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REPORT TO THE CONGRESS

Medical Savings Accounts and the Medicare Program

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Executive summary

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Medicare Medical Savings Account (MSA) plans are one of the choices given Medicare beneficiaries in the Medicare+Choice program, which was created by the Balanced Budget Act of 1997. The Medicare MSA was designed to give beneficiaries more control over their health care by giving them the freedom to use whatever provider they might want under whatever financial arrangements they could negotiate. Because these plans have high deductibles, beneficiaries would become more conscious of the costs of health care and presumably decrease their use of discretionary health care. Although Medicare MSAs were authorized to be offered beginning January 1, 1999, to date no organization has applied to offer one. Congress asked MedPAC to determine how the program might be modified to make it a desirable option for organizations and beneficiaries.

The Commission believes that the current demonstration has shown that the private sector will not offer Medicare MSAs because of two basic market characteristics: (1) little demand from the risk-averse Medicare beneficiary population, and (2) the expense and difficulty of marketing a complex product such as Medicare MSAs to a fragmented and scarce set of customers. These two market characteristics make it unlikely that changing program-specific conditions that may have discouraged insurers would engender much participation. Nevertheless, we investigated several options, including removing limits on the number of beneficiaries and the length of the demonstration, decreasing the encounter and quality data required, changing payment methods, and extending balance-billing protection to Medicare MSA participants. None of these options seems likely to overcome the underlying market characteristics that discourage participation. Furthermore, steps to increase participation would be accompanied in most cases by increased financial risk to either beneficiaries or the Medicare program.

A possible viable MSA alternative (in the sense of a program beneficiaries could enroll in) could be a Medicare-run MSA demonstration, which would provide a test of the MSA principle—that beneficiaries would decrease use of discretionary health care—at relatively low risk to the program. Such a demonstration might help create new market conditions by familiarizing beneficiaries and providers with the MSA concept. If the demonstration succeeded in doing so, the private sector might then decide to enter the Medicare MSA program, which could be modified to incorporate lessons learned from the demonstration. However, in light of the basic market realities facing MSAs for the Medicare population, the Commission does not see a compelling reason to pursue a Medicare MSA option and makes no recommendations for specific legislative changes in this report.

Medical Savings Accounts and the Medicare Program

The Balanced Budget Act of 1997 created the Medicare+Choice (M+C) program, which allowed Medicare beneficiaries to join a variety of health plan types instead of the traditional Medicare fee-for-service program. Among those choices—which included Medicare health maintenance organizations (HMOs), preferred provider organizations, provider sponsored organizations, and private fee-for-service plans—were Medicare Medical Savings Account (MSA) plans, which were to be offered beginning January 1, 1999. The Medicare MSA was intended to give beneficiaries more control over their health care by giving them the freedom to use whatever provider they might want under whatever financial arrangements they could negotiate. A corollary benefit of this approach is that as beneficiaries became more conscious of the costs of health care, they would decrease their use of discretionary health care (American Academy of Actuaries 1995). The regulations governing the M+C program in general and the MSA program in particular were published June 26, 1998, with the final rule published June 29, 2000.

To date, no organization has applied to offer an MSA plan to beneficiaries under Medicare+Choice. The Congress is concerned about this and wants to know how the program could be modified to make it a desirable option for organizations and beneficiaries. Therefore, the Congress required that by November 29, 2000, MedPAC should "submit to Congress a report on specific legislative changes that should be made to make MSA plans (as defined in section 1859(b)(3) of the Social Security Act, 42 U.S.C. 1395w-29(b)(3)) a viable option under the Medicare + Choice program." (Balanced Budget Act of 1999, PL 106-113). This report responds to that charge.

What is a Medicare Medical Savings Account?

A Medicare MSA plan is a combination of a high-deductible insurance policy and a tax-favored savings account for medical expenses. The Medicare program would pay premiums for the insurance policies and make a contribution to beneficiaries' individual MSAs. The beneficiaries would use the money in their MSAs to pay for their own medical care before the high deductible was reached. The sum of the premium and the contribution would equal the payment made by Medicare to any other M+C plan for a beneficiary.

An MSA program for Medicare is a new arrangement for sharing the risk of health care coverage among Medicare, beneficiaries, and health care plans. In the traditional Medicare program, beneficiaries take the risk for all Medicare deductibles and coinsurance with no liability limit. Beneficiaries also retain the risk for all non-covered health care expenses, such as outpatient prescription drugs. The Medicare program retains the risk for all covered expenses beyond the deductible and coinsurance.

Under current MSA regulations, beneficiaries would take on the risk of all health care expenses up to a high deductible amount. The risk for all covered expenses beyond the deductible would be borne by a health care plan. (Technically, beneficiaries could still be liable for expenses beyond the Medicare-allowed amounts if the plan chose not to cover them. However, the plan could set an out-of-pocket maximum equal to the deductible or some larger amount. The plan could also choose to define more broadly, compared with traditional Medicare, the expenses that count toward the deductible.) Medicare would no longer bear the risk for any health care expenses for beneficiaries in MSA plans.

To induce beneficiaries to trade their current risk for the risk of the high deductible, Medicare would make contributions to MSAs in beneficiaries' names. Beneficiaries could then use this money to pay for part of the deductible or for other health care expenses for which they would have paid out of pocket in the traditional system. [1] Although beneficiaries would be assuming the risk of the high deductible, they would also, assuming the MSA plan had an out-of-pocket maximum, be removing the risk of an unlimited liability for cost sharing in the traditional Medicare program.

To induce a health plan to accept the remaining risk for covered expenses, the Medicare program would pay a premium to the health care plan. So far, no plan has decided that there is a sufficient market for this product to make the payment offered by HCFA reason enough to enter the program.

Example

To understand which beneficiaries would benefit from an MSA, take as an example an MSA plan with an annual contribution from the Medicare program of $1,000 into the beneficiary's MSA, a deductible of $2,000, and a plan that provides coverage for all expenses over the deductible for a premium of $4,000.

Compared with traditional Medicare, beneficiaries enrolling in MSAs would be better off in two cases.

- First, if beneficiaries had very low medical expenses; specifically, if their medical expenses minus Medicare's contribution to the MSA was less than their cost-sharing in traditional Medicare. In this example if expenses were less than $1,000, beneficiaries would have money left in their MSAs at the end of the year, whereas under traditional Medicare, those beneficiaries would have had cost sharing to pay out of pocket. [2]

- Second, if beneficiaries had no low-cost supplemental coverage and very high medical expenses; specifically, if their expenses would have resulted in cost sharing of greater than $1,000 under traditional Medicare. In this case, they would have to pay the $2,000 deductible, but $1,000 of that would come from the MSA, resulting in a net out-of-pocket cost of $1,000, less than their cost sharing under traditional Medicare would have been. [3]

In this example, Medicare would pay a total of $5,000 per beneficiary (the $1,000 contribution to the MSA plus the $4,000 premium to the plan), equal to what the program would have paid to any other M+C plan for this beneficiary. If a beneficiary had medical expenses that would have resulted in program costs exceeding $5,000, then the program would be better off financially with the beneficiary in an MSA. If the beneficiary would have enrolled in some other M+C plan the program would break even because its payment would be the same. If program payments would have been less than $5,000 for this beneficiary, the Medicare program would be worse off financially.

[1] Within limitations and subject to a tax penalty, the MSA could also be used to pay for non-medical expenses.

[2] Using HCFA data for 1996, about 59 percent of aged beneficiaries who were in the program in 1996 and 1997 had program payments of less than $1,000. Seventy-two percent of those same beneficiaries also had program costs of less than $1,000 in 1997, so they would do well with the MSA plan in this example.

[3] Based on HCFA data for 1996, about 8 million beneficiaries met this criterion for very high medical expense. About 48percent of aged beneficiaries who met it in 1996 and were in the program in 1997 had liabilities of more than $1,000 in 1997 also.

Plans would make a profit if payments for beneficiaries' medical expenses and expenses for marketing and administration were less than the premiums it received from HCFA. If the expenses were greater, then the plan would incur a loss.

As is evident from the example, the key variables are:

- beneficiaries' annual medical expenses,
- the potential program costs and liabilities under traditional Medicare, and
- the amounts of the MSA contribution, the premium, and the deductible.

One other factor of interest is any decrease in use that might result from beneficiaries' increased awareness of health care costs. This decrease could be of worth to beneficiaries because it would allow use of funds for other purposes that beneficiaries might prefer.

Favorable selection

Because who benefits and who does not is so dependent on medical expenses, the question of favorable selection into MSAs has been a key issue (Rodgers 1995, Kendix 1999). If the beneficiaries who chose to enter MSA plans had significantly lower health care expenses, the health care expenses of those left in the traditional fee-for-service program (or in other M+C plan types) would, on average, be higher. Unless payments were adjusted to take this difference between health care expenses into account, this division of beneficiaries into MSA plans and other plan types including traditional Medicare fee-for-service could feed on itself, making MSA plans even more attractive for those with low expenses and increasing average expenses even more for other plans. This favorable selection concern has influenced regulations for MSAs in Medicare and for the under-65 population.

Current statutes and regulations limit certain aspects of the program, such as eligibility and deductibles, and specify the payment system. Requirements under these statutes and regulations are summarized in Table 1 and discussed in more detail later in this paper as we consider how they affect the putative suppliers of MSA plans.

Lessons learned from commercial MSAs

To make Medicare MSA plans a viable option in the M+C program, it is important to understand why they are not being offered. MedPAC convened an expert panel in May 2000 with participants from the insurance industry, benefits purchasers, health benefit consultants, insurance brokers, and the policy research community to help define the problem. The following sections draw on what we learned from this panel as well as the current literature on MSAs. We first look at the experience in the non-Medicare MSA (or commercial MSA) market.

Tax-favored MSAs first became available to the non-Medicare population in 1997, when the Health Insurance Portability and Accountability Act (HIPAA) went into effect (some non tax-favored MSAs had been available earlier). The designers of the legislation anticipated that many insurers would offer MSAs and that many individuals would open accounts. Instead, the market has been slow to develop. There were approximately 59,000 policies nationwide by our estimate (45,000 participants nationwide in 1999, according to Department of Treasury counting rules, which omit previously uninsured participants) (IRS 1999). Looking at why the market has been so slow to grow may help explain the lack of entry into the Medicare MSA market.

TABLE 1 **Summary of Medicare MSA program**

Status		no plans available, no enrollees
Limits		
	time	enrollment could begin January 1, 1999; no new enrollees after January 1, 2003
	number	total enrollment cannot exceed 390,000
	deductible	maximum $6,300 deductible in 2000, indexed
	balance billing	no limits on balance billing to beneficiary
Payment		
	contribution to MSA	difference between M+C county payment rate and plan-determined average premium, constant for all plan members in county
	payment to plan	difference between risk-adjusted M+C county payment rate for individual and constant contribution to MSA, can differ for each member
Data		
	encounter data	full encounter data required as for other M+C plans
	quality data	network model MSA plans similar to other M+C plans less required minimum performance levels, non-network plans must measure and report performance

Note: MSA (medical savings account), M+C (Medicare + Choice).

Source: MedPAC, based on Federal Register, HCFA Medicare+Choice Final Rule, June 29, 2000.

Limited supply

HIPAA limited eligibility for MSAs to self-employed people and those employed in firms with fewer than 50 employees—that is, to the individual and small-group markets. This, in turn, limited the suppliers of MSAs to insurance companies that participate in or want to enter those two markets. The individual market is further constrained in some states by community rating laws that limit the ability of insurance companies to underwrite policies and require them to charge the same premium regardless of prior health history. In some states, this has reportedly reduced the number of companies in the individual market to one or two. Also, many of the companies that initially entered the MSA market (often by modifying a high-deductible policy) were doing so as a defensive measure in case the program became very popular. Now that it has not, many firms are not marketing MSAs vigorously or at all.

Lack of broker interest

Policies in the individual and small-group markets are usually sold by insurance brokers and agents to individuals and companies. Agent commissions tend to be a set percentage of the premium. Because MSA policies have lower premiums than other policies, agents receive lower commissions for selling them. In addition, it takes more time and effort to sell an MSA policy because customers are generally unfamiliar with the product. An additional complication is the need to set up an account and trustee for the MSA itself, which also requires more of the agent's time. All of these factors make agents reluctant to commit the time necessary to learn about and sell the product.

Limited demand

One potential source of demand is self-employed individuals who face high premiums in the individual insurance market. They need to find health insurance with an affordable premium and may find MSAs attractive. For those with relatively high incomes, the tax-favored status of the MSA may be a further attraction and the risk of having to pay a high deductible is not unbearable. It is not clear how large that market is, however, and many individuals still prefer the typical employer-sponsored health insurance policy—with relatively low deductibles—that they have grown used to. Few potential buyers for MSAs even know they exist or have the time or incentive to educate themselves about the product.

Specific program design problems in HIPAA

HIPAA policy for MSAs was prescriptive in part because of concerns that if the program were very popular among healthy and wealthy people, there would be negative effects on tax revenues and on the health insurance market. Tax revenues could be adversely affected by wealthy participants using MSAs as tax-favored savings accounts. Health insurance markets could be adversely affected by favorable selection into MSA products, leaving a sicker population in other kinds of health insurance polices. This would produce higher premiums for those policies, possibly making them too expensive for some people. Because of that fear, HIPAA limited the number of policies (750,000) and the duration of the demonstration (no new policies could be sold after December 31, 2000). It also imposed minimum and maximum deductibles on the MSA-linked insurance offerings, imposed a limit on out-of-pocket amounts, limited the amount that could be contributed to between 60 percent and 75 percent of the deductible, and allowed only the employee or the employer to contribute, but not both. All of these policies have been cited as reasons for the slow growth of the commercial MSA market. [4]

Many firms were loath to spend substantial sums on developing the MSA product, getting it approved in each state, educating a sales force, and marketing the program to possible customers in the face of a time-limited program with, at most, 750,000 policies nationwide. Marketing is particularly difficult and expensive in the individual market, where demand may be greatest.

The minimum and maximum deductibles and the maximum out-of-pocket amounts were looked upon as unnecessary limitations on design flexibility, particularly in an untried market where consumer preferences had not been established. The low limits on the maximum deductible were looked upon as particularly limiting in high-cost urban markets.

Several of these limitations have been recognized in legislative proposals. The Patient's Bill of Rights Act (S.300), for example, if enacted would reduce the minimum deductible, allow contributions equal to the deductible (rather than only 60 percent to 75 percent of the deductible), remove the limit on the number of MSAs, allow all employers to offer MSAs, and make MSAs a choice for Federal Employee Health Benefit Plan (FEHBP) participants.

[4] In South Africa, MSAs have been more popular. By one estimate (Medical Savings Accounts in South Africa, NCPA Policy Report No.234) they account for about 50% of the private insurance market, which serves about 20% of the population.

Results

As a result of the uncertainty of demand, the high cost of marketing the product, and the program design limitations, few companies have chosen to invest in the product and market it actively. This limited effort combined with limited demand has resulted in few policies being sold.

Limitations in the Medicare MSA market

Some aspects of the commercial MSA market translate directly to the Medicare marketplace. The reluctance of firms to make sizable investments to develop and market a product for a demonstration project of limited size and scope translate directly. Medicare MSAs are limited to 390,000 and no new enrollments are allowed after January 1, 2003. Concerns about the limit on maximum deductibles are also shared (although there is no minimum deductible under current regulations). However, plans that sell supplemental products and M+C plans already participate in the individual market, so that aspect is less of a barrier than it is in the world of commercial insurance.

The critical aspect of the market that concerns potential suppliers is the uncertainty of demand by Medicare beneficiaries for an MSA product. Beneficiaries are viewed as a risk-averse population unlikely to take on the risk of a high deductible, even if it would reduce potential maximum liability. Some see the high percentage of beneficiaries with supplemental (Medigap) insurance as evidence of this risk aversion, and of a willingness to pay a large amount of money for first-dollar coverage. A major beneficiary education effort would be required to overcome current attitudes, and successfully reaching Medicare beneficiaries with a complicated message is considered even more difficult than reaching the commercially insured population.

Also, unlike the commercial population, Medicare beneficiaries already have a low premium option to choose: traditional Medicare. The traditional program provides substantial benefits for a low premium; in areas where M+C HMOs are active, an even more generous benefit package may be available. In addition, the tax benefit for Medicare MSA participants is less than in commercial MSAs because the contribution is from the Health Care Financing Administration (HCFA) and not deductible.[5] In sum, these factors tend to limit potential demand for the product.

On average, medical costs for Medicare beneficiaries are higher than for the commercially insured population, so premiums—and conceivably, MSA contribution amounts—may be greater than in the commercial MSA market. Some argue that the larger amounts of money in play would allow more flexibility in product design and possibly greater accumulations in Medicare MSA accounts than in commercial accounts. However, because Medicare beneficiaries often have chronic conditions with predictably high medical expenses, they may not want to expose themselves to a high deductible. On balance, high medical costs may also dampen demand.

[5] There is a small tax benefit because income earned on the account is not taxed, which could be attractive to wealthier beneficiaries who essentially use the MSA as a tax-sheltered savings account and pay for medical expenses from other sources.

Regulations

Even though HCFA worked with the insurance industry to develop the MSA regulations and some of the MSA provisions are less prescriptive than HIPAA provisions (for example, no minimum deductible), the Medicare program is perceived as more highly regulated than the commercial market. In addition, Medicare's approval cycle can be relatively long for first-of-a-kind plans. For example, the only private fee-for-service plan application took 18 months to be approved. If an application were to take 18 months to approve and the demonstration expires in 2003, only 3 years of marketing and sales would have been possible, given that regulations for the M+C program were published in late June 1998.

Medicare MSA payment issues

According to some panel participants and letters commenting on the implementing regulation, HCFA's payment regulations for Medicare MSA plans have discouraged entry into the program. Of particular concern is that payment to plans for some individuals could be negative, if the MSA contribution were high and the payment and risk factors for the individual were low. In other words, plans could have to pay HCFA if enough beneficiaries with particular characteristics chose their plan.

This possibility arises because the contributions to beneficiaries' MSAs are equal for all participants in an MSA plan in a county, while the total payment for a particular beneficiary varies according to demographic and health status. HCFA chose to require that its contribution be the same for all plan members in a county because that would make the MSA program easier to explain to beneficiaries and administer, and comported with the uniform premium requirement in the legislation. (Analogously, in M+C HMOs for example, all beneficiaries in a plan in a county pay the same premium, although their expected costs and HCFA's payment for them differ.) The equal MSA contribution is computed by subtracting the average (or community-rated) premium proposed by a plan for a county from the county M+C payment rate (which is the same for all M+C plan types).

By law, payments for beneficiaries in all M+C plans must be adjusted for demographic and health status. Therefore, when the actual payment to an MSA plan is calculated (by subtracting the constant contribution to beneficiaries' MSAs from the varying payments for those beneficiaries), the possibility arises that the payment might be negative. This possibility, however remote, reportedly raises doubts with insurers about the payment methodology. More generally, requiring a constant contribution to each beneficiary's MSA struck insurers as arbitrary. (Plans could avoid negative payments by setting average premiums high enough, but that might result in such low MSA contributions that no one would be interested. The average premium is also supposed to result from a calculation of likely plan participants and not be arbitrary.) More generally, if a plan guessed incorrectly about who would join and set its premium too low, the MSA contribution would be higher than it should be, and the resulting payments to the plan would be too low to cover the plan's costs. Covering this additional uncertainty would result in higher premiums, reducing the MSA contribution and the attractiveness of the option to beneficiaries.

The text box gives an example of how the payment method would work. (Page 10)

Payment method example

The payment to a medical savings account (MSA) plan for an individual would be the difference between the Health Care Finance Administration's (HCFA) Medicare + Choice (M+C) payment (demographic and health status adjusted) and the constant contribution to the MSA, which results from the plan's average (community-rated) premium. The resulting payment could differ widely for beneficiaries with different demographic and health statuses.

County payment rate	$500 / month
Plan prosed average premium	$400 / month
Difference	$100 / month
HCFA contribution to MSA	$1,200 / year = 12 x $100 / month
Payment to plan	
Age 65, female, low risk	$150 / month = ($500 x 0.5) - $100
Age 75, male, high risk	$900 / month = ($500 x 2.0) - $100

In this example the county payment rate is $500/month and the plan proposes an average premium of $400/month. The difference is $100/month, which results in a $1,200/year contribution from HCFA to the beneficiary's MSA.

The payment to the plan varies by beneficiary. We show the payment for two different beneficiaries. The first is a 65-year-old woman at low risk. Her total risk factor is 0.5; therefore, her M+C payment rate would be $250 ($500 x 0.5). The $100 difference is subtracted, resulting in a $150/month payment to the plan. The second beneficiary is a high-risk 75-year old-man. The total risk score for him is 2.0 (the demographic factor of 0.9 plus the risk factor of 1.1 related to his prior health history); hence, the payment to the plan for him is $900/month. (Note that although the total risk factors 0.5 and 2.0 differ by a factor of four, the payments to the plan differ by a factor of six.)[1] The payment to a plan for a low-risk individual could theoretically be negative for cases in which the contribution to the MSA is high and the payment and risk factors are low. In the example above, if the average premium were $200, the payment for the 65-year-old low-risk female would be negative; the plan would have to pay HCFA $50/month for each such participant. ■

[1] This example assumes payment to plans is based solely on the risk-adjusted payments. Under current law, risk adjustment is being phased in and does not reach 100 percent until 2004.

Balance billing

HCFA followed what it believed to be Congressional intent by not extending balance-billing protection to MSA plan participants.[6] This policy would allow MSA plan participants to make whatever financial arrangement they wanted with whatever providers they wanted. However, members of MedPAC's expert panel cited the lack of balance-billing protection as a serious impediment to establishing MSA plans in the M+C program. Beneficiaries face the risk of unlimited liability when balance-billing protection does not apply. A provider can charge whatever the provider wishes unless the beneficiary has come to some understanding in advance of what the charges will be. Although some would argue this makes beneficiaries more aware of charges and will help control medical expenses, others think it places a burden on beneficiaries and that most beneficiaries are not eager to bargain with health care providers. Even after the deductible is reached, the plan must cover all charges only up to the Medicare-allowed amount; thus, beneficiaries could still be liable for excess charges. Plans could cover excess charges beyond the deductible, but they would then be at risk unless they had a network of providers with agreed-upon fee schedules. Resolution of this issue may be necessary to induce plans to participate.

Provider participation could also be constrained because of the high deductibles in MSA plans. Providers have raised a concern that they would have difficulty getting paid if beneficiaries were faced with high deductibles. If they provided a service and then billed the beneficiary, the beneficiary might be unwilling or unable to pay it even though it was less than the deductible. The provider would then either have to go to additional expense to collect the bill or write it off as uncompensated care. Some providers might not want to take this risk and, therefore, not provide care to participants in MSA plans.

Data requirements

Plans would be required to provide two kinds of data under current regulations, encounter data and data on quality.

Encounter data

To adjust payments to plans appropriately, HCFA must know beneficiaries' health status. HCFA determines health status using encounter data. Currently, only inpatient encounter data are used, but starting in 2004, HCFA intends to use data from more settings, including physician and outpatient settings. Because payments to all M+C plans are risk adjusted in this way, HCFA requires plans to report encounter data. This requirement is a reason given by insurers for not participating in the Medicare MSA program.

Insurers aver that it would be either impossible or too costly for them to report all encounter data for MSA participants because they anticipate that those who do not have sufficient expenditures to meet their deductible will not send any claims or documentation to the MSA plan. (In fact, not processing as many claims is considered one possible source of savings for MSA plans.) For claims beyond the deductible, the plans would have to forward the data to HCFA, which would add to their costs. Plans consider the data requirement to be a major roadblock to their participation.

[6] Balance billing is the amount a beneficiary is billed above the Medicare-allowable amount. For physician services, for example, when the physician does not accept assignment, balance billing is limited to 15 percent over the Medicare-allowable amount.

If encounter data were not collected for some beneficiaries, then payments for those beneficiaries cannot be risk adjusted in future years. Even if the MSA plan were willing to accept that limitation and the resulting lower payments, a lack of risk adjustment would be a major problem if the beneficiary were to switch to another form of M+C plan in a future year because that plan could be underpaid.

Data on quality

Insurers contend it is inappropriate and impractical to ask MSA plans to provide quality data or run quality programs because they are bill payers, not managed care plans. MSAs are specifically designed to enable beneficiaries, not plans, to control health care decisions and choice of providers. According to this reasoning, holding plans responsible for measuring quality is inappropriate. In addition, collecting data on quality from providers would be an extra cost to plans. Current regulations require plans with a network of providers that beneficiaries would be required to use (network MSA plans) to meet the same quality requirements as other M+C plans. They must have ongoing quality assessment and performance improvement programs. Plans in which a beneficiary can go to any provider with no penalty (non-network MSA plans) are not required to have quality improvement programs, but they must report quality assessment data (namely, the Health Plan Employer Data and Information Set).

Reconsidering the Medicare MSA program

Clearly, if the Medicare MSA program were to be made viable, revisions to the current program would be necessary. Below we outline several options to modify the current program. We begin by establishing some design principles against which these options can be measured.

Design principles

Certain design principles must be kept in mind when considering options to the current Medicare MSA program. These principles are beneficiary protection, equity with other M+C plan types, and fiscal impact.

Beneficiary protection

Plans have objected that they are not given enough design flexibility under current regulations. For example, they would like to be able to tailor benefits and MSA contribution amounts to individual beneficiaries. The disadvantage of this is that beneficiaries may not be able to judge whether the resulting package is a desirable one; comparing deductibles, out-of-pocket maximums, and MSA contributions is difficult enough. However, if a plan also covered services not covered by traditional Medicare or had cost-sharing provisions beyond the deductible, comparisons would become very difficult. Some constraints on plan design may be necessary for beneficiary protection.

Maintaining equity with other M+C plan types

Because Medicare MSAs are part of the larger M+C program, it is desirable to maintain equity with other M+C plan types, such as HMOs and private fee-for-service. Three types of equity need to be kept in mind: payment, enrollment, and requirements of participation.

At its most basic definition, payment equity requires that the Medicare program's costs for any M+C plan type be the same. For most plan types, the Medicare program's cost is the payment to the plan. As currently constructed, Medicare's cost for an MSA plan would be the payment to the plan plus the contribution to the beneficiary's MSA. Because payments are adjusted for health status and demographic factors as well as by county of residence, this would imply that the mechanism for risk adjustment and the data for risk adjustment be the same for all plan types. A slightly looser definition of payment equity might be that payment for the group enrolled in a plan be the same across plan types.

Strict enrollment equity would require that restrictions on enrollment eligibility and rules on open enrollment periods and disenrollment be consistent across all types of M+C plans. A less rigorous standard might allow some variation. For example, the current M+C law does not permit beneficiaries with other government coverage to join MSA plans, although they may join other M+C plans.

The requirements of participation for plans could be equal as well. For example, the rules on accessibility and network adequacy for network plans could be held constant across plan types, as could quality and data requirements. In the current regulations, these requirements differ by plan type.

Fiscal impact

A final design principle is minimizing negative fiscal impact on the Medicare program. There is a real danger of favorable selection into MSAs, which would increase Medicare spending if it were not accounted for by risk adjustment. At its simplest, if each MSA beneficiary cost the program $5,000 in contributions to MSA and premium payments to plans, and yet had medical expenses that otherwise would only cost the program $1,000, the program would lose $4,000 per capita. Because beneficiaries have traditional Medicare to return to—and under current law, they can switch out of the MSA program annually—there is a real possibility of plan switching if a beneficiary had a high-cost medical expense that could be postponed for a few months. Plan switching exacerbates the problem of favorable selection. How to deal with favorable selection must be kept in mind as options for revising the MSA program are considered.

Options

We consider reform options in three categories: removing limits in the current program and lessening data and other regulatory requirements, changing payment policy, and having Medicare offer an MSA benefit package.

Removing limits

The simplest option would be to remove the limits placed on the number of beneficiaries (390,000) and the time limit on enrollments (none after January 1, 2003). These limits could be removed by legislative action, similar to what has been proposed for the commercial MSAs. There is no risk to beneficiaries from this action and, as there are no limits on other M+C plan types, it would move the MSA program toward equity with them. Removing these limits could increase the fiscal risk to the Medicare program, however, if the payment scheme does not adequately adjust for favorable selection into M+C MSAs.

The current risk-adjustment system modifies payments by health status and demographic factors, but it was not designed to adjust for a group of beneficiaries chosen specifically for very low total health care costs. For example, the current risk adjustment methodology puts approximately 88 percent of the fee-for-service population into the lowest risk adjustment category for health status. The group of people choosing MSAs might well be at the lowest cost end of that 88 percent, and it is unlikely that the current risk adjuster would completely account for such extreme favorable selection. This could result in some negative fiscal impact for almost any increase in plan participation.

The limit on the maximum deductible could be removed; it has been cited as discouraging participation by plans in some high-cost urban areas. There would be some decrease in beneficiary protection, although beneficiaries ought to be aware of the deductible when they sign up for the MSA option. There is no comparable limit in other M+C plan types, so equity with other plan types is not an issue. There is no increase in government liability from this option except to the extent that higher deductibles increase the likelihood of favorable selection.

The current program limits beneficiary eligibility. In addition to the eligibility requirements for other M+C plan types (that is, eligible for Part A, participating in Part B, and not having end-stage renal disease), certain other beneficiaries are not allowed to participate, including those covered by some other federal health plan for first-dollar coverage (such as those who are on Medicaid, FEHBP annuitants, and those covered by the Veterans Administration and the Department of Defense). In addition, there is a United States residency requirement of more than 186 days. Some or all of these excluded groups could be allowed to join MSAs. Removing the eligibility limitations would not be a beneficiary protection problem because beneficiaries would not only have the first-dollar coverage of the government programs, but also a government contribution to their MSAs. It would also not be a M+C equity problem because it would be a return to the same eligibility requirements as other M+C plan types. This change would not be fiscally responsible, however, because the government would be paying for coverage twice unless payments were changed to reflect other coverage. In addition, it would destroy the incentive to decrease the use of discretionary medical care, which is part of the rationale for MSAs.

Extending balance-billing protection

Extending balance-billing protection to people enrolled in MSAs would add limits to the program, but it may be desirable. This would be a very important step toward protecting beneficiaries. If it applied to all providers, it would limit the liability of plan members and if a plan agreed to cover any balance billing after the deductible, it would limit liability to the deductible alone. It could conceivably make some providers unwilling to treat beneficiaries, and is in some sense antithetical to the idea of MSAs allowing complete freedom of provider choice and financial arrangements. However, the lack of balance-billing protection appears to be a major impediment to plan participation because plans think beneficiaries will not sign up without it.

It is not clear how balance-billing protection could be extended to Medicare MSA participants. In M+C HMOs, this issue does not arise (except in out-of-network emergency situations) because each plan has arrangements with the providers in its network and enrollees do not receive bills from providers. In the private fee-for-service plan, providers are deemed to have a contract with the plan if they agree to provide services to a beneficiary and the contract has limits on charges. For an MSA participant however, there is no implied contract between providers and the plan for expenses below the deductible and, possibly, for expenses beyond the deductible in a non-network plan. The ordinary Medicare limits should not apply, because beneficiaries have removed themselves from the traditional fee-for-service program and presumably can make any arrangements they want with providers and can go to providers who do not participate in Medicare. Therefore, it is not clear how to extend balance-billing protection to MSA participants and still allow unfettered provider choice and discretionary financial arrangements. One possibility would be to extend balance-billing protection to beneficiaries only when they choose participating providers.

Decreasing requirements for data on quality

The requirement for MSA plans to collect quality data could be eliminated and replaced with a requirement to collect consumer satisfaction data, focusing on whether beneficiaries are satisfied with the level of service provided by the plan rather than on clinical data. Although consumer satisfaction does not equate to clinical quality, it would provide some beneficiary protection in that it could help beneficiaries select MSA plans more knowledgeably. The data collection requirement would not be the same as other M+C plans, but should have no ill effect on program spending.

Decreasing encounter data requirements

Removing the requirement to submit encounter data would make it impossible to apply the currently contemplated risk-adjustment system to MSA participants. If the payment scheme requires risk adjustment, then the option of not requiring encounter data submission may not be feasible. This option also would not be consistent with equity with other M+C plan types.

Compromises in this area are possible, however, such as requiring plans to submit data only for encounters reported in claims beyond the deductible. Arguably, this might be sufficient for any high-cost diagnoses or treatments, which are what the risk adjustment system is interested in. Even this much data reporting could discourage some plans from participating.

Table 2 (page 16) summarizes the effects these options would have on the three design principles of beneficiary protection, equity with other types of M+C plans, and fiscal impact, and their likely effects on plan participation. As is shown, options that increase plan participation have the potential to lead to negative fiscal impacts because of possible extreme favorable selection.

TABLE 2 **Impact of options to remove limits, lessen requirements**

Options	Beneficiary protection	M+C equity	Fiscal impact	Effect on plan participation
Remove limits				
number	o	+	o / –	+
time	o	+	o / –	+
deductible	–	o	o / –	+
eligibility	o	+	–	+
Add balance billing	+	o	o / –	+
Decrease data				
quality	–	–	o / –	+
encounter	–	–	–	+

Note: M+C (Medicare+Choice), + positive effect, o no effect, – negative effect.

Source: MedPAC.

Changing the payment method

No matter the other changes made, the method for calculating payments is essential to determining plan participation. In the extreme, if payments were set absurdly high—assuring high MSA contributions for the beneficiaries, high premiums for the plans, and a small gap between contribution and deductible—there would be no lack of supply of plans or demand by beneficiaries. Such a method would, however, be neither equitable for other M+C plan types nor fiscally responsible for the program.

The current method requires both absolute equality of payments with other plan types and equal contributions to the MSA for each beneficiary in a plan in a county. We consider three options that relax these requirements.

One option would be not to require identical contributions. Instead, plans could be allowed to set contributions as the difference between the payment and the premium determined for individual beneficiaries. The contribution could be set as a percentage of premium, or in some other way. If set in percentage terms, it would increase beneficiary equity in percentage terms but increase variance in dollar terms. This option would be more difficult to explain to beneficiaries and for HCFA to police, and therefore could have negative effects on beneficiary protection. It would be equitable across plan types. It would have no more negative fiscal impact on the program than current policy has.

A more radical alternative would be to jettison the principle of strict equity on an individual basis and settle for equity on a plan-wide basis. That is, Medicare could ensure that payments for a group of beneficiaries would be equivalent regardless of M+C plan type, rather than require that the payment for each beneficiary be equivalent. This alternative would require some sort of experience rating for the group of beneficiaries in a plan and might allow fewer data to be collected. The difficulty is that no such rating system is currently available to the program.

A third option would make payments on the base risk factor (technically, the risk factor that corresponds to a beneficiary with no high-cost hospitalizations). The base factor adjusts for age and sex, whether the beneficiary was previously disabled, and if the beneficiary is on Medicaid. In this option, MSA plans would not get equitable payment compared with other M+C plan types. They could get the same payment, assuming all of the beneficiaries in the plan were at the lowest risk, or they could get less.

This third option essentially assumes perfect favorable selection into the plan. In other words, it assumes all beneficiaries selecting the plan are in the lowest risk group. To the extent that was true, beneficiaries in the plan would be no worse off and the payment would be equitable. It would also require no encounter data collection, simplify administration, and reduce uncertainty for the plan because the plan would know the payments in advance. It would also be fiscally responsible for the program. However, it is not clear that there would be much more supply or demand for MSAs as a result. As long as the risk-adjusted portion of the payment is a small amount, as it is through 2003, this option would result in payments that are nearly the same as current payments. When payment is fully risk adjusted, however, the effect would be greater and might discourage participation. Because beneficiaries could switch plans annually, a plan could experience almost perfect favorable selection. Beneficiaries anticipating major medical expenses could switch back to traditional Medicare and possibly buy a supplemental plan if they knew they would have to pay a substantial part of the deductible. (One way of dealing with this possibility would be to make the choice of an MSA permanent and not allow switching back to traditional Medicare or other M+C plan types, or allow just one switch. This would be unlikely to encourage plan participation unless it were combined with other options.)

Because beneficiaries under the third option would not have a risk score, their choice if they left the MSA plan would have to be limited to entering traditional fee-for-service Medicare. They could not join another M+C plan for a year after they left the MSA because the receiving M+C plan could not get a risk-adjusted payment for the beneficiary. (This would not hold for someone in the first year of eligibility because no one entering Medicare has a risk rating before coming into the program.)

Contributions to the MSA under this option could be set constant for all beneficiaries, according to demographic adjusted rating, or as a percentage of payment. If they were set, as now, constant for all beneficiaries, plans would have to have a good idea of who would be in their plan for the next year to set a contribution that would work out for the plan. If they assumed an older mix than occurred, they could be at risk. If the contribution were set by demographic rating or as a percentage of payment, it would be more difficult to explain to beneficiaries and beneficiaries in the same county would get different amounts in their MSAs.

The effects of these three payment options are summarized in Table 3 (page 18) .

TABLE 3

Impact of options changing payments

Payment options	Beneficiary protection	M+C equity	Fiscal impact	Effect on plan participation
Variable contribution to individual MSAs	–	o	o	+
Group equity	o	+	o	unknown
Base risk factor for all	o	–	+	unknown

Note: M+C (Medicare+Choice), + positive effect, o no effect, – negative effect.

Source: MedPAC.

Offer MSA benefit package through Medicare

A completely different option, which could be considered an interim approach, would be for Medicare to retain the risk for covered services beyond the high deductible, rather than pay a premium to a plan to cover that risk. In this option, the Medicare program would make a set contribution to an MSA for a beneficiary. The beneficiary would pay all medical expenses up to a set deductible amount. The Medicare program would cover all expenses beyond the deductible (or retain some minimal cost sharing after that level is reached). No private plans would be involved.

This proposal would radically simplify the Medicare MSA program. First, having Medicare retain the risk for coverage beyond the deductible would cut out all the difficulties of contracting with private plans to provide the coverage. Second, a single program could be available to beneficiaries with standard benefits and conditions across the nation. (Making the payment into the MSA standard nationwide rather than adjusting it to the fee-for-service county average or the managed care rate by county would give beneficiaries the freedom to move without having to worry about whether the MSA payment would change. It would also make a choice available in areas where M+C plans are unavailable.) Third, beneficiaries could use all Medicare-participating providers and retain the balance-billing protections and favorable rates negotiated by the Medicare program, which would remove the uncertainty inherent in not having a network of providers with pre-negotiated rates. If beneficiaries wanted to see other providers, they could, and they would pay the providers from their MSA. However, only the Medicare-allowable costs would be credited to the deductible.

This approach has several additional advantages:

- Theoretically, if an entity can bear the risk of self insuring, it should do so. Medicare clearly can in this case because it already holds the greater risk of paying for all covered medical care after cost sharing.
- Because this is not a managed care product, no efficiency gains from a private plan managing care would be foregone. However, the reduction in the use of medical services that the high deductible should induce would still occur.
- The high administrative and marketing costs of private plans would be avoided.

- Beneficiaries would only have to deal with Medicare, removing some of the uncertainty of the new arrangement from the beneficiary perspective.

- The ability of beneficiaries to spend MSA dollars on non-covered but desirable medical expenses, such as prescription drugs, would be retained. (Because most preventive care—such as routine physicals—is not currently covered by Medicare, the usual objection to MSAs that people will forgo needed care could in part be reversed.)

- The magnitude of possible increased costs to the Medicare program resulting from favorable selection into the MSA option would be less because Medicare would make only the contribution to the MSA rather than the contribution and the premium payment.

This simplified program would be much easier to explain to beneficiaries and to implement than the current design. It would also provide a good test of the hypothesis that a high-deductible plan would lead to lower use of health care services. If undertaken as a demonstration with limits on enrollment, the financial risk for the program could be controlled.

Conclusion

The Commission believes that the current demonstration has shown that the private sector will not offer Medicare MSAs because of the basic market characteristics of little demand from a risk-averse population and the expense and difficulty of marketing a complex product to a fragmented and scarce set of customers. Although some of the program-specific conditions that have discouraged participation could be changed, doing so is unlikely to engender much participation because of the underlying market characteristics. Furthermore, most steps to encourage plans' participation would decrease beneficiary protection or increase the financial risk to the Medicare program.

A possible way to make the program technically viable—that is, make it possible for beneficiaries to enroll—would be a Medicare-run MSA demonstration. Such a demonstration would, at relatively low risk to the program, test if beneficiaries would be willing to enroll in a high-deductible option, show whether use of discretionary health care would decrease, and show whether providers would be willing to take on the risk of treating beneficiaries with high deductibles. However, the creation of another special program within Medicare should not be undertaken without some thought about its purpose and reversibility. History is replete with examples of temporary programs taking on an air of permanence and becoming difficult to eliminate. Special rules also would have to be created on how to treat participating beneficiaries at the end of the demonstration.

If the demonstration yielded positive results and beneficiaries became more familiar with the MSA product, the private sector might reassess the market. At that time, HCFA would have a better sense of the characteristics and health care use of beneficiaries who choose MSAs and could set payment rates more equitably. The options discussed in this paper—such as paying plans at the base rate for all beneficiaries, minimizing data requirements and administrative rules, and extending balance-billing protection to MSA enrollees—could then be reevaluated and Congress might then be able to make MSAs a viable option in Medicare+Choice. ■

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