to be $750. She said, Oh, I'm going to be paying that out of my own pocket so let me just check around. She called the next hospital and it was $350. So my husband said to her, he is also a physician, "Call around. Keep going." She called another hospital and that same test was going to be $150.

Now if she had any other healthcare plan, she wouldn't have checked. She would have gone to whatever is closest. She would not have cared what anything cost. But you multiply that type of work by the patient by millions and millions of transactions, and you will find healthcare costs go way down.

Mr. MICA. Thank you for your observations.

Dr. Goldfarb, you seemed to be one of the most rabid advocates of Medical Savings Accounts or savings accounts. If I belonged to an HMO or managed care, one of the things that folks point to is that it does provide for preventative care and people are more likely to go and get preventative attention with an HMO. Maybe the premiums are more. Now wouldn't this work in opposite fashion for MSAs? If you have got to take money out of your MSA for preventative care, aren't you going to be less likely to make those trips to the physician? What experience have you seen from a practical standpoint or what would you say would happen under MSAs?

Dr. GOLDFARB. I think it is a very complicated question. First you have to get a person who wants to go to the doctor to have whatever procedure, colonoscopy, say.

Mr. MICA. I'm not anxious to go for that. [Laughter.]

Dr. GOLDFARB. I am just using it for an example. But first somebody has to want to go to the doctor. I have to want to go and be screened. If you don't want to go, that is one situation. If you want to go and your internist says well, I have to send you to a GI guy. He is going to charge the HMO money. Maybe you don't need it. You don't have a positive enough family history. Let's do stool for guaiac, for blood, and we're not going to send you for a colonoscopy. I can tell you this has happened to people that I know. Even though they have had a family history, somebody in their family in their 40's had colon cancer, they are not getting referred by the HMOs. It sounds like it's a health maintenance organization. Their benefit to the insurance company would be to send them for the

early detection. But in the end, they don't even want to do that because they are not that far-sighted.

If you knew you had to go for your own colonoscopy, I mean you have to be an educated patient to some extent, you would just go, and you would pay your $100, your $1,000 for your maintenance healthcare a year, which is generally not that expensive. I have $3,700 in my Medical Savings Account. I will bank the $2,700 until next year. I think that's pretty good. I mean you pay for your little small expenses, your physical, a couple of drugs, a pair of eyeglasses, and you still have thousands of dollars that you can roll forward.

I think with the Kennedy-Kassebaum bill, it is the equivalent of an IRA. It's a retirement account. If you stay healthy your whole life, which most people will do on average, you have money when you retire.

Mr. MICA. Dr. Cauda, you seem to advocate that the self-employed should get the cost for benefit of deduction rather than just making it available for the big employer. How do you think that would work with MSAs? Do you think we should have some tax advantage for the individual with MSAs for a portion of that account? What is your feeling about incorporating your proposal for MSA participants?

Dr. CAUDA. There is no question that the majority of people that I see in my office without insurance are people that work either self-employed or they work for a small business that cannot afford healthcare benefits for their employees. This is a growing problem with the escalating cost of indemnity insurance, or even the HMOs.

If we look at the growth pattern in the HMO policy costs over the last 5 to 10 years, they have approached the indemnity cost. There's getting to be basically no difference between the HMO policy premiums and an indemnity policy premium. People that work for themselves or in small businesses, which is really a good percentage of Americans, they are at a total disadvantage. When they pay $500 a month or $700 a month for their premiums, they are paying with after tax dollars. Someone who works for a big corporation has a great tax plan. The Heritage Foundation did a study that showed that people with greater than $50,000 a year income have a $35 billion tax relief by this tax-free insurance that they are getting through their employers.

Families with incomes of less than $20,000 only glean a $2.7 billion tax advantage. The top fifth of all——

Mr. MICA. Would you repeat that last figure? I got the $35 billion. What was the——

Dr. CAUDA. Receive $35 billion tax relief.

Mr. MICA. Then you went to the other category.

Dr. CAUDA. Those earning less than $20,000——

Mr. MICA. Less than $20,000 get what?

Dr. CAUDA. $2.7 billion. This is from the Heritage Foundation study. The top fifth of wage earners in the United States receives six times the tax relief that the lower fifth of wage earners receive. There is something wrong with this system. Somebody making $100,000 a year can afford better to take out $600 a month or $700 a month or $800 a month for their family than someone who is making $15,000 a year or $20,000 a year. It's an obscenity the way

the tax code is written. This will certainly help our lower wage earners, which also includes younger patients.

You mentioned about younger patients opting out. They certainly wouldn't opt out because of Medical Savings Accounts. They would receive the tax benefit of money that they can roll over from year to year to year, which is a substantial percentage of their annual income. It would enable them to save a tremendous amount of money.

The benefits of MSAs as opposed to our present system, which is just totally collapsing, is incredible. You were mentioning also, Dr. Goldfarb, about the well person care, checkups. HMOs really would like you to delay them because the fact of the matter is that an HMO policy holder holds that policy for about 20 months. They are hoping that they can stall you off with enough low-tech tests such as stool guaiac instead of a colonoscopy long enough so that your business will move onto another HMO and somebody else will get that cost.

Mr. MICA. Interesting observations. I thank the panel. I will yield now to the gentleman from New Jersey, our vice chairman, Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman. I would like to begin with a question for the mayor. I believe, Mayor Schundler, you indicated that approximately 56 percent of a certain group of your employees that were eligible for this opted for the MSAs. I guess that's management level folks. At the same time this was being offered or talked about, you indicated that public employee groups, unions were less interested. I am wondering if you could talk just a little bit about some of their specific concerns, because these are probably similar to some of the concerns that we are hearing among Federal employees.

Mr. SCHUNDLER. The biggest thing is the belief that if it's not done by the Government, it is not good. Now these are Government employees unions. So their feeling is, is this privatization? That's the first issue that is raised. Now the reality is, the State Health Benefits Plan is managed by Blue Cross Blue Shield. We went from having them manage the State Health Benefits Plan to withdrawing employees and having their policy with Blue Cross and Blue Shield. So they were working with the same people, our management employees were working with the same people who working with them before when they were in the State Health Benefits Plan. But the opposition of the unions was they saw it as privatization so that gets people scared.

Health benefits are so important to people that anything that represents change is scary. Since there is absolutely no employee, let's say co-payment in municipal government here, there is not a sensitivity to the cost involved. So their feeling was, well so what if the State Health Benefits Plan costs keep going up. That is not our problem. That is the taxpayers' problem and the politician's problem. That's not our problem. So there was a resistance to any kind of change.

Now I can guarantee you that when they saw their own management employees making more money than they were, on average getting $1,100 back at the end of the year, there was significant interest at the end of the year. The issue with Jersey City, it's real-

ly the biggest issue for us, is that because the city had a history of trying to create opportunities for people who, because of disability or illness may have had a hard time getting employment in the private sector, the city has over the years employed many people who are very, very significant health care users. There is an argument to be made that perhaps government should create opportunities for people who would otherwise find it hard to find employment because of illness. But the city had done that over a long period of time. So it makes ours a very high cost group, if you will. So we save money being part of a large group that is on average much healthier than our own employee system.

Now the real issue for the State of New Jersey is why should they not offer this as part of the State Health Benefits Plan? You should offer this as part of the Federal Health Benefits Plan, because you would end up saving taxpayers money and making sure that employees were able to be in control of their own healthcare decisions and get better coverage. You could do all of this without having any employees get nervous about having to leave the State Health Benefits System or the Federal system.

Mr. PAPPAS. Thank you. As was mentioned earlier, the inclusion of MSAs as an option is being talked about. That is part of the reason that we are here conducting this hearing in Fort Monmouth. Some are advocating that we consider this on a pilot basis for possibly a limited period of time or for a certain percentage or group of Federal employees. I am curious to know if you have an opinion about whether you think that would be a more advisable approach.

Mr. SCHUNDLER. Well, from direct experience, I am such a big believer that I would really love to see all of my employees be able to take advantage of this and all of my taxpayers benefit, at the same time my employees do. But I think pilots are very good because they give you a chance to have direct experience, and it does so because this works so well in such a compelling fashion, that if you are a believer in this, there is no reason to oppose a pilot because it will prove itself to be very successful.

Mr. PAPPAS. Thank you. Based upon your experience with MSAs, and this would be really for anyone on the panel that would choose to respond, there has been some discussion here about what we have in New Jersey is Kennedy-Kassebaum. That being the case, especially for the physicians who are here, but certainly for the mayor, if you have anything to add to this, would you have any specific suggestions to how that could be improved based upon your experience that public policy here in New Jersey?

Mr. SCHUNDLER. The one thing I would say clearly is that after we finish offering MSAs to our employees, we should also deal with the tax code. I have had a chance to testify before the Ways and Means Committee on this as well. There is no reason in the world why contributions to a Medical Savings Account should be taxed as ordinary income. If the money is taken out for non-health care expenses, it should be taxed as ordinary income. But if the money is rolled over or used for medical care, it should receive the same tax preference, if you will, that a corporation's payment for an employee's premium receives. So that is the way to improve it.

I am proud to say that, in New Jersey, we have done that. Assemblyman Richard Bagger, the Republican conference leader, in-

troduced and passed legislation so that there is the same kind of tax treatment for MSA contributions for New Jersey State tax purposes as for basic premium payments. But we don't have that benefit at the Federal level yet.

Dr. ECK. If I were to make a suggestion, No. 1, if we could have people understand that their health insurance is just another way that they are compensated for the work that they do in whatever job it is, whether it's a Government job or a private sector job, they might value the cash instead. Here is how they could benefit.

If Federal employees could have Medical Savings Accounts by which they could purchase their own healthcare and catastrophic insurance, they would be getting their own insurance. When they are 20 years old, they buy a policy that can't be canceled when they get sick. Then that policy, they would carry with them from job to job, with the Medical Savings Account paying routine things. Then if they lost their job, they could pay their premium through their Medical Savings Account that had accrued. You need to start with healthy people when they are 20 years old. Then watch this account grow and grow.

The problem that we have now, is it's very fragmented. People go from job to job, insurance company to insurance company. As Dr. Goldfarb was saying, or was it Dr. Cauda, that if the different companies try to delay getting expensive treatment done until you are in some other insurance company, now all you have to do is make it so that insurance companies cannot drop you when you get sick, and have Medical Savings Accounts. I think that would go a long way in solving the entire problem that we now have with healthcare.

But the other thing is, I don't think employees realize that many of them stay in a job in which they are underpaid simply because they have "health" benefits. This whole thing would totally be eliminated with MSAs. So really they are getting underpaid and they have health benefits, some of which are good and some are not so good. I think their employers are getting away with something there in certain respects. Let the health benefits or the health insurance be the same as their car insurance and their home owners insurance, something that they privately own, carry with them wherever they go, and I think the problem would be solved.

Dr. GOLDFARB. I agree 100 percent. I think in the United States in the 1940's, health benefits were given as an employee benefit. But it was a mistake. It was a real mistake. If you change your job, if you move to another State, you lose your coverage. Then you are uninsured, and you have pre-existing conditions. If you owned your policy and you owned it for your whole life, if you moved from New Jersey to Arizona, it's your policy. You never had a pre-existing condition. Your old insurance company can certainly afford to insure you, so why the hell can't the next insurance company? You would just have your same policy for your whole life. I think it makes much more sense.

I don't know if we can ever unravel the present byzantine system that we have. But that would make a lot more sense.

Mr. PAPPAS. Do you have anything to add?

Dr. CAUDA. Basically I think everything has been said. We just have to remember that the Kennedy-Kassebaum in a sense keeps

on adding more and more bureaucracy to a situation that maybe shouldn't need that bureaucracy with certain changes. Just one other thing about MSAs and the portability, which is a big plus, is that of the 37 million estimated uninsured in the United States, a half of which are uninsured for 4 months or less, if they had MSAs and the money in their accounts that they could carry over, we would eliminate half of the uninsured in the United States. Basically when you look at only about 15 percent of the uninsured are uninsured for greater than 2 years. So it certainly would——

Mr. SCHUNDLER. Congressman, I just want to throw out one other idea. When you talked about pilots, one group that you could target would be congresspeople and their immediate staffs. So you would have such direct experience with it, you become the most significant experts in the country. I think you would find that you had incredible bipartisan support for this. You would find other Federal employees complaining that you have given yourself a benefit that they are not entitled to. So you would find tremendous pressure put upon you to expand it for all Federal employees.

Mr. MICA. That might be a good approach.

Dr. GOLDFARB. Give it to Hilary Clinton.

Mr. PAPPAS. I have just a couple of other questions. One is for Dr. Eck. I remember, I probably should have asked you this before the hearing. But as you were speaking, I remember reading an op-ed piece that you had written a few years ago that appeared in the local paper, where you spoke of the experience of one particular woman who had had some bad experiences with I guess it was an HMO. It was I guess she was in a coma or something like that. Do you recall the story?

Dr. ECK. I think I can remember the story. It was a woman that had contracted HIV before she came to this country. She was married here and was well until she got sick with AIDS. Her husband worked for a company that only provided an HMO. He was happy to have anything, but it was amazing how I watched the care that this woman got. She wound up having a stroke at the age of 36. She was home. The HMO wouldn't let her go into the hospital. After a couple hospitalizations, they said, you just stay home. But I went to her house. She was lying on a couch and her 4-year-old daughter was suctioning her. She couldn't move and her 4-year-old daughter was suctioning her. I was able to get on the phone and find out who the case manager was. She was two States away and had never seen the patient. I said I would like to paint you a word picture and I described the scene. A hospital bed arrived the next day.

But she had a doctor who was paid $10 a month to take care of her. That doctor was overwhelmed with other patients and just didn't really do anything for her. The other sad part about this, which is pointed out by what I said before about the job relation, her husband missed getting to work on time a couple of times because of having to take care of her. They saw that she was costing them a lot of money through the insurance system so they ended up laying him off. So she lost the poor insurance she had anyway. At least she had her prescriptions with that HMO.

It was really a pathetic scene. It wound up that the church took care of her. People came in with several volunteers. They went onto

shifts. They did all the care for free that the health insurance should have been doing for her. She finally died peacefully at home. That was the end of that story. The husband is now just making his way by himself.

Mr. PAPPAS. Thank you. One last question. I assume, I know that Dr. Eck, you in your practice do not deal with any health maintenance organizations. You other two gentlemen, I mean do you have any——

Dr. CAUDA. We have to out of necessity because of their penetrance now in this part of the county. People cannot afford out-of-pocket, especially for a surgeon health care. But in my practice, we have 15 surgeons; we're a multi-specialty practice. Two of them in their early 50's, prime in their career, have left medicine for other ventures.

Mr. PAPPAS. My question is, since at least for one of you the answer is yes, how many—have you seen any kind of a change in the personnel structure of your own practice regarding administrative costs that may have changed with what I have heard from other physicians in dealing with some of these plans, can you comment on that? What changes and what costs you feel you have incurred?

Dr. GOLDFARB. We have had to hire another person to do the insurance work. Our every procedure needs to be pre-approved. My secretary has to call up the insurance company. They put her on hold for 30 minutes. We have a speaker phone so you can function and do some other office work during that time. I think this is a rate-limiting step that is put in the way, that they only can do a certain number of approvals a day, and that's part of their cost management. They are managing their profit. They are not managing care. They provide care, but that's their business. But they are really managing their profits.

I think it's just going to get worse and worse and worse. We are going to become capitated. People are going to be paid, as Dr. Eck said, $10 a month to take care of a patient. A lot of doctors will have no incentive to take care of their patients properly.

Dr. CAUDA. The process and decisionmaking is no longer left to the physician because it's almost uniform where we have to hire extra girls, not only to call the insurance company to get approval. Sometimes it takes two and three phone calls where finally I have to take time from my day to get approval to speak to a physician from the insurance company. When you multiply this by dozens of patients each month, it reaches a proportion that just totally it stifles your ability to work. It's gridlock.

Managed care plans are now, we have seen where anesthesiologists have had to say that they would not accept patients from the care plans because they do not reimburse correctly. You talk about a danger from managed care. Last week's Asbury Park Press, I have the article right here, speaking about I believe it's Oxford Healthcare Plan refusing assistant surgeons on procedures where an assistant surgeon is required by the State Board of Medical Examiners. The health care plan is saying that we will not pay them. Who is to pay them?

Mr. MICA. I thank the gentleman. Now I would like to yield to Mr. Hendricks, who is going to represent our ranking member, Mr. Elijah Cummings, the gentleman from Maryland for questions.

Mr. HENDRICKS. Thank you, Mr. Chairman. I just have a few questions for Mayor Schundler.

Mr. Mayor, you testified that in 1994, Jersey City undertook its MSA program, and that that would make your jurisdiction the governmental entity with perhaps the most experience with MSAs across the country. Is that correct?

Mr. SCHUNDLER. Right. I think.

Mr. HENDRICKS. Now does Jersey City today continue to offer its MSA program?

Mr. SCHUNDLER. What happened with us, you can think of it as if again, a single individual is very ill, it's not wise for that person to try to go and buy insurance on an individual basis. It makes a lot more sense to go into a group plan where their costs will be averaged down by the group. So we decided that it doesn't make sense for us to be alone. We should go in with the State plan, given the particular character of our management employee group, where we do have a number of people who are more ill than average and more older than average.

Mr. HENDRICKS. So you had to shut your MSA program down?

Mr. SCHUNDLER. Right. So we went back into the State plan. I think we have a pretty good chance of getting the State plan to offer this, because they have had a chance to see some of the benefits that we have experienced.

Mr. HENDRICKS. OK. Now your testimony suggests that the demise of your MSA program was attributable to your work force being comprised largely of people with disabilities, illnesses of various sorts, or being just elderly. Is that correct?

Mr. SCHUNDLER. Having a higher than average medical usage.

Mr. HENDRICKS. OK. Now when you appeared before the subcommittee at our December 1995 hearing, you shared a panel with a county commissioner by the name of Gary Glenn from Ada County, ID.

Mr. SCHUNDLER. Yes.

Mr. HENDRICKS. He testified that his jurisdiction had just, as yours had around that time, undertaken to establish an MSA program. Is that correct?

Mr. SCHUNDLER. Yes.

Mr. HENDRICKS. OK. Are you familiar with what happened in Ada County?

Mr. SCHUNDLER. No.

Mr. HENDRICKS. OK. I have an article from something called the Health Care Policy Report that's published by the Bureau of National Affairs. It's an organization that does a lot of writing about things that happen on Capitol Hill and everywhere else. But this is an article dated August 11, 1997. It's headline says "Idaho, State's most populous county dropping Medical Savings Accounts." It goes on to say that what they experienced was a 15 percent increase in healthcare premiums as a result of having launched their MSA. It says here that the county saved only $39,000 by offering MSAs to the 150 employees who selected the MSA option. But on the other hand, the 15 percent increase would have meant a $328,000 increase in their premiums.

It says here in the last sentence that, "The economics of making the decision to drop the MSAs was simple." Now last, let me just

point out that a guy named Terry Johnson, who was the Ada County human resources coordinator, says that the reason for the increase in insurance rates was due to the adverse selection of the MSA that drove up costs for the other imdemnity plan. I guess they had an indemnity plan running side by side with the MSA.

Now it sounds like then that Ada County, which started its program around the same time as you did, its program met the same fate as your program. Adverse selection drove up the cost and ultimately caused both Jersey City and Ada County to terminate their programs. Is that a correct reading of what occurred?

Mr. SCHUNDLER. No. You can create a policy where if you don't match your MSA with the catastrophic policy, you could create an adverse selection situation. In Jersey City, now I don't know what they did in Ada, but I can say in Jersey City, we coupled the MSA with a catastrophic policy and you did not experience any adverse selection. You had sick people in the MSA plan in the same numbers as in the general distribution.

Mr. HENDRICKS. Whether you call it adverse selection or not, the result was that your costs went up, that led to——

Mr. SCHUNDLER. It is a total misreading of the reality. My HMO costs, all of our costs are higher because their claims are higher. Now if you have a sick person, his costs are going to be higher than my costs. I am not sick. The issue isn't should I, if I am an individual who is sick, try to get into a big group which is healthier than me. Of course you should. The issue is what, regardless of your situation, whether you are sick or healthy, is the best way for you to buy health care.

If the city of Jersey City were forced to go it alone because someone said we don't want your sick employees with ours, you are increasing our average cost to this plan, so they threw us out and they forced us to go alone, well, if we were forced to go alone and I just offered the three plans that the State Health Benefit Plan offers today, my costs would continue to rise because there is no first party incentive to seek value in health care.

But because we offered the MSA, you have an awful lot of employees who did become health conscious. That is why that particular policy is such a break versus the standard indemnity plan. I might add that that policy comes in at about the same level as the HMO, even though the HMO achieves its price advantages versus the standard indemnity plan because of rationing.

Mr. HENDRICKS. Let me just ask one last question then. In both Jersey City and Ada County, Blue Cross/Blue Shield was the insurance company that provided the MSA. It would appear because neither jurisdiction today has an MSA that there was some difficulty in working the problems out. I just want you to explain the extent to which your jurisdiction endeavored to try and work with your insurer to preserve the program and why some successful remedy wasn't at hand.

Mr. SCHUNDLER. Well, I think there is a successful remedy at hand.

Mr. HENDRICKS. I ask because Blue Cross/Blue Shield does a big chunk of the business within the Federal Employees Health Benefits Program.

Mr. SCHUNDLER. The problem was not with Blue Cross/Blue Shield, again. We had the same faceless bureaucrats that we were working with while we were part of the State Health Benefits Plan as we had after. When someone fills out a form and sends it in, for the most part, they don't meet the person who is at the other side of the process. Blue Cross/Blue Shield was administering the State plan. It was administering our MSA plan. So it is the same people who are administering the Jersey City program. Again, the options they had, we provided the same three options in our own program as they were providing in the State Health Benefits Plan. The only thing we did was offer a fourth.

So there was no problem with Blue Cross/Blue Shield. They were fine to work with. The only issue is that it doesn't make sense for us to stand alone. It makes sense for us, as it would for a sick individual, to get into a large group where the average healthcare usage is lower. Then the issue is now that you are part of a group, whether you are going to stand alone or you are part of a group, does it make sense to offer three options or does it make sense to offer four options.

If what you want to do is give a better deal to the employee and a better deal to the cost payer, in this case the taxpayer, you want to offer the four options. The reason why I say I think we will be able to work things out is I do think the State will offer this fourth option. Looking at our results, I think they will make the very clear decision that it would be a good deal for them to offer a fourth option to State employees.

Mr. HENDRICKS. Mr. Chairman, I don't have any more questions. I just want to point out that within our program, we have a high number of older employees and we have a high number of retirees that are members in the program. So it just strikes me that some of the characteristics of your workforce that led to the problems that you experienced, could in fact be manifested within our work force. So it just leaves me a little concerned and cautious about going forward with the idea when the experience in Jersey City proved not to be a successful one.

Mr. SCHUNDLER. It did prove to be a successful one.

Mr. HENDRICKS. And the experience in Ada County proved not to be successful. Thank you, Mr. Chairman.

Mr. SCHUNDLER. I think your employees are like our employees. I think you would have the same positive experience with this program.

Mr. MICA. Dr. Eck, could you briefly respond?

Dr. ECK. Yes. I am familiar with the situation in Ada County. I know that Gary Glenn experienced intense opposition when he first had the idea of Medical Savings Accounts. The other two commissioners were vehemently opposed to it for reasons that were never ever made clear. It is also possible that the insurance companies might not have a great incentive to offer reasonably priced high deductible policies. That is what we found in New Jersey.

When we were paying $585 for $1,000 deductible, Blue Cross/Blue Shield turned around and said well it's going to be $545 for a $4,500 deductible. Who in their right mind would give up $3,500 worth of insurance for $40 a month? It did not make sense. I didn't understand why the insurance company was unwilling to provide

the low priced insurance. I think something like that happened in Ada County. The insurance companies did not want to see Medical Savings Accounts succeed, as far as I could tell.

Mr. SCHUNDLER. You need to understand why, because they operate on a cost-plus system, so the higher the cost, the bigger the plus.

Mr. MICA. Dr. Goldfarb, very briefly.

Dr. GOLDFARB. If they are losing out on my $3,700 because I am going to get to keep it and roll it forward, they are not going to make as much money and profit and neither will the brokers, which is why they are not being pushed by the insurance companies.

Mr. MICA. I want to thank our panelists for their input. Mayor Schundler, it's good to see you back. We appreciate the leadership you have provided for your community. I know it had some difficult times when you took over. We wish you every success. I look forward to working with you. We thank our other panelists for the insight they have provided to the subcommittee based on their experience and providing their recommendations to our panel. We certainly will pursue some of the recommendations that you have provided for us today.

I will dismiss the panel. I will call our second panel this morning. Our second panel includes experts in the law, financing and marketing of MSAs. We have Dr. Madeline Cosman, who has followed developing trends in medical law and financing for more than 30 years. She adds a strong voice of experience to our hearing this morning. We have Mr. William Raab. He will provide a perspective from the insurance industry. Finally, we have Ms. Janine Kenna of Merrill Lynch's Plainsboro office, who will provide insight into the savings dimension of MSAs.

As I explained before, this is an investigations and oversight subcommittee of Congress. We do swear in our witnesses. So if you will remain standing.

[Witnesses sworn.]

Mr. MICA. The record will reflect the witnesses answered in the affirmative. I would like to welcome our three panelists and witnesses this morning. As I explained to our previous panel, we generally allow 5 minutes. We give leeway for an oral presentation. Then if you have extensive, lengthy statements you would like to be made part of the record or submit documents, we will do that upon request.

So with those welcoming remarks, I would like to first call on Mr. Raab.

STATEMENTS OF WILLIAM RAAB, VICE PRESIDENT OF MARKETING, ANTHEM HEALTH AND LIFE INSURANCE CO.; MADELINE COSMAN; AND JANINE KENNA, ASSOCIATE MANAGER OF PRODUCT DEVELOPMENT, MERRILL LYNCH

Mr. RAAB. Thank you, Mr. Chairman. Good morning. It is an honor to be here. Thank you for inviting me to speak. I will give a brief synopsis of my written testimony, if you would be so kind as to enter the full testimony in the record, I would appreciate it.

Mr. MICA. Without objection, your full written testimony will be made a part of the record.

Mr. RAAB. Thank you.

Mr. MICA. Can you pull the mic or just get as close as possible so we can hear you?

Mr. RAAB. Is this better?

Mr. MICA. That's great.

Mr. RAAB. Thank you, Mr. Chairman. My name is Bill Raab. I am vice president of marketing for Anthem Health and Life Insurance Co., in Piscataway, NJ. My company, Anthem Health, is a nationwide employee benefits company currently servicing in excess of 10,000 small employer policy holders. We introduced our MSA product to our sales force in March 1997. We do offer a complete package with a variety of deductibles and a savings account features. Our program is currently available in most States.

The idea of lowering healthcare premiums to save money by purchasing a high deductible plan isn't new. In fact, high deductible plans have been available since at least the 1970's when I started selling employee benefits. In fact, as Dr. Eck pointed out, high deductible plans are really more consistent with the basic concept of insurance, which is basically that you should insure against unpredictable events and catastrophic losses and budget for lower cost, and more predictable expenses.

In fact, I heard a consulting actuary speak at an industry trade seminar on MSAs back in 1996. He stated that in any given year, you could expect that 60 percent of all claimants in the population would actually experience medical claims less than $1,000. If we accept those numbers as reasonable, it would appear that 60 percent of the population would be a likely candidate for high deductible plans. But my personal experience indicates that that's not the case.

Basically, employees have always wanted better benefits, which they interpret to mean low out-of-pocket costs. Employees have been conditioned for decades to expect good health benefits. They have utilized them quite freely. Since these benefits had low out-of-pocket costs and were heavily subsidized by the employer, employees were to a great extent immunized from the economic consequences of their utilization decisions.

So essentially MSAs were introduced into a market which had historically not been receptive to high deductible plans, but yet there is tremendous interest in them. I guess that brings up the question what has changed and what would make MSAs popular? Well, I think the timing of the introduction of federally qualified MSAs has been fortuitous. They have been introduced in the midst of a backlash against strict forms of managed care. We have heard plenty of testimony regarding that backlash already this morning.

I think the tax advantages built into Kennedy-Kassebaum have been a tremendous impetus to sales. I won't discuss in detail the benefits. You have heard other testimony already. I think we all know what the benefits are and the possible benefits that can be reaped from MSAs.

I did want to talk about sales results, however. Although sales results at first were slow, the pace is picking up. We find reason for encouragement regarding the MSA concept, bearing in mind of course that we're speaking about small employers under the Kennedy-Kassebaum pilot project. So we looked at the first 10 months

of sales of this product from April 1, 1997 through January 31, of this year. Essentially this new concept of a federally qualified MSA with a high deductible plan has essentially enabled us to double our high deductible business in just 10 months. I think that is a pretty remarkable achievement.

For that same 10 month period, MSA compatible plans represented approximately 20 percent of new policy holders sold in small groups, and about 8 percent of our new business sales revenue in small groups.

We have also done some analysis of our typical buyer of an MSA product. So far, 53 percent of these new policy holders are concentrated in a few industries: professionals, such as doctors, dentists, lawyers, accountants and engineers, management and high tech consultants, and also financial services people, such as insurance and real estate agents, and securities and commodities brokers. What surprises me in fact is that these people represent only half of the buyers.

I heard some concerns raised this morning about adverse selection. I would just like to close my comments by saying that if indeed 60 to 70 percent of the population purchased an MSA, there might be some concern about adverse selection. But I think the best hopes of MSA proponents and the worst fears of MSA opponents have been exaggerated.

When you look at the experience of HMOs, which have essentially had Federal backing, the HMO act required employers to offer HMOs as part of a dual choice. They did offer low cost, and yet it took them 20 years to get a 33 percent market share. So I think it is unrealistic to expect that MSAs are going to cause a market dislocation. I think in reality they will appeal to a certain segment of the population and that those people should be given the opportunity to purchase them. I think the experience with Federal employees would probably be the same. Initially it would be the better educated and high income employees, and eventually you may find that the appeal is really broader than anyone would expect. I don't think there would be any harm to the risk pool for the Federal plan. Consequently, I urge favorable consideration. Thank you.

[The prepared statement of Mr. Raab follows:]

Testimony of William Raab
Vice President of Marketing
Anthem Health and Life Insurance Company
Before the House Civil Service Subcommittee
Hearing on Medical Savings Accounts
Ft. Monmouth, New Jersey
March 9. 1998

Introduction

Good morning. Thank you for inviting me to speak. My name is Bill Raab. I am Vice President of Marketing for Anthem Health & Life Insurance Company (Anthem Health) in Piscataway, NJ. My full biography and a profile of my company are attached to my written testimony. I have held a variety of employee benefit sales and management positions since 1971. I have been in my current position for three years.

My company, Anthem Health, is a nationwide employee benefits company. We currently service in excess of 10,000 small employer policyholders, representing approximately $200 million in annualized revenue.

Before discussing how MSA's might fit in to the Federal Employees Benefit Plan, I will discuss MSA's in general and our experience with them.

MSA Offering

Anthem Health's MSA product is called "Anthem Rewards Medical Savings Account", and was released to our sales force on March 5, 1997. This product offers a complete package combining a MSA-compatible high-deductible medical plan and a Medical Savings Account. Anthem Health selected American Health Value (AHV) to be their designated MSA administrator.

The Anthem Rewards MSA program features nine medical plan options that have been designed to meet federal guidelines. Three comprehensive major medical and six preferred provider organization plan choices are available with deductible limits ranging from $1,500 and $2,000 for an individual and $3,000 and $4,000 for a family.

Because of the nature of the MSA, individuals have more responsibility for Healthcare expenses. Anthem Rewards MSA program works in conjunction with a no-cost medical management component that permits participants to obtain information aimed at improving their health. By using the "Anthem Be Healthy" program's toll-free telephone line, covered individuals can gain answers to health-related questions and obtain printed information on a variety of medical topics to help them make more informed health care decisions.

The Anthem Rewards MSA program is currently available in all states except Connecticut, Hawaii, Indiana, Kentucky, Maryland, Minnesota, North Dakota, Ohio, Rhode Island, and Wisconsin. The requirement to comply with first dollar state mandates (other than preventive care) does not allow us to sell in Connecticut, North Dakota, Rhode Island and Wisconsin. However, this program can be offered in these 4 states to prospects of 50 lives and under for self-funded plans.

Historical Perspective

An historical perspective may be helpful in understanding consumer reaction to MSA's. The concept of lowering health care premium to save money by purchasing high-deductible plans is not new. High-deductible medical plans have been widely available since at least the 1970's. In fact, high-deductible plans are more consistent with the basic concept of insurance (i.e., that you should insure against unpredictable events and catastrophic losses, while budgeting for lower-cost predictable expenses). Nonetheless, high-deductible plans have not had broad market appeal. For example, prior to the introduction of MSA plans, high-deductible plans (annual deductibles of $1,500 or more) represented less than 3% of our small group policyholders and less than 1% of our small group revenue. I would expect that the experience of other carriers is essentially the same.

These statistics appear strange when compared to the pattern of incurred claims in the population as a whole. At an insurance industry seminar on MSAs in late 1996, a consulting actuary stated that in a recent year only 12% of claimants in the insured population incurred claims in excess of $5,000. Their claims represented 77% of all claim dollars. He further stated that 60% of claimants incurred claims less than $1,000. If we accept those numbers as reasonable, it would appear that 60% of the population should have an interest in high-deductible plans. Yet, high-deductible plans have not had anywhere near that market penetration. Why?

In my twenty years of experience selling benefit plans, there were two basic underlying premises: employees wanted better benefits, and employers wanted lower costs. I believe these premises to be just as valid today as they were in 1975.

When it comes to employee perceptions of medical plans, one of the major components of "better benefits" is "low out-of-pocket costs." Employees have been conditioned for decades to expect good health benefits, which they have utilized quite freely. Since these benefits were heavily subsidized by the employer, employees were to a great extent immunized from the economic consequences of their health care utilization decisions.

With this as a backdrop, it is clear that high-deductible plans, which would increase out-of-pocket costs, would be perceived as a reduction in benefits and would have little appeal to employees. If the employees were paying the premium they might have reacted differently, but there is no guarantee that this is so. I have had personal experience where business owners and professionals deliberately opted for more expensive low-deductible plans, as opposed to saving the premium and budgeting for routine medical expenses.

In addition, I have seen market research presented at industry seminars which indicates that, when employees have the ability to choose from multiple plans, one of the major decision drivers is "low or no deductible". Given all of this, it is no surprise that there has been little demand in the market for high-deductible plans. This also probably helps explain why initial demand for MSA's has been slow.

Meanwhile, employers are struggling with the problem of controlling costs. Some of this has been accomplished by moving deductibles marginally upwards with inflation. For example, the $100 deductible of the 1970's may become a $250 or $300 deductible today. Most employers were not willing, however, to force deductibles to high enough levels to significantly impact premiums.

One could argue that they did not have to take that unpopular action because a different cost-containment tool became available: Managed Care, and, specifically, HMO's. HMO's offered both low costs and low (or no) deductibles, so they had appeal to both employers and employees. They were able to offer the perceived "better benefits" at "lower costs" by putting controls on health care providers. It is impossible to know whether or not the full implications of this were known or understood by health care consumers initially. It is widely understood today.

HMO's also emphasized wellness and prevention, which are obviously desirable. Whether or not this actually lowers costs is still open to discussion. Some have argued that HMO's initially attracted large numbers of low-risk (young and healthy) insureds. If true, this would also help account for the "low cost."

Traditional insurance companies also attempted to lower costs by implementing utilization controls such as hospital pre-admission review and mandatory second opinion for surgery. This did enable them to lower premiums without raising deductibles to unpopular levels.

Introduction of MSA's

So MSA's have been introduced into a market that has historically not been receptive to high-deductible plans. Employees still want "better benefits" and employers still want "lower costs." Has anything changed that would make MSA's popular? What are their benefits? What are the marketing results?

The timing of the introduction of federally-qualified MSA's has been fortuitous. They have been introduced in the midst of a backlash against strict forms of Managed Care. Employers and employees have the same concerns they have always had, but now they have something new to look at as an alternative. The publicity surrounding the Kennedy-Kassebaum bill, and the fanfare of carriers entering the market gave a significant boost to consumer awareness.

The tax advantages given to MSA's provide additional impetus to the concept. The formalized savings account mechanism with rules and procedures for deposits and withdrawals should make it easier than ever before to sell and implement high-deductible plans. No such structured depository for premium savings existed when we tried to sell high-deductible plans in the '70's or 80's.

MSA Benefits

MSA's can produce several good results if sufficient numbers of people utilize the concept. These are in addition to the obvious benefit of providing an additional choice. First, MSA's do have the potential to reverse health care spending patterns. Rather than spending someone else's money, the insured is spending his or her own money, and is directly accountable for the results. This should lower utilization over the long term.

Second, the insured is more likely to actively participate with his or her physician in managing his or her own care. This should lead to more individual responsibility.

Third, thrift is rewarded, but money is there if you need care. Long-term MSA savings can supplement other retirement savings vehicles. This is particularly advantageous for high-income individuals, for whom Social Security will provide a smaller percentage of income replacement.

If these benefits are desirable for the small employer market, I think they are desirable for federal benefit plans as well.

Sales Results

There appears to be some disagreement about the IRS count of qualified MSA's established to date. I am not in a position to know if the actual number of accounts has been understated or not. I think all involved would agree however, that whatever the actual number is, it is well below the caps in Kennedy-Kassebaum.

However, I am in a position to know our sales results. (Recall my initial comment that, prior to the introduction of MSA's, high-deductible policies represented less than 3% of our small group policyholders, and less than 1% of our small group revenue.) Our results have been encouraging. Although slow at first, MSA sales are accelerating.

The earliest possible effective date for an MSA with Anthem Health was April 1, 1997. We can measure ten months of sales, through January 31 of 1998. Our MSA-compatible high-deductible plans already account for 6% of our small group policyholders, and 2% of our annualized small group revenue. In other words, the Federally-qualified MSA concept has enabled us to double our high-deductible business in just ten months. Although these plans are still a small portion of the total block, this is a remarkable outcome.

The results are even more impressive when considered in the context of new business sales. For the same ten month period, MSA-compatible plans represent 20% of new policyholders sold, and 8% of new business sales revenue. The percentages are even higher when only January 1998 sales are considered.

We have done some preliminary segmentation studies to identify our typical buyer. So far, 53% of policyholders and annualized revenue are concentrated in a few industries. These are professionals (doctors, dentists, lawyers, accountants and engineers), management and high-technology consulting, and financial services (insurance and real estate agents and securities brokers). It is no surprise that well-educated, high-income people would be attracted to this concept. What is a surprise, at least to me, is that they represent only half the buyers. This could very well indicate that MSA's would appeal to a broad spectrum of federal employees.

Impediments to Sales

Much has been written in trade journals about the slow initial response to the MSA concept, so I don't need to discuss it in depth here. The two major obstacles that have been widely discussed are the complexity and newness of the concept, and the resistance of insurance agents and brokers.

As I have indicated previously, this is not really a new concept. It just hasn't been widely used in the past. Kennedy-Kassebaum does add a new twist (the savings account piece) to the standard insurance sale, which accounts for the "complexity" argument. As the concept becomes more widely understood, this obstacle will disappear.

The vast majority of small employers utilize an intermediary (an insurance agent or broker) when purchasing an insurance product. Our own research supports the position that there has been some resistance to the MSA concept on the part of these intermediaries. The reason is obvious: premiums for high-deductible plans are 40-50% less than low-deductible plans, which drastically reduces commissions. Competitive market forces will gradually resolve this situation, and agents and brokers will sell the concept or risk losing clients. Our recent sales results indicate that this is already happening.

A Better Mousetrap

As currently structured, federally-qualified MSA's do have appeal. However, there are several improvements that could be made which would make MSA's more attractive. The Sub-committee may wish to consider incorporating these design changes into the program before it is offered to federal employees.

First, I think the current tax-qualified funding limits on annual deductibles should be raised. Insured should be able to put up to 100% of the annual deductible into the MSA on a tax-favored basis. This makes the concept more viable in practice, although I don't know the revenue impact to the Treasury.

In addition, I think both employers and employees should be permitted to make contribution to the MSA in the same year. This enhancement, along with the first I mentioned, would be helpful in answering one of the major concerns of MSA's: that people will forego necessary care to save money.

Finally, I believe that a technical flaw in Kennedy-Kassebaum should not be replicated in this bill. The requirement that insurers administer family claims as an aggregate deductible, as required under Revenue Ruling 97-20, should be eliminated. This runs counter to decades of industry practice and consumer expectations, and can penalize families if only one member has claims in a year.

The next step would be to incorporate these changes into the MSA's available under the pilot project.

Issues of Concern

There were concerns raised about MSA's during the debate on Kennedy-Kassebaum. I will discuss two of them.

First, there is a fear that people will choose saving money over getting necessary medical care. This is particularly feared when it relates to routine preventive care, such as childhood immunizations. I can understand this concern. The pilot project is too new for us to draw any meaningful conclusions from our emerging claims experience. Until we can see what the facts are, I question the fairness of making an assumption about employee behavior and enacting a form of prior restraint based on that assumption. After all, we are discussing an optional benefit, not a mandated one. In addition, the proposed funding changes mentioned above could obviate this concern.

Second is the widely discussed concern that MSA's will lead to adverse selection, impair the ability to spread risk, and create two pools. One pool would consist of healthy insureds with low premiums, and the other pool would consist of unhealthy insureds paying high premiums. Once again, I understand the concern. Since this theory was advanced by noted actuaries, how can a lay person refute it?

If 60-70% of the population purchased MSA's, the feared adverse selection might become a reality. But I think the best hopes of MSA proponents and the worst fears of MSA opponents have been exaggerated. Consider the experience of HMO's: even with the considerable support of the Federal Dual Choice Mandate, and even though they offered benefit and cost levels with inherently broad appeal among employers and employees, it has taken them twenty years to get 33% market share. Since MSA's inherent appeal is to a narrower segment of the population (savers as opposed to spenders), I consider it highly unlikely that MSA market share could ever get large enough to cause a major dislocation.

Summary--MSA's for Federal Employees

How does all this relate to federal employees? I would expect that federal employees want what other employees want. Consequently, I expect their reaction to the concept to be consistent with what we have already seen. Initially, MSA's would appeal to the well-educated and high-income employee. Next, you will probably find that MSA's have a much broader appeal than expected, as we discovered.

The same benefits that I outlined above would accrue: choice, the opportunity to change spending patterns, active participation in managing one's care, and encouragement of thrift.

I believe this can be accomplished without harm to the employees' health, and at little or no risk to the FEHBP risk pool. Consequently, I urge favorable consideration. Thank you for your time.

Background

William A. Raab is vice president of marketing for Anthem Health & Life Insurance Company (Anthem Health) in Piscataway, NJ. In this position since 1995, he oversees all marketing, advertising, communications and field operations functions for the company.

Raab joined the organization in 1986 as district group manager in the Pennsylvania office and was promoted to vice president of research and development in 1994. He began his insurance career in 1971 with Phoenix Mutual Life Insurance Company as a district group representative and a group billing supervisor, and later worked for Mutual Benefit Life Insurance Company as a regional group manager.

He is a past multi-year member of Anthem Health's top sales honor clubs, the President's Council and Executive Council.

Raab is a graduate of Allegheny College, Meadville, PA, and a US Army veteran. He serves as vice president of the Board of School Directors of the Upper Perkiomen (PA) School District and as a director of the Lions Club. He is also a past president of the Upper Perkiomen Parents' Association for Gifted Education.

Raab and his wife, Janine, live in East Greenville, PA. They have three children.

Anthem Health is a subsidiary of Anthem, a Fortune 500 company and one of the nation's larger health care management and insurance companies. Anthem Health conducts business in 49 states and the District of Columbia. Its affiliate, Anthem Health & Life Insurance Company of New York, serves New York.

Together, these companies satisfy the increasingly complex needs of a broad range of groups by offering a variety health, life, disability and dental products and associated services to thousands of employers throughout the country. Two voluntary products, Anthem Voluntary Group Term Life and Anthem Personal Dental Plan, as well as the Anthem Rewards Medical Savings Account, are also offered.

Sales activities are conducted through 25 sales offices nationwide, which exclusively promote Anthem Health products through a network of more than 23,000 independent agents and brokers.

Subject: Additional MSA Info

During Monday's Q&A, Mr. Pappas asked me for our sales results by industry. The attached chart shows the breakdown for sales 4/1/97-1/31/98.
Please thank the Subcommittee for their courtesy in giving us the opportunity to express our views.
Bill Raab

Anthem Rewards Policies by SIC Code

SIC Code	Industry	Policy Count	Exposed Lives
0100	Agriculture Production - Crops	1	3
0200	Agriculture Production - Livestock	2	4
0740	Veterinary Services	2	7
0780	Landscape	1	1
0800	Forestry	1	8
0910	Commercial Fishing	2	2
1500	Binding Construction - General and O	1	3
1520	General Contractors - Residential	7	14
1710	Plumbing, Heating, Air Conditioning	4	10
1720	Painting and Paper Hanging	4	9
1730	Electrical Work	2	3
1750	Carpentry and Flooring	2	6
1790	Special Trade Contractors, NEC	2	8
2430	Millwork, Plywood, Kitchen Cabinets	3	41
2490	Miscellaneous Wood Products	1	1
2700	Printing, Publishing & Allied Industries	15	46
2740	Miscellaneous Publishing	1	2
2820	Plastics & other Man-Made Fibers	1	2
2840	Soaps, Detergents, Perfumes & Cos	1	1
2850	Paints and Allied Products	1	5
3320	Iron & Steel Foundries	1	1
3500	Industrial & Commercial Machinery	1	3
3600	Electronic & Other Electrical Equipm	1	3
3730	Ship and Boat Building	1	1
3900	Misc. Manufacturing Industries	4	10
4210	Trucking - Local	1	2
4213	Trucking - Long Haul	2	4
4220	Public Warehousing	4	22
4491	Cargo Handling	1	5
4499	Water Trans, NEC	2	2
4500	Air Transportation	1	2
4720	Arrangement of Passenger Transport	1	1
4730	Arrangement of Transportation of Fre	1	3
4800	Communications; Telephone, Telegr	2	2
5000	Wholesale Trade - Durable Goods, N	20	105
5093	Scrap & Waste Materials	1	3
5100	Wholesale Trade - Non-durable Goo	2	9
5200	Building Materials, Hardware & Gard	2	9
5400	Good Stores	1	2
5410	Combination Mini Marts	1	9

5520	Used Car & Truck Dealers	2	14
5530	Auto & Home Supply Stores	2	23
5600	Apparel and Accessory Stores	1	2
5700	Home Furniture, Furnishings & Cons	1	1
5734	**Computer & Computer Software Store**	**1**	**2**
5811	Eating Places	3	10
5812	Eating & Drinking Places	1	5
5900	Miscellaneous Retail	16	54
5921	Liquor Stores	2	6
5932	Used Merchandise Stores	1	2
5994	Tobacco Stores	1	1
6000	**Banking**	**1**	**14**
6100	**Non-depository Credit Institutions**	**1**	**2**
6200	**Security and Commodity Brokers**	**15**	**44**
6400	**Insurance Agents, Broker & Related**	**34**	**66**
6500	**Real Estate; Agents, Brokers & App**	**15**	**28**
6530	Building & Real Estate Management	6	16
6700	**Holding & Other Investment Offices**	**5**	**10**
7000	Hotels	3	10
7210	Laundry, Cleaning & Garmet Services	2	4
7220	Photographic Studios; Still or Video	4	5
7230	Barber & Beauty Shops	2	4
7290	Miscellaneous Personal Services	2	4
7310	**Advertising**	**1**	**2**
7330	Mail Services	4	5
7342	Pest Control Services	1	4
7349	Building Cleaning & Maintenence	2	4
7350	Equipment Rental & Leasing	1	3
7370	**Computer & Data Processing Serv**	**13**	**62**
7380	Miscellaneous Business Services, N	19	40
7381	Detective, Guard & Armored Car Ser	1	2
7389	Auto Reposs/Bail Bondsmen	2	3
7500	Automotive Repair Shops	5	20
7600	Miscellaneous Repair Services	4	36
7800	Motion Pictures	7	14
7910	Dance Halls	1	4
7920	Theatrical Productions	2	2
7999	Amusements NEC	2	3
8010	**Offices of Physicians**	**67**	**305**
8020	**Offices of Dentists**	**12**	**34**
8040	**Offices of Other Health Practitioner**	**18**	**41**
8070	Medical & Dental Labs	2	3

8100	**Legal Services**	**19**	**59**
8299	Modeling & Finishing Schools	1	2
8350	Child Day Care Services	3	30
8390	Social Services, NEC	1	5
8400	Museums, Art Gall., Botanical & Zool	1	2
8660	Operation of Religious Organizations	2	33
8710	**Engineering, Actuarial, Arch. Surveying**	**6**	**19**
8720	**Accounting, Auditing & Bookkeeping**	**20**	**62**
8730	**Research, Development & Testing S**	**4**	**16**
8740	**Management & Public Releation Serv.**	**34**	**65**

Mr. MICA. Thank you, Mr. Raab.

Dr. Cosman, you are recognized. Welcome.

Mr. COSMAN. Thank you. I am delighted to be here. I have been invited to speak about the legal benefits of Medical Savings Accounts. I have got a nice 33 year history in medical law to give me some legitimacy in doing it.

The Medical Savings Accounts really give credit to every American's intelligence, individuality, and responsibility. The law governing Medical Savings Accounts helps each individual overcome at least seven of the nastiest problems which most other managed care law cause for each patient today. First, an MSA avoids capitation. What most people don't fully perceive is that capitation means the pre-payment of a practitioner or a medical facility in advance per head of American. So that the practitioner gets no more and does not get paid more frequently whether the head comes in with a splinter, with a virus, or the head has its heart in cardiac arrest.

The second value of an MSA from a legal point of view is that it avoids community rating, which is the arrangement, as we have heard, whereby an insurance company must charge the same premium for everyone in a geographic area, no matter the age or the sex or the state of health. Because the individual patient pays out of his or her own MSA, there is no problem as to what is paid. It is the market value for that particular medicine or surgical procedure.

A third and very important advantage from a legal point of view of an MSA is that it avoids the violation of confidentiality. In virtually every circumstance in which say a Medicare patient, or for that matter, anyone who is having an insurance reimbursement, the physician must provide to the insurer some aspect of the patient's confidential medical record. With an MSA there is no such providing of confidential information to anyone. The only two people making the decisions and therefore having that record of the medical or surgical event are the patient and the practitioner.

Related to that is the fourth important advantage. That is that an MSA avoids any third party definition of medically necessary treatment. Now we who are all highly intelligent creatures here make the assumption that medically necessary means that which is necessary to help prevent or treat or cure a disease or injury. But that's not what medically necessary means in the current medical law, particularly under managed care. Unfortunately, medically necessary means whatever the third party payer wants to pay for. MSAs avoid that. What is medically necessary is indeed what the patient and the practitioner decide is correct for that patient.

The fifth important point making Medical Savings Accounts valuable for Government employees as for all other Americans is that it partially avoids what I have been calling the criminalization of American medicine. Most physicians do not realize, and most patients do not realize that the law now guiding and guarding medical care as under the Medicare and Medicaid Patient and Program Protection Act, as under the Health Insurance Portability and Accountability Act, which we have all been calling Kennedy-Kassebaum here, is not civil law. It is criminal law, which means that any practitioner who by accident, let alone intention, violates a rule on medically necessary care or violates a billing code rule, may

suddenly find himself guilty of a felony, fined, have all of his assets forfeited, and also find himself in jail.

An eye surgeon in the State of California was accused of performing 15 medically unnecessary cataract operations which his patients voluntarily requested and which improved their vision. He was convicted on a technicality of fraud against the U.S. Government of $65,000 over 5 years. He is now serving 11 years in a Federal penitentiary. He was fined $16.2 million in penalty. Here, in our magnificent USA.

Related to that, and it's related to this case, is my sixth point about the law. Namely, that Medical Savings Accounts will avoid the possibility of what is becoming increasingly frequent. That is a particularly vicious and distressing type of legal action. It will help avoid qui tam actions. For those in the audience, a qui tam action is a whistleblower action whereby the person who is reporting the so-called fraud gets up to 30 percent of whatever the Government can collect in penalties. While for big Government contractors and while for a nation under war, the whistleblower legislation and qui tam actions are valid and wonderful, they are being used now for disgruntled fired office workers, for disgruntled spouses who find that a qui tam is quicker and cheaper than the divorce court. They are being used by envious competitors in medicine. I have seen a few horrendous cases. Now under Kennedy-Kassebaum and HEPA, health insurance portability, they are being used to elicit from patients reports through various fraud hotlines to encourage them the bring qui tam actions. This is an abuse of both the law and reason.

The last point, the seventh, is that MSAs help avoid medical rationing by third parties. The MSAs will encourage individual patients medical prudence. Managed care, on the other hand, uses the carrot and the stick. It uses the carrot of a bonus and the stick by the so-called withhold to reward practitioners who avoid sending their patients for expensive diagnostic procedures and treatment methods such as surgery.

The MSAs avoid all of these seven unpleasant legal circumstances. They place the personal rights and responsibilities in the mind and in the hands of the American individual needing medical care. An MSA does not require as a Medicare law does, an operation restore trust with its harsh penalties, its fines, its forfeitures and its criminal penalties for physicians and surgeons.

Under an MSA, the physicians' allegiance is to the patient, namely the patient who pays, and not to a third party payer. Trust is not violated. So there is no need for restoration.

I heartily encourage for Government workers the same sort of respect for their intelligence, their individuality and their initiative as we will lavish upon the best working outside of Government. Thank you.

[The prepared statement of Ms. Cosman follows:]

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LEGAL and FINANCIAL BENEFITS of MEDICAL SAVINGS ACCOUNTS

Madeleine Pelner Cosman, Ph.D., Esq.

Testimony for Committee on Government Reform and Oversight
House of Representatives
105th Congress of the United States

Port Monmouth, New Jersey
Pruden Auditorium, Building 1206, Avenue of the Memories
March 9, 1998

BRIEF BIOGRAPHY

Dr. Madeleine Pelner Cosman is an attorney specializing in medical law and the relationship between legislation and medical practice. She is President of Medical Equity, Inc., a national medical and surgical practice brokerage located in Tenafly, New Jersey, which sells medical practices for physicians who retire, relocate, or retrain.

She lectures nationwide for medical, law, and popular audiences, and teaches Continuing Medical Education and Continuing Legal Education courses. Here August, 1997, lecture Who Owns Your Body? was telecast nationally on C-Span. Dr. Cosman is Professor Emerita of the City University of New York where for 30 years she taught medical students medical law, medical ethics, and medical business, and directed a 15 department degree-granting Institute. One of her 14 books and over 120 published essays was nominated for the Pulitzer Prize, the National Book Award, and sold as a Book of the Month Club dividend volume.

Dr. Cosman holds her J.D. from Benjamin N. Cardozo School of Law in New York City, a B.A. from Barnard College (1959), an M.A. from Hunter College (1960), and a Ph.D. from Columbia University (1964). She is a member of the New York State Bar, the New Jersey Bar, and American Bar Association Sections on Health Law and on Law Practice Management. Between 1989 and 1994 she served as Associate Editor of National Trial Lawyer. She is a Barrister of the Arthur Vanderbilt Inn of Court.

DISCLOSURE :*M. P. Cosman does not now have any current federal grant, contract, or subcontract nor has she had any grant, contract, or subcontract during the previous two fiscal years. She does not sell insurance or any product.*

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LEGAL and FINANCIAL BENEFITS of MEDICAL SAVINGS ACCOUNTS

Medical Savings Accounts (MSAs) credit each American's intelligence, individuality, discretion, and responsibility. MSAs always are paired with true insurance against catastrophic medical costs. MSAs are not discounted prepayments of medical care, which is the way most other medical insurance masquerades today. True catastrophic medical insurance (like auto insurance and life insurance) protects assets against expenses for catastrophes we hope will not happen but know are possibilities. MSAs pay for whatever minor medical problems a person reasons it worth paying a practitioner to solve. He who owns his body and mind decides what is medically necessary along with the doctor providing medical care.

I. MSA LAW

MSA law controls behavior of doctors and patients just as American law guides and guards other important commodities of life and other owned property. People have rights to have, to hold, to quietly enjoy, and to convey what they have bought, inherited, or received as a gift.

MSA law assumes *tort law* protection for patients against medical malpractice and *contract law* protection against false promises and overpayments. MSA law diminishes the seven severest intrusions upon patient freedoms imposed by health laws governing managed care, health maintenance organizations (HMOs), and Medicare.

1) MSA law partially avoids *capitation* which is the prepayment of a physician or medical organization per head of American, whether the head is troubled with a splinter, a virus, or a cardiac arrest. Three HMOs now offer MSAs and others plan to (according to the 1997 U.S. General Accounting Office survey).

2) MSA law partially avoids *community rating* whereby insurance companies must charge the same premium for all people of all ages in a geographic area, as in New York and New Jersey, and Open Enrollment all year, as in New York, where insurers must provide coverage no matter the person's current health or prior illness.

3) MSA law partially avoids *violation of confidentiality*. Every Medicare patient encounter as well as almost every claim for routine insurance payment requires the confidential medical record to be reviewed by insurance or government personnel and private data entered into a networked computer databank. Confidentiality disappears.

4) MSA law partially avoids *third party definitions of medically necessary* treatment. While in standard English medical necessity means medication or surgery necessary to prevent, treat, or cure a disease or injury, medical necessity in modern medical law has been perverted to mean whatever the third party payor will pay for. Medical necessity under MSAs is a two party

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decision for medical success joining ideas of the patient and the physician.

5) MSA law partially avoids *criminalization of medicine*. Physicians under the Medicare and Medicaid Patient and Program Protection Act and the Health Insurance Portability and Accountability Act (Kennedy-Kassebaum) risk fines, forfeits of assets, felony conviction, and prison terms for differing on judgments of medical necessity. Amazingly, patients also risk fines and jail, even for insisting that confidential medical records remain confidential. An eye surgeon in California accused of performing 15 medically unnecessary cataract operations which his patients requested and which improved their vision was convicted of "defrauding" the government of $65,000 over 5 years (*U.S. v. Rutgard*). He is now serving 11 years in a federal penitentiary and assessed a penalty of $16.2 million dollars.

6) MSA law partially avoids *qui tam* legal actions, the federal whistle blower actions for False Claims against the government, whereby a disgruntled fired employee, a divorcing spouse, an unhappy patient, or an envious medical competitor can report a physician's supposed billing abuse, and then collect up to 30% of any penalty.

7) MSA law partially avoids *medical rationing by third parties* but encourages the individual patient's medical prudence. Managed care law, on the other hand, uses the "bonus" carrot and the "withhold" stick to financially reward physicians who refuse to recommend expensive diagnosis and surgery, and who pledge allegiance to cost containment rather than to the patient or reasoned medical judgment. Many managed care contracts retain "gag clauses" requiring doctors to not reveal to patients expensive, available alternatives for their care.

MSA law places personal rights and responsibilities in the mind and hands of the American individual requiring medical care. MSA law does not require Medicare's *Operation Restore Trust* with its harsh penalties, fines, forfeitures, and prison terms for physicians and surgeons. Under MSA law the physician's allegiance is to the patient who pays, not to a third party payor. Trust not violated needs no restoration.

II. MSA FINANCE

MSA financing also respects the citizen's intelligence, individuality, initiative, and bank account. Individual patients determine the benefit versus the cost of each medicine or procedure before consent. Cardiologists and urologists have the same market incentives to behave reasonably when selling their talent and services as other professionals, craftsmen, and purveyors of honest product.

Community medical costs and national costs will decrease if a true medical market is permitted to flourish. Many currently costly medical procedures are not inherently expensive but become outrageous because of habitual cost shifting from those who will not or cannot pay the fair price to those whose insurance will pay. Practitioners reimbursed $4 per patient encounter, the amount the largest New York state managed care Medicaid program pays obstetricians and gynecologists, must make up money elsewhere for that less than minimum wage recompense for their time and talent.

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MSAs financially are better than popular corporate Flexible Spending Accounts under IRS Section 125, allowing contributions of pre-tax dollars for spending on medical care or other perquisites. Flexible Spending Accounts require the owner to use the annual money or lose it. But Medical Savings Account owners can use money for desired medical care or save it. The MSA owner with a prudently healthy year can roll over the unused money to let it continue earning interest year after year.

Even if the MSA owner later suffers a medical disaster, the MSA account will lose no more than the stipulated "deductible" for that particular year. Then catastrophic medical insurance monies take over. A reasonably healthy person almost cannot fail to make money with an MSA prudently invested. Customary health insurance, on the other hand, which is not true insurance but discounted prepayment for medical services, produces for the policy holder at year's end nothing but a canceled check.

Under medical law and the dictates of finance, MSAs are rational, logical, responsible, prudent celebrations of the intelligence, diversity, and comparative good health of America. MSAs are a worthy choice for government personnel at all levels.

For all who cherish medical freedom, MSAs are important. Who benefits? Patients freely select their doctors and make reasoned decisions about their own care. Employers pay no more, usually less, for MSAs plus catastrophic health insurance than for other health insurances. Doctors favor MSAs for allowing them to practice good medicine without threats of costly litigation and protective measures required against accidentally violating criminal laws. Over 3000 diagnostic codes (ICD-9) and over 3000 treatment codes (CPT) changed in 1997; even the most meticulous, ethical, careful physician billing for medical service will err. Criminal intent is not necessary for the doctor's guilt to be proved and punished as a felony under strict Federal Sentencing Guidelines.

Medical innovation and medical entrepreneurship benefit the medical market. Insurance carriers, insurance marketers, and insurance agents benefit (though less than from customary indemnity policies). Banks benefit. With MSAs everyone wins except social engineers who want to impose protections against personal freedoms, control quality and quantity of medical care, and redefine "medically necessary" as whatever they think is medically best.

Dependable information sources on MSAs are:

Patient Power Report, a monthly newsletter Greg Scandlen edits. Health Benefits Group, Box 806, Frederick, MD 21705 TEL 301-682-8029, FAX 301-682-7241

Patient Power, the 1992 book by John Goodman and Gerald Musgrave, Cato Institute, 1000 Massachusetts Ave, N.W., Washington, 20001, 1-800-767-1241

On the web: MSA Central's site www.msacentral.com.

M.P. Cosman, Medical Equity, 32 Knickerbocker, Tenafly, New Jersey, 07670, TEL 201-567-2424, FAX 201 567-2534

Mr. MICA. Thank you for your testimony.

Now I'll recognize Ms. Kenna.

Ms. KENNA. Thank you. Mr. Chairman, my name is Janine Kenna. I am the associate manager for product development at Merrill Lynch, responsible for our MSA product. Thank you for giving me the opportunity to testify here today.

As you know, Merrill Lynch provides investment financing, insurance, and related services on a global basis. In particular, Merrill Lynch is the industry leader in the establishment and maintenance of Individual Retirement Accounts. Because MSAs are in many ways similar to IRAs, Merrill Lynch used its IRA experience and infrastructure to become the first full-service brokerage firm to offer MSAs to its clients.

I would like to share with you the experience that we have had with MSAs since they first became available in January 1997. At the outset, let me thank you for conducting these hearings. The MSA concept is one of the most exciting and innovative developments in recent years from both a health policy and savings perspective. For individuals, MSAs provide an attractive means of accumulating assets for the payment of current and future health care expenses that are not covered by insurance. Today MSA eligibility is limited to employees covered under small employers high deductible health plan and self-employed individuals. We commend this committee's efforts to consider expansion of the group eligible to maintain MSAs.

Providing individuals with an MSA option has a number of benefits. MSAs give consumers more control over how their health care dollars are spent. MSAs improve the portability of healthcare coverage. When an individual changes jobs or becomes temporarily unemployed, the MSA goes with them. MSAs promote increased personal savings. If an individual does not have to spend their MSA assets on medical expenses, those funds remain available for future medical expenses or their retirement savings.

To date, the Merrill Lynch experience with MSAs has been positive. About 75 percent of our MSAs have been established by self-employed persons. The average age of those establishing a Merrill Lynch MSA is 46 years old. Significantly, 15 percent of our current clients report that they were previously uninsured. Let me caution however, that this data is preliminary.

Our clients tell us that the two most important factors that led them to establish an MSA were one, the ability to control their choice of doctors, and two, the ability to use funds that are not used for medical expenses to supplement their retirement savings.

Our experience with MSAs also suggests that the major problems with the MSA law today are its complexity and the limited segment of the population that is eligible for MSAs. For example, determinations of eligibility to establish an MSA can be burdensome, as can the calculation of the maximum amount that can be contributed. Finally, MSAs are only effective on a pilot basis with the number of MSAs that can be established limited to 750,000.

Those two factors, complexity and limited availability, have combined to frustrate the growth of the MSA market. First because of the limited nature of the pilot project and the concern over convincing customers to move to a complex new product. Many health in-

surance companies have not offered MSA-eligible health plans, or have not designed them in a manner that maximizes the advantages of an MSA.

The complexity and limited availability of MSAs have also combined to limit the effectiveness and the volume of advertising. Explaining a complex new product in an advertisement is not cost effective if the target market is too small. Despite these difficulties, we would emphasize that the MSA remains an attractive option for many people. We anticipate that the public's interest in MSAs will continue to grow slowly as the level of understanding increases, especially among professional advisors.

We commend you, Mr. Chairman, for introducing legislation that would provide Federal employees with an MSA option beginning next year. Your legislation could substantially improve MSAs by helping to deal with the major problem with the existing MSA regime, the small target market. By expanding the potential market for MSAs to include Federal employees, health insurance plans would be hard pressed not to offer a competitive MSA-eligible high deductible policy—policies that could then be offered to others who are also eligible for MSAs.

In addition, the financial incentives to advertise the MSA product would improve, particularly in markets with a high concentration of Federal workers. Thank you again, Mr. Chairman.

[The prepared statement of Ms. Kenna follows:]

Introduction

Mr. Chairman, I am Janine Kenna, Associate Manager for Product Development for Merrill Lynch. Thank you providing me with the opportunity to address the Subcommittee today on the subject of Medical Savings Accounts (MSAs). Merrill Lynch provides investment, financing, insurance and related services on a global basis. In particular, Merrill Lynch is the industry leader in the establishment and maintenance of Individual Retirement Accounts (IRAs). Because MSAs are in many ways similar to IRAs, Merrill Lynch used its IRA experience and infrastructure to become the first full-service brokerage firm to offer MSAs to its clients.

Today, I would like to share with you the experience that Merrill Lynch has had with MSAs since they first became available in January of 1997. I hope this will help the Committee in its consideration of legislation that would provide federal employees the opportunity to choose MSAs as an option under the Federal Employees Health Benefits Program (FEHP).

At the outset, let me thank you for conducting these hearings. The MSA concept is one of the most exciting and innovative developments in recent years from both a health policy and a savings perspective. Congress is to be commended for enactment of the MSA concept and this Committee's efforts to consider appropriate expansion of the group eligible to maintain MSAs is an important one.

Medical Savings Accounts

Today, MSA eligibility is limited to employees covered under a small employer's high deductible health plan and self-employed individuals regardless of the size of their business. Those who are eligible are given the opportunity to save for the payment of unreimbursed health care expenses through an MSA. For individuals, MSAs provide an attractive means of accumulating assets for the payment of current and future health care expenses that are not covered by insurance. Investing in an MSA can significantly strengthen health care security, enhance retirement security, and potentially decrease current tax liabilities.

For the self-employed, 100 percent of eligible MSA contributions are deductible for Federal income tax purposes. For employees of small businesses that set up MSAs, employer contributions are not taxed under either the Federal income tax or Federal payroll taxes. After contributions are made, MSA assets grow tax-deferred and, if funds are needed to pay medical expenses, they are not taxed under federal law when withdrawn.

Providing individuals with an MSA option has a number of benefits:

MSAs give consumers more control over their health care dollars -- control over where, when and from whom to get their health care.

MSAs improve the portability of health care coverage. When an individual changes jobs or becomes temporarily unemployed, the MSA goes with them. This provides assets to continue paying health insurance premiums or to pay for medical expenses that may arise during a job transition.

MSAs promote increased personal savings. This important advantage of MSAs is often underemphasized. If an individual does not have to spend MSA assets on medical expenses, those funds remain in the account and are available to fund future medical expenses or as a supplement to retirement savings.

MSAs create the opportunity for expanding health insurance coverage to some individuals who could not otherwise afford it.

The Merrill Lynch MSA

The Merrill Lynch MSA is, by design, not associated with any particular high deductible health plan. The self-employed individual or small business puts an MSA-eligible individual or group health plan in place, and then participating individuals establish a Merrill Lynch MSA. Some of the important features of our MSA include:

Access to liquid funds to pay medical bills through an MSA VISA® debit card or through unlimited check-writing privileges. These access options allow the account holder to pay their doctor directly from the MSA and make it easy to keep records of medical expenses.

Investment choices similar to those available to IRAs, including money market funds, Certificates of Deposit, mutual funds, bonds, and equities.

The advice of investment professionals trained to help the client identify financial needs and investment goals, and then help select the investments that are most appropriate for an MSA.

Regular comprehensive statements detailing all transactions.

The delinking of the Merrill Lynch MSA from any particular health plan distinguishes the Merrill Lynch MSA from many other MSA products on the market. By giving the individual a broader array of investment options, the individual can choose the option that best suits their own needs. As a result, the individual has the ability to use the MSA wisely as an investment vehicle until the assets are needed to offset medical expenses. This contrasts with certain other MSA products on the market that simply offer MSAs a fixed interest rate comparable to the interest paid on a savings account.

Merrill Lynch's MSA Experience

To date, the Merrill Lynch experience with MSAs has been positive, at least for those who are eligible and who take the time to understand the many advantages of the product. Approximately 75% of Merrill Lynch's MSAs have been established by self-employed persons, although that may change as more small employers go through an open season with their existing health plans. The average age of those establishing Merrill Lynch MSAs to date is 46. Significantly, 15% of our clients report that they were previously uninsured. Let me caution, however, that this data is preliminary. MSAs have been in existence for just over a year and our experience with new concepts of this type is that it takes time for the general public to achieve an understanding of the advantages of, and to develop a comfort level with, the concept.

Our clients tell us that the two most important factors that led them to establish an MSA were: (1) the ability to control their choice of doctors and (2) the ability to use funds that are not used for medical expenses to supplement retirement savings. This latter point is consistent with findings in the 1997 Ninth Annual Merrill Lynch Retirement and Financial Planning Survey (the Baby Boom Retirement Survey), which found that there is a substantial disparity between the percentage of income that should be allocated to retirement and the income that is actually allocated to retirement.

Our experience with MSAs also suggests that the major problems with the MSA law today are its complexity and the limited segment of the population that is eligible for MSAs. For example, determinations of eligibility to establish an MSA can in some instances be burdensome, involving a monthly analysis of the health coverage of the individual and the individual's spouse. Similarly, the calculation of the maximum amount that can be contributed to an MSA can become very complicated, involving multiplying a percentage by the health insurance plan deductible that was in place in each month. Moreover, MSAs are only effective on a pilot basis from January 1997 through December 2000 and the number of MSAs that can be established has been limited to 750,000 accounts. These limits apply in addition to the general small employer and self-employed limits on MSA eligibility.

Those two factors, complexity and limited availability, have combined to frustrate the growth of MSAs in a number of ways. First, because of the limited nature of the pilot project and the concern over convincing customers to move to a complex new product, many health insurance plans have not offered MSA-eligible plans, or have not designed them in a manner that maximizes the advantages of the MSA. Similarly, the complexity and limited availability of MSAs have combined to limit the effectiveness and the volume of advertising. Explaining a complex new product in an advertisement is not cost effective if the target market is small.

Despite these difficulties, we would emphasize that the MSA remains an attractive option for many people. We anticipate that the public's interest in MSAs will continue to grow slowly as the level of understanding increases, especially among professional advisors.

MSAs for Federal Employees

We commend you Mr. Chairman, along with Government Reform and Oversight Committee Chairman Burton, Ways & Means Committee Chairman Archer and the other cosponsors for introducing the "Federal Employees Health Care Freedom of Choice Act" (H.R. 3166). That legislation would provide all eligible Federal employees with an MSA option beginning in 1999. We would note, in particular, that we are pleased that the legislation appears to allow each Federal employee to choose his or her own MSA. Allowing this type of competitive market for MSAs is critical to their ultimate success, both among the Federal workforce and in the general population.

Providing MSAs as an option under the FEHP has the potential to substantially improve MSAs by helping to deal with a major problem with the existing MSA regime -- the small target market. According to the Employee Benefits Research Institute, almost 9 million individuals received coverage under the FEHP in 1992. By expanding the potential market for MSAs to include those Federal employees, health insurance plans would be hard pressed not to offer a competitive MSA-eligible high deductible policy -- policies that could then be offered to others who are eligible for MSAs. Moreover, the financial incentives to advertise the MSA product might improve, particularly in targeted markets with a high concentration of Federal workers. These improvements would "spill over" into the other groups that are eligible for MSAs and could improve the existing MSA pilot program.

Thank you again, Mr. Chairman.

Other factors that have impeded MSA growth include: certain state laws that have limit (or have delayed) the offer of MSA-eligible high deductible plans; restricting MSA contributions to a percentage (65% for individual coverage and 75% for family coverage) of the deducible, thus limiting the ability to achieve full protection from unexpected health expenses; a rule that says if an employer contributes anything to an MSA for a year then the individual cannot make additional contributions in that year.

Janine Kenna is an Associate Manager of Product Development at Merrill Lynch. In this role, she manages the Medical Savings Account, a tax advantaged savings vehicle for self employed individuals and small businesses. Janine joined Merrill Lynch in 1995 as a member of the Private Client Development Program. She is a graduate of Yale University.

Mr. MICA. Thank you for your testimony, and each of our panelists for providing us with their insight.

First, Mr. Raab, I am trying to figure out, and maybe you can tell me based on your experience or knowledge looking at the MSA market—first of all, I think your testimony indicated that you felt a very small percentage of folks would take advantage of MSAs if offered. Is that correct based on your experience?

Mr. RAAB. Yes, Mr. Chairman. That was our original presumption, that this would appeal to essentially high income better educated people because of the complexity and because of the long-term savings feature. But that has only been partially borne out. Actually only approximately 50 percent of our purchasers are in industries that we would consider high-end. So I think our results might be debunking the preconception already.

Mr. MICA. The other question is if their premiums are lower, and the cost to the employers are lower, there are definite advantages to both the employee and the employer. But when there are other plans available, the accusation, again, is raised about adverse selection, and that costs will go up for some of these other plans because people will cherry pick or the healthier folks will opt out. What is your comment observation?

Mr. RAAB. Well, I have two comments for that. First of all, at the pace these are being sold in the small employer market, it would probably take a decade before there could be a major dislocation because of so-called cherry picking. But there is an easier answer to that. That is, if you as a carrier have both parts of the risk, both the low deductible and the high deductible within one financing mechanism, then you are not harmed by the adverse selection potential.

Mr. MICA. You think that should be part of the mix, the required part of the mix?

Mr. RAAB. Exactly. I think that's what Mayor Schundler was getting at. If you offer all four options within the same plan, then you can't adversely select against the plan because all the possible options are being paid into the same pool of money, so to speak.

Mr. MICA. Dr. Cosman, you had talked about the criminalization under all the laws we have passed now, and how we have criminalized health care providers. Some of that was done in an effort to eliminate waste, fraud, and abuse from the system. You have testified today that you think individuals can do a better job in making that determination, or we wouldn't have the same degree of criminalization. Is that correct or do you think that under MSAs, there would still be the same amount of fraud, maybe not utilization because people are going to individually choose to participate or to get service provided. I am trying to think of how you are telling us that there would be less criminalization under MSAs.

Mr. COSMAN. The problem is that with certain of our current medical laws, we are more concerned with protecting the program than we are with protecting the patient. If one looks at the Medicare and Medicaid Patient and Program Protection Act, one finds that most of the accusations against physicians are not for fraud which in any way hurts the patient, but for what might be construed as billing fraud. Then when one looks at that carefully, it is not fraud at all, but rather accident. That is to say physicians

who are being reimbursed by Government payers are for the most part submitting bills to the Government, and they are not themselves submitting the bills. They have billing secretaries or their billing assistants or their billing systems are.

If a practitioner whose billing secretary or billing system accidently uses a wrong code and uses it several times, and remember, these codes, these CPT codes as they are called, in the last year of 1997, 3,000 new CPT codes were introduced, 3,000 new diagnostic codes were introduced. Even the most meticulous, precise, honest and ethical practitioner can make an error completely accidently. My point is that because we are so concerned with protecting the program and its costs, which is a valid concern, we are over criminalizing the actual provision of medical care.

Under MSAs, since one doesn't have to then worry about a third party payer under criminal law, there are the usual ethical, intelligent market forces. There is the usual American tort law which protects the patient against medical malpractice. There is the usual American contract law which protects the patient against say excessive fees or misrepresentation.

My belief is that the MSA allows a normal, natural, and intelligent legal system to guide and guard medicine. It is the over-legalization under criminal law of such programs as Medicare and HMOs which leads to the excessive use of criminal law against good practitioners.

I point out I am not interested in defending the quacks and the charlatans and the real frauds. I am eager to see us allow reason, balance, and intelligence to return to the doctor-patient relationship.

Mr. MICA. Thank you. Ms. Kenna, Merrill Lynch, how long have they been offering MSAs?

Ms. KENNA. We have been in the market nationally since September 1997.

Mr. MICA. So it's a fairly short period of time.

Ms. KENNA. Very short.

Mr. MICA. Are you saying that 15 percent of MSA clients previously had no medical insurance?

Ms. KENNA. Yes.

Mr. MICA. Have you looked into any reasons why these folks didn't have coverage?

Ms. KENNA. We have done some focus groups with our clients, asking them exactly that question because it seems unusual that generally sophisticated investors don't have health insurance. But as I mentioned earlier in my testimony, about 75 percent of our client base are self-employed individuals. They found it very difficult to procure health insurance at a competitive rate. As a self-employed individual, you don't have the benefit of being subsidized by a large organization. So they have not found health insurance that has been something that they could afford. This was a way that they could get a tax break at the same time as making sure that their family was insured.

Mr. MICA. You said that the average age of your participants is?

Ms. KENNA. Forty six.

Mr. MICA. Forty six. Do you know what portion is under and above? Have you looked at that?

Ms. KENNA. We haven't looked at that yet, but I can get you that information if you are interested.

Mr. MICA. I think that would be interesting for us to see. It's only a short period of time, but it would be interesting to see if you are attracting elderly and young, and for what reasons. So we would appreciate your followup with our subcommittee.

I have no further questions at this time. I will yield to Mr. Pappas, the gentleman from New Jersey.

Mr. PAPPAS. Thank you, Mr. Chairman. Thank you folks for staying and participating.

Mr. Raab, you spoke of the individuals that you dealt with, 53 percent are professionals, attorneys, physicians, engineers, and others. You didn't talk about the other 47 percent. I am wondering if you could talk to us a little bit about who they are.

Mr. RAAB. Well the other 47 percent are scattered amongst the full range of standard industrial codes, which is how we searched our client data base, including, I believe, some farmers. We essentially searched all the standard codes. We did notice this concentration which we expected, but the concentration was not as heavy as we had expected.

This concept burst on the scene so quickly that we didn't really have time to do market research to get an idea what to expect. So we didn't have a real scientific notion. We just had our own instincts to tell us. Lo and behold they were only somewhat correct, but also pretty wrong. We expected about probably 75 to 85 percent concentration in the professions. We were just wrong. Pleasantly surprised, I might add.

Mr. PAPPAS. The first panel I asked the question which I want to ask of you folks as well. In New Jersey, we have what people refer to as the Kennedy-Kassebaum. I am wondering what changes, if any, you think should be considered.

Mr. RAAB. Changes to the way the plan was designed in Kennedy-Kassebaum?

Mr. PAPPAS. Yes.

Mr. RAAB. Yes. In fact, I think there are three things that should be done. First of all, I think it makes more sense to permit funding the savings account up to 100 percent of the deductible as opposed to 65 or 75 percent of the deductibles as currently structured.

As a corollary to that, I think it would also make sense to permit both employers and employees to contribute tax favored funds to the account in the same way. The current law prohibits that. Obviously, therefore, if the employer can't afford or is unwilling to make a full contribution, I think it would make sense to permit the employee to do it. Current law won't permit it.

Finally, I think the way the Internal Revenue Service has interpreted Kennedy-Kassebaum has actually narrowed market availability; not necessarily intentionally, but revenue ruling 97–20 requires carriers to administer claims in essentially a manner that is counter to decades of industry practice and consumer expectations. Families with only one sick person in them are really discouraged from buying into the MSA concept because of the way the claims must be adjudicated.

Mr. PAPPAS. Doctor?

Mr. COSMAN. I would like to see two changes. One, as has been mentioned, I would love to see the employees be able to get the tax advantage of providing their money into their MSA in addition to the Government.

The second, I would very much like to see the possibility of avoiding what is in essence a type of community rating, whereby we essentially make those living in less expensive areas pay as much as those living in very expensive areas. Therefore, there is a somewhat perverse subsidy in which those who are able to get lower cost medical care are in essence subsidizing those living in more expensive geographic areas.

Mr. PAPPAS. Do you have anything to add, Ms. Kenna?

Ms. KENNA. I would agree both with Dr. Cosman and Mr. Raab. There is no reason why these shouldn't be 100 percent deductible. I think that would foster a much larger market than we have today.

I would also concur that both employer and employee contributions should be permissible in the same year. It just maximizes the potential of these accounts.

The one thing that I would contribute on top of that is that the market is so limited right now that it's very difficult for consumers, especially in the private sector, which is with what I am most familiar, to find education on this product and to build their familiarity with it. By extending availability both to Medicare and to Federal employees in the next year, I think that people would become much more aware of what it is, and how to use it. We'll all become much savvier consumers.

Mr. PAPPAS. Dr. Cosman, in your seven points that you made very well, and you submitted that to us in writing, I want to focus upon the medically necessary definition that you expounded upon. I am wondering if you could describe any court rulings that have dealt with this issue, this contentious issue, and have there been rulings that have been at odds with one another?

Mr. COSMAN. The whole phrase medically necessary, has become essentially perverted in the courts as well as in our language. Let me just refer to that case that I suggested in which the eye surgeon in California was accused of medically unnecessary cataract operations.

The patients were not only not harmed, they were helped. The patients requested the care. Three years after the event, Federal investigators looked at certain of the numbers in the so-called refractions. Was it 20–20 is normal, was it 20–200 or was it 20–170, what were the numbers. Well, because a few of those cases were what might be construed as borderline cases, they were then disallowed after the fact, but as opposed to being merely construed as differences in medical opinion, they were viewed as criminal violations.

Now this is an outrageous interference in medical judgment as well as in the patient-physician relationship. What was medically necessary for those patients was determined by the physician and patients at the time the work was performed. It was only after the fact that the phrase medically necessary became in essence a criminal charge.

My point is that there is a common understanding both in reality and in the law that medically necessary should be what is required for the particular patient's disease or injury for its prevention or its treatment or its cure. Medically necessary shall not be or should not be that which an insurer will pay for. That is what it has become.

Let me just give you a very quick example. Literally as I was driving down on the very wet rainy highway, I got a call on my car phone from a urologist in another State who had in his office a police officer who had been shot. The problem was not with the bullet wound, but with an infection of the police officer's genitalia. The question was, did this urologist dare to put on the medical record a particular antibiotic which would quickly cure the infection because that same antibiotic is used for the cure of venereal disease. The police officer was worried that if anyone got a hold of his medical record, it would first impede his advancement and his elevation in the police department, but second, interfere with his marriage.

Now what is medically necessary for that officer was that high price excellent antibiotic. The practitioner was worried that not only would he be providing what is medically necessary, but he would be essentially potentially wrecking the reputation of the man if he provided what was truly medically necessary, but someone later misunderstood that and viewed it as not only not medically necessary, but as evidence of venereal disease.

So that gives you an example of the two points I was making. One, what is medically necessary shall be truly what's medically necessary. Two, potential violation of confidentiality when the confidential medical records ceased to be confidential because of their being open to insurance and other investigators.

Mr. PAPPAS. Thank you.

Ms. Kenna, one final question. You in your testimony indicated that you are providing this product, MSAs to your clients. As I am sure you know, this pilot project is limited 750,000. One question which I guess I could answer is that would you want to see this number increased. I'm sure the answer to that is yes. If so, what do you think would be a reasonable increase to maybe assist companies such as your, your actuaries to get a feel for what impact this may have to just the coverage, health care coverage for your client base?

Ms. KENNA. We would like to see the entire numerical limitation taken off of this 750,000, because the private sector at least looks at this and they think oh, 750,000, that will go by like that. I already probably missed the boat, which is not in fact the case. Again, it has been very difficult to find insurance that's compatible with these Medical Savings Accounts.

So, from our perspective, just from a public relations standpoint and a consumer education standpoint, I think it would be helpful to remove the 750,000 limit and not to put in another numerical limitation in its place, because I think, to be frank, that is scaring a lot of people away at this point.

Mr. PAPPAS. Mr. Raab, would you want to answer the same question?

Mr. RAAB. Yes. I agree. I think in the free market of ideas and products and services, that I don't see a need for any numerical

cap. To get back to your earlier question, if it would be helpful to the committee, I could send down to the staff a listing of all our purchasers by industry, if you would find that helpful.

Mr. PAPPAS. Thank you.

Mr. MICA. Thank you. I would like to yield now for the purpose of questions to the representative for our ranking member, Mr. Hendricks.

Mr. HENDRICKS. Thank you, Mr. Chairman. Just a few questions, in fact, one for each of you.

Mr. Raab, does Anthem Health do any public sector MSA business presently?

Mr. RAAB. My company is Anthem Health which is here in New Jersey. Our parent corporation is Anthem Blue Cross Blue Shield. They may or may not be in the public sector environment. I don't know. We are only offering products in areas where our parent does not write coverage. We are offering it only in conjunction with the pilot project.

Mr. HENDRICKS. Thank you. Ms. Kenna, let me ask you the same question. Does Merrill Lynch presently do any public sector MSA business?

Ms. KENNA. To the best of my knowledge, currently all of our accounts are contained within the private sector.

Mr. HENDRICKS. OK, thank you.

One last question for Dr. Cosman. You stated in your testimony that reasonably healthy people could not fail to make money with an MSA. Is that correct? Is that your testimony?

Mr. COSMAN. That was part of my written testimony, yes. The audience did not hear that.

Mr. HENDRICKS. Now does it then follow that sick and elderly people could very well lose money with an MSA?

Mr. COSMAN. No. I don't think that is too likely. Of course people could make errors. But let me explain my point. When a person has an MSA and has whatever is the amount dedicated to it, $1,800 or $2,000 to use for that year, if only a certain small amount is used that year, let us say half, then that $900 is then rolled over to the next year and added to the next $1,800 which comes in that year, and constantly and continuously earns interest.

My point is that the person of any age or any degree of health who does not use all of the amount has the opportunity to make money and generally to make a fair amount of money, just as our IRAs enable us to make money.

Now the person who has very high medical bills and uses up all the money in the MSA has nothing at the end of the year, that is true. But it is also true that under our current indemnity insurance at the end of the year what do we have? A canceled check, nothing more. My point is that if we have a good year, we make profit. If we have several good years, we make a lot of profit.

The person who is very ill with a serious chronic disease may not make profit, but probably will come out ahead because he or she will not have to pay the copayments which are customary in the first dollar indemnity plans.

Mr. HENDRICKS. Then let me just add this followup question. Are copayments characteristic of the high deductible catastrophic plan?

Mr. COSMAN. Here it depends upon the State we're dealing with and the particular company selling it. My point here is that when we are dealing with money paid out of an MSA, there is no problem in copayments. One pays the amount according to the agreement between the physician and the patient and that's it. That is almost invariably better for someone who has got, if you will, an expensive chronic disease than having to pay 20 percent of whatever is the payment for service under a usual indemnity insurance plan.

That is, there are numerous figures which I can provide for the subcommittee, if you so wish them, which demonstrate that even the sickest people come out ahead. They do not do as well as the well people, but they still get an economic advantage.

My final point on the economic advantage is that much like an IRA, there is a tax benefit so that this is really tax advantaged to everyone who has an MSA. They are making minor profit or as I would hope most people in the audience, major profit.

Mr. HENDRICKS. Thank you, Mr. Chairman.

Mr. MICA. Thank you. I want to take this opportunity to thank each of our panelists for their participation today. We may have additional questions we would submit to you. If you have additional comments you would like made for the record, they will be made a part of the record. You are excused. Again, we appreciate your testimony.

Ladies and gentlemen, this will conclude the formal part of our hearing; we've turned into this afternoon; we started this morning. I did want to provide an opportunity, though, and somewhat abbreviated because of time constraints and flight arrangements, to at least one other request for a comment.

I think we have Mr. Collier from the National Association of Retired Federal Employees. Mr. Collier, you are welcome to come up if you would like and make a brief presentation to the subcommittee. Can you first identify yourself? You have a gentleman with you. If you would go ahead and be seated. I am not going to swear you in. We are in an informal open mic session here. But if you could identify yourself for the record and then we will have you later give us your address for subcommittee purposes.

Mr. Collier, you are recognized, sir.

STATEMENT OF BENJAMIN COLLIER, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, ACCOMPANIED BY FRANK BEEG, LEGISLATIVE DIRECTOR, NEW JERSEY FEDERATION OF NARFE

Mr. COLLIER. Thank you, Mr. Chairman. I have with me Mr. Frank Beeg, who is the legislative director of the New Jersey Federation of NARFE. I am also a member of NARFE and have been working with Congressman Pappas and some others in this regard.

I know that you have had a meeting this week with Judy Park, our national legislative director, so I won't go over many of the things that you may have discussed with her. But I would like to read into the record a statement by our national president, Mr. Charles Jackson, on this matter of MSAs.

The National Association of Retired Federal Employees reaffirms its opposition. Your legislation that imposes Medical Savings Ac-

counts [MSAs], on the Federal Employees Health Benefits Program. NARFE members adopted this position at our last biannual convention. While supporters of this bill say that MSAs will allow participants to select the doctor of their choice, FEHBP fee-for-service enrollment enrollees already have an unlimited choice of physicians. MSAs are neither warranted in FEHBP nor wanted by Federal employees and annuitants.

NARFE bases its opposition to H.R. 3166, you know the bill introduced by Representative Barton, on the following points. One, since MSAs tend to attract healthy persons their defection from FEHBP plans that already provide limitless choice will upset the community of coverage and force insurance carriers to cut benefits, raise premiums or both. Studies have found that persons who perceive their MSA balance as their money are more likely to delay seeing a physician at the onset of a health problem, leading to more serious and costly complications later. I think Dr. Eck mentioned something of this nature.

Previous estimates by the non-partisan Congressional Budget Office on similar proposals require MSAs and catastrophic insurance in FEHBP indicate such plans will cost, not save, the Government money. Of the MSAs currently available, demand and interest is low. The Internal Revenue Service says that in more than a year and a half after MSAs were offered by the Kassebaum-Kennedy bill in 1996, less than 20,000 MSA accounts have been opened, far less than 750,000 policies this law made available for the self-employed and small business employees.

It is quite clear that most Americans are not clamoring for MSAs as the cure for their healthcare wishes, says our New Jersey federation chairman president Sam Girson. Certainly we all support good affordable health care being available to all Americans. But we don't believe expanding MSA catastrophic plans into the FEHBP program is the answer. That is the end of the statement, sir.

Mr. MICA. Thank you so much. We have enjoyed working with Charles Jackson, your president. It's good to hear his comments again. Judy Park, we also work very closely with. The concerns that they have expressed about adverse selection we intend to address in any legislation that is passed, making this option available. We are also very concerned about reducing the healthcare costs for our Federal retirees, which I think you know and I think I stated in my opening comments, were 15 percent increased on average last year, which is burdensome.

So we're trying to find a way to bring those costs down, both for the active Federal employees and for our retirees. We appreciate your comments both on behalf of the New Jersey NARFE and also on behalf of Charles Jackson, the national president of the National Association of Federal Retirees.

Excuse me, sir, would you please repeat your name too for the record?

Mr. BEEG. My name is Frank Beeg. State legislative officer of New Jersey NARFE.

Mr. MICA. Thank you. You are recognized, sir.

Mr. BEEG. I just want to reiterate some items that Ben brought up. First of all, one of the last members of the panel, was talking

about self-employed people. The average age of those people is 46 years old, which is a much healthier group than I am associated with.

We feel that tinkering around with this plan can only harm it. There is no benefit to be made by introducing MSAs into the FEHBP plan right now at this current time. In fact, the notes I have show that Kassebaum-Kennedy opened up 750,000 accounts for people to participate in. Somewhere like 20,000 people actually have opted to go into this plan, which is actually less than 3 percent of the spots that were to have been filled.

People in FEHBP plans are very happy with their plan. They are contented with what they have. As I travel around the State attending different meetings, this is one of the things I constantly hear. To put it in the vernacular of the older population, if it ain't broke, why fix it? They are contented with what they have and they don't want to see anything that will endanger their health coverage.

One further point. The information I have is that the CBO says that this conversion will actually cost the Government money, and it will not save the Government money. So it befuddles a person to understand what would be the benefit of this if the Government is going to be spending more money. That's about the end of my observations on this.

Mr. MICA. We want to thank you for your observation and comments today. Of course the concerns that you raise have been concerns that we subcommittee members have. We certainly wouldn't want to adopt anything that would increase costs. We do want to look at what will reduce costs, both for our active employees, and particularly for our Federal retired employees, who are probably in a much more difficult financial position to keep up with the increased costs that are, in most instances, double digit, while their increase and funds available are very minimal.

So we, in fact, are trying to approach any institution of this as an option in light of the concerns that have been raised. I have also advocated, as chairman, that we do this on a demonstration basis to; that we can have some test as to how it is utilized. We have noticed that some folks said under Kennedy-Kassebaum that there would be tremendous utilization. Yet, in fact, there has been a smaller number of folks making themselves available. So on the one hand, that does also counter the argument that everyone in the Federal employment would rush to MSAs. We don't know that to be the case based on what we have seen with the Kennedy-Kassebaum.

We appreciate your opinion. We look forward to working with both the State organization, and our continued efforts with the national organization to see whatever is implemented is done on a sound concurrent basis.

Mr. COLLIER. Just one statement. I am happy to hear that you used the word COLA, because we are happy that we got our COLAs this year starting in January rather than having to wait until the middle of the year almost.

Mr. MICA. Did you want to personally thank me for fighting for that?

Mr. COLLIER. Yes. We do thank you and Mr. Pappas both.

Mr. MICA. We do try to do that. Mr. Pappas—whoops, our platform is falling apart here. Maybe it is time to go. But we are working on that. We are also trying to make certain that we continue the open season on retirement. We will continue to not allow Federal retirees to be picked out and picked on, at least from the COLA standpoint.

Again, I want to thank each and every one of you for coming out today. I wish we had more time to hear from everyone from the audience. We have run a little bit late. We do have some transportation commitments to keep. But I will leave the record open, as I said. Anyone is welcome to add comments written to the House Subcommittee on the Civil Service, Washington, DC, 20515. We welcome your further participation.

Again, Mr. Pappas, I thank you so much for your hospitality and having us here in your community, and the opportunity to hear from individuals in your community and New Jersey on their perspective on MSAs and our Federal Employees Health Benefits Program.

There being no further business to come before the subcommittee, this meeting is adjourned. Thank you.

[Whereupon, at 12:49 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Additional information submitted for the hearing record follows:]

Next Generation Marketing

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The Honorable John L. Mica
Chairman, Civil Service Subcommittee
Committee on Government Reform and Oversight
2157 Rayburn House Office Building
Washington, DC 20515-6143

March 17, 1998

Dear Mr. Chairman:

Thank you very much for giving me the opportunity to testify on behalf of Merrill Lynch before the Civil Service Subcommittee's field hearing on providing medical savings accounts to federal employees. I hope the information I provided was informative and useful to the committee, as well as to the federal employees in attendance.

In my testimony, I stated that the average age of Merrill Lynch MSA account holders is 46. You asked if I knew the age distribution of our account holders who are greater than 46 in age, a statistic that I have included below for your reference.

Currently, 51% of Merrill Lynch MSA holders are more than 46 years old. Our highest account holder age concentration is between 46 and 50 years old which includes 19% of the total client base, followed by the 51-55 age range, which includes 17% of account holders. 9% of our MSA clients are between 55 and 60, and 6% of the client base is in excess of 60 years old.

Again, thank you for giving me the opportunity to testify, and please contact me if I can be of further assistance to you.

Sincerely,

Janine Kenna

Benjamin A. Collier

FOR IMMEDIATE RELEASE
March 9, 1998

CONTACT:
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NARFE SAYS MEDICAL SAVINGS ACCOUNTS (MSAs) ARE NEITHER WARRANTED NOR WANTED IN FEDERAL HEALTH PLAN

The National Association of Retired Federal Employees (NARFE) reaffirmed its opposition to legislation that imposes Medicare Savings Accounts (MSAs) on the Federal Employees Health Benefits Program (FEHBP) at an informational hearing hosted today by Rep. Mike Pappas (R-NJ) in Ft. Monmouth, New Jersey.

NARFE members adopted this position at their last biennial national convention.

"While supporters of this bill say that MSAs will allow participants to select the doctor of their choice, FEHBP fee-for-service enrollees already have an unlimited choice of physicians," said NARFE President Charles R. Jackson. "MSAs are neither warranted in FEHBP, nor wanted by federal employees and annuitants."

NARFE bases its opposition to H.R. 3166, introduced by Rep. Dan Burton (R-IN), on the following points:

- Since MSAs tend to attract healthy persons, their defection from FEHBP plans that already provide limitless choice will upset the community of coverage and force insurance carriers to cut benefits, raise premiums, or both.
- Studies have found that persons who perceive their MSA balances as "their money" are more likely to delay seeing a physician at the onset of a health problem, leading to more serious – and costly – complications later.

(over)

National Association of Retired Federal Employees

Charles R. Jackson, President | Al James Golato, Vice President | Bess T. Jensen, Secretary | Frank G. Alexander, Treasurer

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* Previous estimates by the nonpartisan Congressional Budget Office (CBO) on similar proposals to require MSAs and catastrophic insurance in FEHBP indicate such plans will cost - not save - the government money

* Of the MSAs currently available, demand and interest is low. The Internal Revenue Service (IRS) says that, in more than a year and a half after MSAs were offered by the Kassebaum-Kennedy bill in 1996, less than 20,000 MSA accounts had been opened, far less than the 750,000 policies this law made available for the self-employed and small business employees.

"It's quite clear that most Americans are not clamoring for MSAs as the cure for their health care woes," said NARFE New Jersey Federation President Sam Girson. "Certainly, we all support good, affordable health care being available to all Americans, but we don't believe expanding MSA-catastrophic plans into the Federal Employees Health Benefits Program is the answer."

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NARFE, one of America's oldest and largest associations, was founded in 1921 with the mission of protecting the earned rights and benefits of America's active and retired federal workers. NARFE has a membership of nearly 300,000 men and women.

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