Changing Survey Strategies in the Evolution of Health Care Plans

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From 1979 to 1994, the structure of employer-sponsored health insurance plans dramatically changed in response to economic pressures. During the period, employers sought to curb the rising cost of care by restructuring their health plans to emphasize cost containment techniques.[1] Under these pressures, innovative health insurance plan designs emerged, creating a diversity of methods for delivering health care benefits and reimbursing subscribers that did not exist in the early 1980s.[2] The methods available for financing health care benefits evolved along with the developments in benefit delivery and reimbursement systems.

Keeping pace with this rapidly changing environment has been a challenge for the Bureau of Labor Statistics' Employee Benefits Survey (EBS), which studies the incidence and detailed provisions of health care plans along with other major insurance, retirement, and paid leave benefit plans. Ensuring the reliability of data and capturing the rapidly changing circumstances surrounding health care meant benefits survey questions needed to be revised. Furthermore, the survey's analytic procedures required revision to ensure that plans and the methods used to finance them are correctly classified. As former Commissioner of Labor Statistics Janet Norwood observed several years ago in predicting the difficulties in measuring employee benefits:

> Quality management will have to be outwardly, as well as inwardly, directed. When the specifications themselves are in flux, it will not be enough to ensure that the system is working according to specifications. More and more resources will have to be devoted to monitoring developments in the field. Survey measuring instruments and computer systems will have to be frequently retooled to keep current. To keep pace, survey designers will have to prospect for themselves as well as for data users.[3]

And, since former Commissioner Norwood made that statement almost 10 years ago, EBS has expanded the survey to publish data on part-time workers, State and local governments, and small private establishments, as well as augmenting the survey to better capture data on changing benefits.

This article traces developments in plan delivery and reimbursement methods, discusses the changes the survey has undergone to keep up-to-date with the changing structure of employer-provided health care, and concludes with an evaluation of the survey's current classification system for health care plans.[4]

Basic types of health care plans

One way of viewing health care plans is to examine how health care claims are reimbursed. Two key questions are: Do plan subscribers have to pay part of the cost of plan services; and, if so, how are these payments determined? Increasingly,

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the answers to these questions depend on whether plan participants have unrestricted choice among health service providers, or must use designated providers. Several major types of plans can be identified, depending upon the answers to these questions.

Fee-for-service (FFS) plans reimburse participants or providers for covered charges after they are incurred. Although participants in these plans are generally free to choose their own health care providers, benefits are rarely covered without limitations. Typically, there are limits such as deductibles and coinsurance payments that apply to most, if not all, services. A deductible is a payment required of plan participants before their benefits commence; today, deductibles of $100, $200, and $250 are common. Coinsurance refers to the percent that the plan pays for covered services, compared to the percent that the plan participant must pay. FFS plans frequently pay 80 percent of expenses with the remaining 20 percent paid by the participant.

Preferred provider organizations (PPO's) are special types of FFS plans that have networks of health care providers. Although participants can still venture outside the network for health care, they pay a greater share of the costs than if they seek care from the network providers. In a typical case, a plan will pay 90 percent for covered expenses for a network doctor, compared to 80 percent if a participant goes outside the network.

Health maintenance organizations (HMO's) constrain the choices among service providers further. Usually, participants are required to receive care from the health providers that contract with the HMO's, or they will not be reimbursed. HMO's offer specified health care services for a prepaid fee, and most medical services are either covered in full without limitations or require patients to make only a small copayment. For example, a patient may make $5 or $10 copayments for each visit to the physician's office. Because HMO's both finance and provide health services, they emphasize preventive care to their participants.

Table 1. Percent of full-time participants of HMO's by type, medium and large private establishments, selected years, 1988-93

Type of model	1988	1989	1991	1993
Total, all models	100	100	100	100
Group/ staff/ network	37	44	49	41
Individual practice association	55	53	43	52
Mixed	7	4	8	7

Table 2. Percent of full-time participants by type of health care plan, medium and large private establishments, selected years, 1979-93

Type of plan	1979	1980	1981	1982	1983	1984	1985	1986	1988	1989	1991	1993
Total, all types	100	100	100	100	100	100	100	100	100	100	100	100
Fee-for-service	98	97	96	95	96	95	92	86	74	74	67	50
Health maintenance organization	2	2	3	4	3	5	7	13	19	17	17	23
Preferred provider organization[1]	–	–	–	–	–	–	–	1	7	10	16	26
Other	([2])	1	1	1	1	([2])	1	([2])	([2])	([2])	([2])	1

[1] Data not tabulated until 1986 survey.

[2] Less than 0.5 percent.

The two most common types of HMO's are the group model and the independent practice association (IPA). In the group model, the HMO contracts with a single independent group to provide care in a central location. In an IPA, the HMO contracts with physicians in private practices to provide care.

There are three other HMO models: Staff, network, and mixed. The difference between the staff and group models is that in the staff model the HMO directly employs the physician group. In the network model, an HMO contracts with two or more group practices to provide health services in a central location. When an HMO uses a combination of these models, it is referred to as a mixed model. The large majority of HMO participants are in either group/staff or IPA-model HMO's. (See table 1.)

When the Employee Benefits Survey was first conducted in 1979, virtually all plan participants were enrolled in FFS plans, with a small minority subscribing to HMO's. (See table 2.) PPO's were so rare that they were not even tabulated. The early surveys were only able to publish data on the provisions of FFS plans, because the number of employees enrolled in HMO plans was insufficient to support valid survey tabulations. By 1993, the most recent year for which data on medium and large private establishments are available, HMO's and PPO's accounted for as many health plan participants as FFS plans. In the 15 years covered by the survey, participation in HMO's rose from 2 percent to 23 percent, while FFS participation fell by nearly half, from 98 percent to 50 percent. PPO's were first surveyed in 1986 and accounted for 1 percent of health plan participants; by 1993, PPO enrollment accounted for 26 percent. These trends are illustrated in chart 1.

A similar picture emerges in small private establishments, though survey data are limited to 1990, 1992, and 1994. In 1990, fee-for-service plans enrolled 74 percent of

Table 3: Percent of full-time participants, by type of health care plan, State and local governments, selected years, 1987-94

Type of plan	1987	1990	1992	1994
Total, all types	100	100	100	100
Fee-for-service	67	61	43	38
Health maintenance organization	24	22	27	30
Preferred provider organization	7	17	29	30
Other	2	(1)	1	2

[1] Less than 0.5 percent.

full-time health plan participants in small establishments, with PPO's (13 percent) and HMO's (14 percent) splitting the remainder. By 1992, PPO's gained 5 percentage points at the expense of FFS plans, while HMO participation held steady. In 1994, the last time these establishments were surveyed, FFS participation declined to 55 percent of the total, while PPO participation increased to 24 percent and HMO's to 19 percent.

Alternatives to FFS plans account for the majority of full-time employees participating in health care plans in State and local governments. These alternative plans together included 1 in 3 health care participants in 1987; by 1994, these plans covered 5 in 8. (See table 3.) Most of the growth came in PPO's at the expense of FFS plans.

The shift to HMO's and PPO's from FFS plans is due, at least partially, to the rapid increase in health care costs. With employers treating health care services like other commodities subject to stringent cost-benefit analysis, new strategies for controlling medical care cost increases have emerged. The implementation of health plans that emphasize managed care has been a major response to this health care cost escalation.[5]

Managed care refers to the practice of ensuring that services rendered to participants are medically necessary and are provided in the most appropriate health care setting. Some basic features of managed care programs include preadmission certification for hospitalization, preadmission testing, and second surgical opinions. Managed care has led employers to move toward health care plans that will enable them to provide their employees with adequate care at lower costs. Traditional FFS plans were slower to embrace managed care features than either HMO's or PPO's. By virtue of their design, which restricts the subscriber's choice among service providers, HMO and PPO plans manage care by directing participants to specific providers or services.

In the last few years, new types of health care plan designs have emerged. To a large degree, these new types are refinements, combinations, or hybrids of the three basic types. Among the fee arrangements that have been introduced to manage costs better are: Exclusive provider organizations, point-of-service HMO's, and physician hospital organizations.

Exclusive provider organizations (included in the "other" category in tables 2 and 3) are types of FFS plans that require participants to receive health care services from a network provider; if not, they are not reimbursed for any care. They are not prepaid plans. The 1993 EBS results from medium and large private establishments indicate that exclusive provider organizations cover only 1 percent of medical plan participants.

Point-of-service HMO's (included with HMO's in tables 2 and 3) combine characteristics of both PPO's and HMO's. Like HMO plans, they are prepaid and use a network of contracted providers. Most benefits received from network providers are covered in full. However, like PPO's, participants can seek care outside the network but receive a less generous reimbursement. Also, the enrollee is subject to such limits as deductibles and coinsurance requirements when non-network providers render services. Ordinarily, point-of-service HMO's cover a full array of preventive services. One-tenth of HMO participants in 1993 were in plans with a point-of-service feature.

Physician hospital organizations (included in the "other" category in table 2) are formal partnerships between physicians and hospitals that offer complete health care coverage.[6] By joining forces with

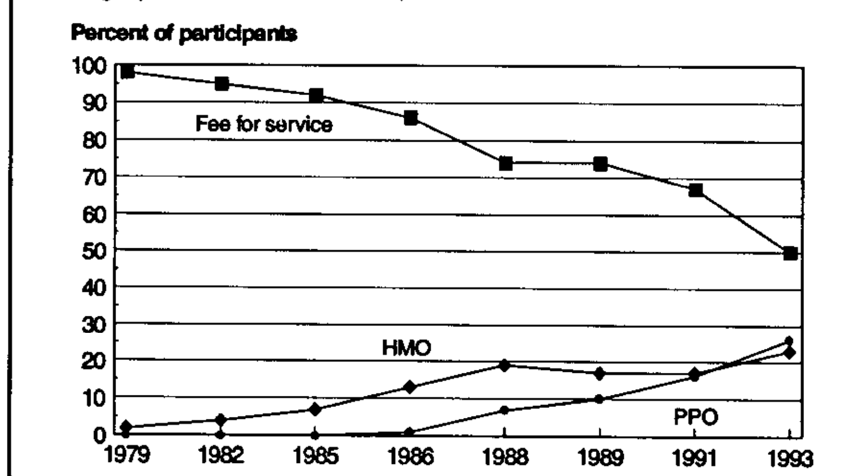

Table 4. Percent of full-time participants with medical benefits, by financial intermediary, medium and large private establishments, 1988 and 1993

Participants	1988	1993
Total with medical care	100	100
Self-insured	34	47
Commercial insurers	30	21
Blue Cross/Blue Shield	16	13
Independent organizations	15	18
Combined financers	5	([1])

[1] Less than 0.5 percent.

hospitals, doctors believe that they can better defend their role in medical decision-making against continued encroachment from non-medical professionals.[7] However, these new fee arrangements are still relatively rare.

These innovations have made it more difficult to sort health care plans into distinct categories. What were once discrete plan types are now merging into hybrid forms that mix and match access to medical services, reimbursement methods, and financing arrangements. In some aspects, exclusive provider organizations, a type of FFS plan, resemble HMO's, especially in restricting the employee's choice of health care providers. But unlike HMO's, they do not provide services for a prepaid fee. On the other hand, point-of-service HMO's emulate PPO's by allowing employees to select non-network providers. Yet, like traditional HMO's, they provide prepaid services.

Survey analysis techniques and data presentations have evolved over the past 15 years in an attempt to describe this rapidly changing environment. In the early years of the surveys, data on specific plan provisions (such as hospital room and board coverage and surgical benefits) were presented for all types of plans together, because participation in non-FFS plans was not sufficient to affect the tabulations significantly. By the early 1990s, however, survey techniques had evolved to present data separately for the three main types of plans, recognizing differences in the ways plans reimbursed medical services. The growing incidence of PPO's and HMO's permitted the generation of separate estimates for these major plan types that met survey statistical quality standards.

Methods of financing

Methods of plan financing have changed in tandem with innovations in plan delivery and reimbursement mechanisms. The term "financial intermediary" refers to the organization that bears the risk for payment of health care claims.[8] The financial intermediaries currently tabulated by EBS are: Self-insurers; commercial insurers; Blue Cross/Blue Shield; independent organizations; and combined financers.

There has been steady growth in the percentage of participants covered by self-insured plans in recent years. Data from the 1993 EBS for medium and large private establishments showed that 47 percent of medical care participants were in self-insured plans compared with 34 percent in 1988, and 11 percent in 1979. The increase in self-insured plans (up 13 percentage points) during the 1988-93 period matched the total decline in the share of medical care participants who were in commercially insured plans (down 9 percentage points) and Blue Cross/Blue Shield plans (down 3 percentage points). Table 4 shows the percentages of full-time participants in medical plans by financial intermediary, without regard to fee arrangement.

Self-insurers. Establishments may finance the cost of benefits out of the general revenues of the company or they may set up a trust fund. Self-insured plans are particularly attractive to employers because they are not subject to State insurance premium taxes. They also, in the view of some observers, give the employer more control over health care costs.[9]

There are many varieties of self-insurance arrangements. While many self-insurers administer their own plans, others hire organizations to handle the administrative aspects like claims processing or legal questions by using "administrative services only" contracts. Moreover, some self-insured employers may pay claims up to a certain level then contract with an insurer to pay any claims above this designated level in an arrangement known as a "minimum premium plan."

All types of health plans except HMO's can be financed on a self-insured basis, according to EBS definitions. HMO's are not considered self-insured because they are prepaid on a capitation basis.[10] Capitation refers to a uniform fee per "head" or person. Whereas conventional insurance plans customarily reimburse participants for covered charges they incur, HMO's operate by charging periodic fees up front in return for providing covered medical services.

Commercial insurers. Instead of financing the costs of medical benefits themselves, establishments may contract with commercial (for-profit) insurance companies to pay the costs of medical claims. Commercial insurers charge a premium for the protection that they offer. The premium covers such items as the benefits to be paid, administrative costs, taxes, and profits. Insurance companies sponsor all three primary types of medical plans—FFS, PPO, and HMO.

Blue Cross/Blue Shield (BC/BS). This organization is a network of non-profit insurers. Although many plans use the BC/BS name, each member of the network usually

operates independently in a specific geographic area. Under BC/BS, there is generally a group of participating physicians and hospitals. Like commercial insurers, BC/BS sponsors the three major types of medical plans. The EBS defines BC/BS plans as FFS (rather than PPO) even when benefits differ between participating and nonparticipating providers. This is because the vast majority of doctors and hospitals in any area typically accept payment from BC/BS. In essence, there is no explicitly limited network of preferred providers. An individual can go to almost any doctor and still receive the most advantageous reimbursement. However, if there is a more restrictive list of doctors than just BC/BS participating providers, then it is EBS policy to categorize such a BC/BS plan as a PPO.

In addition to non-HMO plans, BC/BS sponsors various HMO's around the country. BC/BS sponsors standard HMO's and HMO's with point-of-service options. In addition, BC/BS HMO's can be any of the model types described previously, such as group, independent practice association, or network.

Independent organizations. These organizations are normally HMO's because they provide and finance medical benefits on a prepaid basis. They routinely operate in more than one State and they are not affiliated with either insurance companies or BC/BS. In 1993, somewhat less than one-fifth of full-time workers with employer-sponsored medical benefits received them by way of independent organizations. This category also includes organizations that operate in a single State or limited geographic area.

Combined financers. Sometimes establishments use two different financial intermediaries to provide benefits. Fewer than 1 percent of medical plan participants in 1993 were covered under combined financing arrangements. Establishments may, for example, contract with BC/BS to pay part of the medical benefits and with an insurance carrier to pay the remainder. Under a combined financing arrangement, payments come from at least two of the previously mentioned financial intermediaries based on the type of medical benefit. As an example of combined financing, an establishment may use BC/BS to cover basic claims for hospitalization, physician services, and surgical procedures and a commercial insurer to cover major medical claims that are excluded under basic coverage or go beyond the basic provisions.[11] This differs from a minimum premium plan where the responsibilities for paying claims are based on the level of payment. An example of what EBS considers a minimum premium plan would be an establishment that self-insures a certain level of payments and contracts with an insurer to pay any outstanding claims above this level.

Types of plans and financing methods

The relationship of plan types and financing arrangements can be confusing. As noted above, in today's health insurance market each type of plan can be associated with each type of financial intermediary. This dynamic situation is shown in tables 5 and 6, which cross-tabulate [1]

Table 5. Percent of full-time employees receiving health care benefits, by type of financial intermediary and fee arrangement, medium and large private establishments, 1991

Type of fee arrangement	1991						
	Total	Self-insurers	Commercial insurers	Blue Cross/ Blue Shield	Independent organizations	Combined financers	Other
Total	100	39	25	17	12	6	1
Fee-for-service	67	33	17	12	(1)	4	1
Preferred provider organization	16	6	6	3	(1)	1	(1)
Health maintenance organization	17	(1)	2	2	12	(1)	-

[1] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

Table 6. Percent of full-time employees receiving health care benefits, by type of financial intermediary and fee arrangement, medium and large private establishments, 1993

Type of fee arrangement	1993					
	Total	Self-insurers	Commercial insurers	Blue Cross/ Blue Shield	Independent organizations	Combined financers
Total	100	46	21	14	18	(1)
Fee-for-service	50	30	12	8	(1)	(1)
Preferred provider organization	26	16	6	3	(1)	(1)
Health maintenance organization	23	-	3	3	17	(1)

[1] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

health insurance participants for the 1991 and 1993 surveys of medium and large private establishments by type of plan and by financial intermediary. The financing of HMO's illustrates this trend, with HMO's being financed by commercial insurers and Blue Cross/Blue Shield organizations, as well as by independent organizations.

When the survey began in 1979, the environment was very different: Virtually all health care participants were covered by FFS plans. The survey classified participants by type of intermediary according to type of medical benefit: Basic hospital, basic surgical, basic medical, and major medical.[12] In that year, over 9 in 10 participants received basic hospital benefits, which were provided through BC/BS organizations to 31 percent of plan participants, with commercial carriers accounting for 48 percent, and self-insurers for 11 percent. HMO's were included as a type of financial intermediary and covered 2 percent of participants. The coverage figures differed for basic surgical, basic medical, and major medical benefits. For example, commercial carriers provided major medical benefits to 7 in 10 plan participants. This scheme made it difficult to determine overall what proportion of health plan participants were covered by each type of intermediary.

As the survey tracked the changing circumstances surrounding health care through the mid-1980s, this classification scheme became less and less satisfactory. Employees increasingly enrolled in alternatives to FFS plans; additionally, employer efforts to stem the rising tide of health care costs led many plans to abandon basic coverage in favor of major medical coverage by subjecting initial expenses for services like hospital room and board to deductible and coinsurance provisions. These two developments made the EBS data presentation of plan types and funding media both outdated and difficult to compare over time.

In 1986, PPO's were added to the survey, and by 1988, a new classification scheme was adopted. This new scheme classified each major type of plan by each form of financial intermediary. Data were summarized for three major categories of care: Medical care, dental care, and vision care.

Evaluation of survey classifications

Two methods for assessing a survey's classification scheme are to examine how many cases are classified as a residual or "other" category, and to measure how long it takes the survey to track new developments. In evaluating the survey's performance against these criteria, however, the survey's standards of precision also should be considered.

As tables 2 and 3 show, the classification of plan types accounted for at least 98 percent of plan participants each year between 1979 and 1993. The "other" or residual category never exceeded 2 percent of participants. When new types of plans, such as PPO's, point-of-service HMO's, or exclusive provider organizations, were introduced, they never exceeded 1 percent of the total number of health care plan participants. Given the survey's sample size, and accompanying limitations on precision, these results show that the scheme for accounting for plan types has been satisfactory.

The assessment of the funding intermediary definitions and classifications is less sanguine. In the mid-1980s, the survey clung too long to the classification scheme inaugurated in 1979. As a result, it became very difficult to gauge the overall incidence of the plan types. Additionally, because the new and old classification schemes were not explicitly linked, it is very difficult to compare current survey results with those recorded prior to 1988. It is evident that, with continued innovation in all aspects of health care plan design, the Employee Benefits Survey will have to monitor the changing scene very carefully to ensure that it provides up-to-date, relevant information.

Medical Savings Accounts: A New Cost Containment Strategy?

Continued emphasis on health benefits cost management will undoubtedly result in innovative strategies. Among them, medical savings accounts (MSA's) are a much discussed mechanism to lower health care costs and to satisfy diverse employee needs. MSA's combine catastrophic insurance coverage (provided by employers) with high annual deductibles. For example, each employee is responsible for the first $1,500 or $2,000 of individual medical expenses, and $3,000 of family medical expenses. Employers then purchase catastrophic insurance protection for the expenses above these amounts. As medical expenses are incurred, individual employees have a fund to which they contribute and from which they withdraw. Employers contribute some of their insurance premium savings to each employee's account. Under current law, the contributions are usually made from after-tax money and any unused portions can be withdrawn or rolled over at the end of the year.

Supporters of MSA's claim that they produce better consumers of health care services by pressing service providers to compete on the basis of price. The result will be lower prices for all medical care consumers, not just for those with MSA's.

Detractors of MSA's claim that the cost savings are unproved. Moreover, critics believe that the high deductible would be particularly attractive to the healthy and wealthy. Those who could most afford to do so could save as long as they did not need to use their deductible, and thus the cost to the healthy with catastrophic coverage would be reduced. Such adverse selection would result in "bad" risks (the poor and the chronically sick) increasingly bearing the burden of the additional costs associated with their medical care.[13]

A bill currently before Congress, H.R. 1818, the "Family Medical Savings and Investment Act, " would permit individuals to set up tax-favored MSA's. To participate, individuals must be covered by a catastrophic health plan with an annual deductible of at least $1,800 per individual and $3,600 per family. These numbers would be indexed for inflation. Individuals, or their employers, could contribute an amount up to the deductible, but no more than $2,500 (or $5,000 for family). Contributions to the MSA's would not be taxed but any investment earnings would be taxable. Also, any unused funds in the MSA's would remain the property of the individual.[14] Once again, the idea is that if employees were using their own money, they would be more cost-conscious in their use of health services. With tax-favored MSA's, they would be more likely to accept higher deductibles as well. Nevertheless, there remains concern that the emphasis of MSA's on catastrophic coverage could actually increase health care costs due to the resulting de-emphasis on preventive services.[15]

Newer managed care and managed cost strategies will require an ongoing examination of the EBS classification structure and of the presentation of survey data. Additional ways of presenting medical care benefits will be both informative and necessary.

[1] See, for example, Robert B. Grant, "Outpatient Surgery: Helping to Contain Health Care Costs," *Monthly Labor Review*, November 1992, pp. 33-36, and Thomas P. Burke, "Alternatives to Hospital Care Under Employee Benefit Plans," *Monthly Labor Review*, December 1991, pp. 9-15.

[2] These developments have also created a diversity of choice for employers and employees. See Michael Bucci and Robert B. Grant, "Health Insurance: Employer Offerings and Employee Choice in Small Private Establishments," *Compensation & Working Conditions*, August 1994, pp. 1-3; Michael Bucci and Robert B. Grant, *Health Insurance: Employer Offerings and Employee Choice in State and Local Governments, 1992*, BLS Report 94-7, July 1994; and Michael Bucci and Robert B. Grant, "Employer-sponsored Health Insurance: What's Offered, What's Chosen?" *Monthly Labor Review*, October 1995, pp. 38-44.

[3] Janet L. Norwood, "Measuring the Cost and Incidence of Employee Benefits," *Monthly Labor Review*, August 1988, pp. 3-8.

[4] From 1979-1986, the Employee Benefits Survey studied private industry establishments with either 50, 100, or 250 employees or more, depending on the industry; coverage in the services industries was limited. The 1987 survey examined benefits in State and local governments with 50 or more employees, while the 1990, 1992, and 1994 surveys included government establishments of all sizes. In 1988, 1989, 1991, and 1993, the survey included private sector establishments with 100 or more employees in all nonagricultural industries. The 1990, 1992, and 1994 surveys covered private establishments in all nonagricultural industries with 1-99 employees. Since 1990, State and local governments andsmall private establishments (1-99 employees) are surveyed in even-numbered years, while medium and large private establishments (100 or more employees) are surveyed in odd-numbered years. We do not believe that the changes in survey industrial classification and establishment size coverage materially affect the data presented on health insurance; however, readers are cautioned that the survey dimensions were not uniform over time. For selected tables comparing the 1988 survey (which represented the first in the current series of medium and large private industry establishment surveys) with the prior 1986 survey coverage, see *Employee Benefits in Medium and Large Firms, 1988*, Bulletin 2336, Bureau of Labor Statistics, 1989, pp. 122-139.

[5] Anita J. Slomski, "How Business is Flattening Health Costs," *Medical Economics*, July 11, 1994, pp. 87-99.

[6] David Azevedo, "PHOs: Castles in the Sand?" *Medical Economics*, October 24, 1994, pp. 71-84.

[7] Lauren M. Walker, "Where Doctors Fit in Those New Hospital Networks," *Medical Economics*, April 25, 1994, pp. 124-130.

[8] In the discussion that follows, the organization responsible for paying medical claims is considered the financial intermediary. Within an establishment, different arrangements may be made for paying the claims for supplementary benefits, such as dental or vision care.

[9] *Fundamentals of Employee Benefit Programs*, 4th ed., Employee Benefits Research Institute, 1990, p. 179.

[10] To keep survey procedures from becoming overly complex, we decided to ignore the special case of a health maintenance organization providing benefits to its own employees. This could be viewed as a self-insured arrangement. In the survey tabulations, employees of HMO's or organizations administering HMO's are included in the data for HMO's rather than for self-insurers.

[11] As noted above, this discussion is limited to methods of financing medical benefits. It is common, however, for establishments to use different intermediaries to finance dental and vision care benefits.

[12] In this context, "basic" benefits referred to cases where the plan paid all or some of the initial expenses incurred by the plan subscriber. In contrast, "major medical" benefits did not pay for initial expenses, due to the imposition of a deductible.

[13] Paul Ellwood, M.D. and Alain Enthoven, "Responsible Choices for Achieving Reform of the American Health System," A Draft Discussion Paper from the Jackson Hole Group, March 1995, p. 23.

[14] American Academy of Actuaries, "Medical Savings Accounts: An Analysis of the Family and Medical Savings and Investment Act of 1995," *Public Policy Monograph*, October 1995, p. i.

[15] Ellwood, M.D. and Enthoven, p. 22.