Medicare MSA Issues and Options

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PREFACE

The Balanced Budget Act of 1997 proposed several new options for Medicare Beneficiaries besides traditional FFS and risk HMOs. In particular, there was to be a demonstration of allowing beneficiaries to choose Medical Savings Accounts (MSAs). In such MSAs, the difference between the premium charged by insurance companies for a catastrophic deductible and the contribution that would have been made by Medicare to a risk HMO for taking care of the beneficiary is deposited into an account that can be used for out-of-pocket medical spending. Although the Act outlined some of the rules for this choice, there were many questions about the parameters of the program, and what insurance companies, banks, providers and beneficiaries would have to do. RAND was given a contract to write options papers to help the Division of Demonstration Programs with the difficult task of developing and implementing the MSA program on a short time line.

This report contains the options memos on issues selected by RAND or the Health Care Financing Administration MSA workgroup over the course of the contract. They should be of interest to health policy analysts and those trying to understand or develop MSA products in this market. Some of the memos provide context or background information. Others address specific implementation problems. In general, the memos that deal with specific problems lay out a range of alternatives and describe the major strengths and weaknesses of each policy option. We tried to consider a wide range of alternatives. Some of these turned out to be ill-advised, but we thought it was important to at least bring them forward and consider them explicitly.
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1. INTRODUCTION

The Balanced Budget Act of 1997 (BBA) contained some of the most significant changes in Medicare since the program was introduced in 1965. Under the “Medicare+Choice” provisions, beneficiaries will have several new options besides traditional Medicare and risk Health Maintenance Organizations (HMOs):

1. **Coordinated Care Plans.** There will be three types of plans in this category: HMOs, Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs).
2. **Private Fee-For-Service Plans.**
3. **Medical Savings Account (MSA) Plans.** Beneficiaries who sign up for insurance plans with costs low enough to reduce premiums below the value of the current Medicare policy to put the savings into an account that can be used to pay for non-covered medical expenses.

The third option, Medicare+Choice MSAs, is the focus of this report. The program rests on the theory that beneficiaries should play a greater role in their health care purchasing decisions. As the Health Care Financing Administration (HCFA) observes in the *Federal Register* (1998, 35033), the goal is to ensure that the health care resources [beneficiaries] needs are allocated in an efficient manner. This increased consumer control is believed to have the potential for discouraging the overutilization of health services. Medicare+Choice MSAs, therefore, may be thought of as a demand reform as opposed to supply reforms such as prospective payment, Diagnosis Related Groups, and risk HMOs. Moreover, the MSA option is the first to give Medicare beneficiaries cash for choosing less generous insurance. Although risk HMOs reduced beneficiary out-of-pocket spending, there was a rule of the “ACR” process that said that all provider savings had to be passed on to beneficiaries through additional covered services rather than with cash rebates (see Appendix C for further discussion).

MSA supporters argue that the program will help contain soaring Medicare costs, while at the same time expanding choice and quality of care for senior citizens. Opponents view MSAs as a dangerous scheme that will benefit the healthy and wealthy, who can risk higher out-of-pocket costs than other beneficiaries can. To the extent that healthier seniors are more likely to choose the MSA option, the Medicare trust fund could end up spending
substantially more on these seniors than if they had stayed in the traditional Medicare program. As a legislative compromise, MSAs were introduced as part of the Medicare+Choice program, but only on a limited basis. Most notably, the MSAs are offered as a demonstration program and are limited to four years and 390,000 enrollees.

Medicare+Choice MSAs build on the MSA program now available to individuals under the age of 65 as part of the Health Insurance Accountability and Portability Act (HIPAA). There are, however, several key differences between HIPAA MSAs and Medicare+Choice MSAs. First, the way in which the two types of MSAs will be marketed differ. In the senior market, HCFA is required by the BBA to play an active role in informing beneficiaries about their Medicare+Choice options. With HIPAA MSAs, by contrast, this responsibility is left to insurers and financial institutions. Second, the rules regarding deductibles and out-of-pocket expenditures are less restrictive for Medicare+Choice MSAs than for HIPAA MSAs. Whereas Medicare+Choice MSAs can have a deductible of up to $6,000, HIPAA MSAs must have an annual deductible of between $1,500 and $2,250 for an individual, and between $3,000 and $4,500 for a family. (For both Medicare+Choice MSAs and HIPAA MSAs, these figures are raised annually to account for inflation.) Third, beneficiaries in Medicare+Choice MSAs cannot spend money from their MSAs on most health-related insurance related premiums or family members' medical expenses without penalty. By contrast, workers who are under 65 can. Fourth, penalties for spending MSA funds on non-medical uses differ. The HIPAA MSA requires a 15% penalty on top of the taxes for any amounts withdrawn for nonmedical purposes (except if the owner of the MSA is 65 or older). The Medicare+Choice MSA, on the other hand, has no extra penalty as long as the balance stays above 65% of the insurance plan's deductible.

UNSETTLED ISSUES

Many of the features of Medicare+Choice MSAs are described clearly in the BBA. However, some issues are open to interpretation. For example:

- **Information dissemination**: HCFA is required to distribute information to Medicare beneficiaries to help them make informed decisions with respect to their choice of Medicare coverage. What information is required to enable beneficiaries to choose between Medicare+Choice MSAs and other Medicare options? How is this information best conveyed?
• **Balance billing:** Section 1852(k)(2) establishes balance billing limits for Medicare+Choice private fee-for-service plans. Should HCFA impose similar limits on balance billing under Medicare+Choice MSA plans?

• **Supplemental insurance:** How will Medicare+Choice MSAs interact with supplemental insurance and employer-sponsored insurance for Medicare beneficiaries? Is it legal for a beneficiary to keep an existing policy that covers a portion of the Medicare+Choice MSA deductible?

• **Risk adjustment:** What is the amount that is risk-adjusted—the health insurance plan premium, the deposit in the MSA account, or both? How should HCFA collect the data that are needed to implement risk adjustment?

• **Minimum deductible:** Although Congress did not specify a minimum deductible amount in the BBA, the legislative history suggests that Congress may have intended that MSA plans would have higher deductibles than other plans (see discussion in *Federal Register* 1998, 35033). Should there be a minimum deductible for the health insurance plan that accompanies the MSA? If so, what should it be?

• **Enrollment cap:** The Medicare+Choice demonstration project is limited to 390,000 enrollees. What should HCFA do if the number of applications exceeds 390,000?

• **Deductible for mid-year enrollees:** Should HCFA establish specific requirements on deductibles for individuals who enroll in Medicare+Choice MSAs effective on a date other than January 1 of a given year?

• **Hospice and End Stage Renal Disease (ESRD) benefits:** Should Medicare+Choice MSA enrollees have to pay for these services out of their MSAs, or should HCFA provide first-dollar coverage (other than minor copayments), as is the case for enrollees in risk HMOs?

• **Bundling:** Should HCFA require that the insurance plan and MSA account be bundled? Should these be kept separate? Or should HCFA allow these products to be either bundled or unbundled (i.e., leave it to the market to decide)?

• **Transferring funds:** Should HCFA transfer funds directly to insurers and financial institutions? Are there other ways to transfer these funds that would impose less of an administrative burden on HCFA?
• **Tax issues:** While tax treatment and enforcement issues will largely be resolved by the Internal Revenue Service, are there tax issues that HCFA should familiarize itself with or help untangle?

**ORGANIZATION OF THE REPORT**

The remainder of this report consists of 16 memos from RAND to HCFA on various issues relating to Medicare+Choice MSAs, including the ones listed above. When the project began, RAND created an outline of implementation and evaluation issues (see Appendix A). Many (but not all) of the issues we ultimately wrote about were selected from this list.

The topics of the memos were chosen by HCFA in consultation with RAND. Other than minor editing changes (mainly spelling and grammatical corrections) and footnotes describing recent regulatory developments, the memos have not been altered.

Appendix A is an outline of issues, grouped by topic, with footnotes showing which memo answers them. It can be used as an index. Appendix B gives language from the law defining MSAs. Appendix C contains excerpts from our oral proposal to HCFA.
2. OVERVIEW OF MSA MARKET

OBJECTIVE
The purpose of this memorandum is to provide an overview of developments in the under-65 and Medicare MSA markets with special attention to firms' regulatory concerns.

METHODS
We contacted 27 companies that are in or might be considering entering the MSA field. 20 of these companies are insurers or financial institutions in the under-65 market; based on news accounts and our conversations with industry analysts, we believe this list of 20 includes all the major players in the under-65 market. The other seven firms are insurance companies that are not currently selling MSAs but might, by virtue of their product niche, consider selling Medicare MSAs; this group consists of carriers offering Medicare risk HMOs, Medicare Supplemental insurance, and/or long-term care insurance. A list of all 27 companies, our rationale for contacting each company, and whether the company granted us an interview, is shown in Table 1.

Interviews varied from company to company, but all covered at least three basic issues. First, for companies already selling MSA products, we asked how many MSAs the company has sold to date. Second, we asked if the company is currently planning to offer MSA products to the Medicare market. Third, we asked if the company has concerns about particular regulatory issues—barriers in the under-65 market as well as concerns about regulations in the Medicare MSA market.

\[1\]Memo 12/1/98

[2]This question can be interpreted in different ways. To carriers, we asked about the number of qualifying high deductible policies sold, even though some of these policies might not be linked to MSAs. To financial institutions, we asked about the number of MSAs opened.
Table 1.
Companies Contacted

<table>
<thead>
<tr>
<th>Name of Company</th>
<th>Location</th>
<th>Reason for Contacting</th>
<th>Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golden Rule Insurance Co.</td>
<td>Lawrenceville, IL</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Time Insurance Co.</td>
<td>Milwaukee</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Savings Insurance Co.</td>
<td>Indianapolis</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Trigon BCBS</td>
<td>Richmond, Va.</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>BCBS of New Jersey</td>
<td>Hackensack, NJ</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>BCBS United of Wisconsin</td>
<td>Milwaukee</td>
<td>Insurer in under-65 market</td>
<td>No</td>
</tr>
<tr>
<td>BCBS of Michigan</td>
<td>Detroit</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>BCBS of Texas</td>
<td>Dallas</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>NYLCare Health Plans</td>
<td>New York City</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Mutual of Omaha</td>
<td>Omaha, Neb.</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Wellpoint Health Networks</td>
<td>Woodlands Hills, Ca.</td>
<td>Insurer in under-65 market</td>
<td>No</td>
</tr>
<tr>
<td>Anthem Life &amp; Health</td>
<td>Cincinnati</td>
<td>Insurer in under-65 market</td>
<td>No</td>
</tr>
<tr>
<td>Humana</td>
<td>Louisville, Ky.</td>
<td>Insurer in under-65 market</td>
<td>No</td>
</tr>
<tr>
<td>StarMark</td>
<td>Lake Forest, IL</td>
<td>Insurer in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>A top-25 financial institution¹</td>
<td></td>
<td>Bank in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Federal Savings Bank</td>
<td>Napa, Idaho</td>
<td>Bank in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Wells Fargo Bank</td>
<td>San Francisco</td>
<td>Bank in under-65 market</td>
<td>No</td>
</tr>
<tr>
<td>Northern Trust Co.</td>
<td>Chicago</td>
<td>Bank in under-65 market</td>
<td>No</td>
</tr>
<tr>
<td>Fifth Third Bank</td>
<td>Cincinnati</td>
<td>Bank in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>Merrill Lynch</td>
<td>New York City</td>
<td>Brokerage in under-65 market</td>
<td>Yes</td>
</tr>
<tr>
<td>United American Insurance</td>
<td>Dallas</td>
<td>Major Medigap insurer</td>
<td>Yes</td>
</tr>
<tr>
<td>AARP</td>
<td>Washington, DC</td>
<td>Major Medigap insurer</td>
<td>Yes</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>Santa Ana, Calif.</td>
<td>Major Medicare risk HMO</td>
<td>No</td>
</tr>
<tr>
<td>Aetna U.S. Healthcare</td>
<td>Hartford, CT.</td>
<td>Major Medicare risk HMO</td>
<td>No</td>
</tr>
<tr>
<td>HIP Health Plan</td>
<td>New York City</td>
<td>Major Medicare risk HMO</td>
<td>No</td>
</tr>
<tr>
<td>Metropolitan Life (MetLife)</td>
<td>New York City</td>
<td>Long-term care insurer</td>
<td>No</td>
</tr>
<tr>
<td>John Hancock Mutual Life</td>
<td>Boston</td>
<td>Long-term care insurer</td>
<td>No</td>
</tr>
</tbody>
</table>

¹This bank granted an interview on the condition that its name not be used in this report.

After interviews were completed, we summarized the current status of the under-65 market and preliminary developments in the Medicare MSA
market. Next, we created a table showing each company's position in the under-65 market and its intentions regarding the Medicare MSA market (see Table 2). With the exception of two companies—Humana and Wellpoint Health Networks—we excluded companies that did not grant interviews to us. Humana and Wellpoint are included because we were able to obtain information about them from news accounts. Finally, we identified the major regulatory concerns of interviewees and summarized them by subject matter.

### Table 2

**MSA Overview**

<table>
<thead>
<tr>
<th>Name of company</th>
<th>In MSA market now?</th>
<th>Covered lives</th>
<th>Planning to enter Medicare MSA market?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golden Rule Insurance Co.</td>
<td>Yes</td>
<td>55,000</td>
<td>Maybe</td>
</tr>
<tr>
<td>Time Insurance Co.</td>
<td>Yes</td>
<td>7,000</td>
<td>Maybe</td>
</tr>
<tr>
<td>Medical Savings Insurance Co.</td>
<td>Yes</td>
<td>1,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Trigon BCBS</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>BCBS of New Jersey</td>
<td>Yes</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td>BCBS of Michigan</td>
<td>Yes</td>
<td>200</td>
<td>No</td>
</tr>
<tr>
<td>BCBS of Texas</td>
<td>Yes</td>
<td>&lt;1,000</td>
<td>Yes</td>
</tr>
<tr>
<td>NYLCare Health Plans</td>
<td>Yes</td>
<td>10</td>
<td>No</td>
</tr>
<tr>
<td>Mutual of Omaha</td>
<td>Yes</td>
<td>&gt;3,000</td>
<td>Maybe</td>
</tr>
<tr>
<td>Wellpoint Health Networks</td>
<td>Yes</td>
<td>33 as of May, 1997 (Anders 1997)</td>
<td></td>
</tr>
<tr>
<td>Humana</td>
<td>Not any more</td>
<td>198 as of May, 1997 (Anders 1997)</td>
<td></td>
</tr>
<tr>
<td>StarMark</td>
<td>Yes</td>
<td>600</td>
<td>No</td>
</tr>
<tr>
<td>A top-25 financial institution</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Home Federal Savings Bank</td>
<td>Yes</td>
<td>3,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Fifth Third Bank</td>
<td>Yes</td>
<td>75</td>
<td>Yes</td>
</tr>
<tr>
<td>Merrill Lynch</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>United American Insurance</td>
<td>No</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>AARP</td>
<td>No</td>
<td>0</td>
<td>No</td>
</tr>
</tbody>
</table>

*Unless otherwise noted, figures are approximate. Blank spaces indicate that the company declined to provide this information.*
RESULTS

An Overview of the MSA Market

Presently, the market for MSA health insurance plans is dominated by Golden Rule Insurance Co., which has sold approximately 55,000 MSA-qualified high-deductible health insurance plans since January 1, 1997. That is eight times as many policies as Golden Rule's largest competitor, Time Insurance Co. Golden Rule's CEO, Jack Whelan, recently said in a press release that demand has "gone well beyond" his company's expectations.

With the exception of Golden Rule and its partner Northern Trust, which serves as custodian for MSAs held by Golden Rule's health insurance enrollees, companies in the MSA field appear to be off to a sluggish start. New York-based NYLCare Health Plans Inc., for example, has sold only 40 MSA-qualifying health insurance plans, and just ten of those have been coupled with MSAs. Humana Inc. reportedly stopped marketing MSAs in August after its sales fell short of expectations (Medicine & Health 1997). Wellpoint Health Networks of California had sold only 33 MSA plans as of May, according to the Wall Street Journal (Anders 1997). Fifth Third Investment Advisors, which was identified in a recent American Banker article as one of the top five banks in the MSA field (McConnell 1997), has set up just 75 accounts.

Financial institutions currently serving the under-65 MSA market say they plan to offer MSA products to the senior market, but they want to see the regulations. "We would like to participate in the Medicare MSA program," said John Scott, an attorney for Fifth Street Bank, "but we don't know who to contact at HCFA, and no information is available about how to go about participating."

Health insurance companies appear to be approaching the Medicare MSA market more cautiously than financial institutions are—or at least more discreetly. Of all the carriers we interviewed, only two relatively small players—Medical Savings Insurance Co. and Blue Cross/Blue Shield of Texas—said they are planning to offer Medicare MSAs. Golden Rule, Time and Mutual of Omaha would say only that they are or will be considering that decision. "On the surface it sounds like a great opportunity," said

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3Some carriers—like Golden Rule—bundle their catastrophic policy with a savings account. Other carriers, preferring to allow enrollees to choose their own MSA custodian, do not.
Wayne Stoltenberg, vice president of the Medicare supplement segment at Time, “but a lot of regulations have yet to be defined.”

Several smaller MSA carriers said they are unlikely to enter the Medicare MSA market. StarMark doesn’t sell to the senior market and wants to stick to its current market niche. NYLCare has had little success with MSAs thus far and plans to focus on its Medicare risk product rather than branch out into a new area. Trigon Blue Cross/Blue Shield doubts that there will be much demand among Medicare beneficiaries for MSAs.

AARP, one of the country’s largest providers of Medicare Supplemental insurance, almost certainly will not enter the MSA market. “AARP is opposed to MSAs,” said Bill Decker, a policy analyst. “We’re not likely to do anything in direct opposition to that policy.”

Another major Medigap carrier, United American Insurance Company, also is unlikely to sell MSAs. “We have considered it and have not made a decision yet, but it’s not very high on our radar screen,” said Joyce Lane, VP and Assistant to the President. “We’ve got some other irons in the fire right now.”

Humana and Wellpoint Health Networks are major question marks. Both carriers have experience with both MSAs and the senior market. Given that, they would seem like logical suppliers of the Medicare MSA product, but neither company responded to repeated requests seeking comment.

**Regulatory Concerns**

Interviewees expressed concern about a number of regulatory matters. Some of these concerns related to the under-65 MSA market. We report concerns that might have implications for the Medicare market:

- **Rigidity and complexity of federal regulations.** Most of the interviewees view the federal MSA rules in the under-65 market as too rigid, too complex, or both. “Presenting information about health plans already can be complicated, especially when you add a financial component to it,” said Eric Anderson, senior marketing coordinator at Blue Cross/Blue Shield of New Jersey. “Anything to simplify MSAs would be a step forward.” (Anderson stressed that he was speaking on behalf of himself, not his company.)
Interviewees were especially critical of federal rules limiting the deductible on the catastrophic plan. "We need to be able to offer individual deductibles anywhere from $3,000 to $5,000," said Bill Draznik, VP at StarMark. "That is not a high deductible in comparison to what actually sells out there. The most popular plans have $500 and $1,000 deductibles. $1,500 is not that much more than that. It's certainly not a big enough jump to be able to get the premium down enough."

This theme was amplified by Alan Gorlewski, VP at BlueCross BlueShield of Texas: "When they wrote the regulations for the MSA, they said, 'A high deductible plan is going to be this.' God bless the policymakers who probably have a plan that has a $250 deductible. But a lot of self-employed people have health plans with a $5,000 deductible, and they can't switch that over to the MSA. We need to emphasize with HCFA that the real world changes rapidly—that it's sometimes way ahead of where policymakers are."

Brian McManus of Golden Rule questioned the need for HCFA to specify a minimum deductible for qualifying health plans, noting that low-deductible MSA plans would be penalized in the marketplace insofar as their premiums would be relatively high.

- **Gaps in federal regulations.** Several financial institutions expressed concern that MSA regulations, while overly complex and rigid, are also insufficiently comprehensive. "Let's have some regulations, please. Don't tell a banker that there are no regulations," said a representative from a top-25 financial institution. "Are MSAs FDIC-insured? We don't know. What happens when someone dies? The regulations aren't clear. What portion is escheatable? No one will tell us."

- **Lack of information about Medicare MSA regulations.** All of the financial institutions with which we spoke are eager to obtain more information about how the Medicare MSA program will work. Several interviewees said that they would like to know who to contact in HCFA about participating in the Medicare MSA program, and when information will be made available.
• **State regulations.** Several states require carriers to provide first-dollar coverage for certain preventive services. Yet, according to carriers, the Treasury Department says that plans offering first-dollar coverage of preventive services do not qualify for favorable MSA tax benefits. "It's a catch-22," said Draznik. "Kansas fixed this problem relatively quickly. Wisconsin did not fix it until March 1, 1998. That prevented us from selling any products in that state for 15 months." Differences between state laws can also complicate the efforts of companies trying to sell a uniform MSA product nationally, noted Allison Alkire, VP of marketing at NYLCare Health Plans.

• **Payment for government-sponsored MSA brochures.** Pat Rooney, Chairman of Medical Savings Insurance Co., expressed concern that companies selling Medicare MSAs will be forced to pay for government brochures that explain the Medicare MSA concept. Rooney believes the government should pay for its brochures.

• **Restrictions on direct marketing.** Rooney said suppliers of Medicare MSAs should be permitted to do direct marketing to seniors on radio and television, just like Medicare HMOs do. "That's the way the HMOs have been building business," he noted.
3. BROCHURES

OBJECTIVE

The purpose of this memorandum is to review how firms in the under-
65 market describe Medical Savings Accounts in their promotional literature.
This information is designed to help HCFA to develop educational MSA
materials for the senior population.

METHODS

We contacted 20 companies that are in the under-65 MSA market and
asked them to send MSA marketing materials. A list of these companies is
provided in Table 3.

RESULTS

At the time of this writing, we have received marketing materials from
six companies: Golden Rule, Time, Blue Cross Blue Shield of Texas, Merrill
Lynch, NYLCare and Medical Savings Insurance.

These marketing materials vary in style, format and emphasis. Golden
Rule presents information in a short, simple 8-page booklet, while one of
Merrill Lynch's brochures spans 17 pages and reads like a legal document.
Time, Golden Rule, Merrill Lynch, and Medical Savings Insurance produce
all of their materials in-house, while NYLCare and Blue Cross Blue Shield of
Texas rely heavily on materials produced by MSAver, an MSA
administration company. Medical Savings Insurance discusses only the
positive aspects of MSAs, while Time provides both “best case” and “worst
case” analyses.

Despite these differences, the companies that sent us their materials
generally cover at least eight basic issues: (1) a description of MSAs; (2)
what money from MSAs can be used for; (3) what qualifies as a “high-
deductible” plan; (4) eligibility requirements; (5) MSA management fees; (6)
withdrawals and reimbursements; (7) tax benefits; and (8) amount that can
be deposited in MSAs. We examine each of these issues in turn.

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*Memo 12/8/97*
Some of these issues, such as eligibility requirements and amounts that can be deposited would not be relevant to Medicare MSAs, and other items would have to be mentioned: the accounting rules below and above the deductible, balance needed to withdraw money without penalty, etc. Also, how topics to be explained would be split between the government and private company brochures must be decided. In these brochures, the sellers are providing almost all the needed information. The brochures are useful in showing in the best case how to convey needed information in a way that can be understood.

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Location</th>
<th>Type of firm</th>
<th>Obtained materials?</th>
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<tbody>
<tr>
<td>Golden Rule Insurance Co.</td>
<td>Lawrenceville, IL</td>
<td>Insurance company</td>
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<td>Time Insurance Co.</td>
<td>Milwaukee</td>
<td>&quot;</td>
<td>Yes</td>
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<tr>
<td>Medical Savings Insurance Co.</td>
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<td>Trigon BCBS</td>
<td>Richmond, VA</td>
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<td>NYL Care Health Plans</td>
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<td>A top-25 financial institution</td>
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<td>Wells Fargo Bank</td>
<td>San Francisco</td>
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<td>Northern Trust Co.</td>
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<td>Fifth Third Bank</td>
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<td>Merrill Lynch</td>
<td>New York City</td>
<td>Brokerage</td>
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5This bank granted an interview on the condition that its name not be used in this report.
1. DESCRIPTION OF MSA

Golden Rule: “A Medical Savings Account (MSA) is a savings account created for the purpose of paying medical expenses.”

Time: “Medical Savings Accounts, usually referred to as MSAs, are tax-favored accounts set up to pay for medical care and to allow for the build-up of savings for future medical expenses.”

Blue Cross/Blue Shield of Texas: “A Medical Savings Account (MSA) is a trust created exclusively to pay for qualified medical expenses on a tax-deferred basis. Income earned on an MSA fund is not taxed if the money stays in the account or is used for qualified medical expenses.”

NYLCare: “The Health Insurance Portability and Accountability Act, signed by the president in August 1996, created a brand new way to help pay for health-care and save you money. It’s called a Medical Savings Account, or MSA for short. The MSA is an individual trust account set up for the purpose of paying medical expenses. Like an IRA, contributions to an MSA are tax deductible and can earn income on a tax-deferred basis…”

Merrill Lynch: “The Merrill Lynch Medical Savings Account, which is designed to work in conjunction with a qualified high-deductible health insurance plan, enables you to save and invest for qualified medical expenses.”

Medical Savings Insurance: Does not provide a succinct definition but discusses MSAs at length. Stresses that MSAs put the consumer “in control” of their health care with “no rationing” and “no gatekeeper.” Describes the account itself using insurance terminology: “First-dollar benefits (no upfront deductible). Now you have a Cash Account to use for routine expenses without worrying about the initial deductible.”

2. WHAT MSA MONEY CAN BE USED FOR

Golden Rule: “The MSA money can be used to help pay the major medical deductible and medical expenses not covered by the major medical.”

Time: “MSA funds can be used to pay for any medical services covered under your high deductible health plan. MSA funds can also be used to purchase a wide variety of medical services (eyeglasses, dental services, etc.)
not covered under your health plan. These expenses would not be applied
toward your plan deductible.”

**Blue Cross/Blue Shield of Texas:** “Funds may be used without penalty for any IRS-qualified medical expense; deductibles and coinsurance; non-covered medical expenses such as glasses or dental work; long-term care insurance premiums; COBRA premiums and health insurance premiums while unemployed.”

**NYLCare:** Provides a complete list of medical expenses that qualify for tax-free withdrawal from MSA based on Internal Revenue Service Publication 502.

**Merrill Lynch:** “Qualified’ medical expenses are expenses (that have not been compensated or reimbursed by insurance or otherwise) for medical care (generally defined in section 213(d) of the Tax Code). Examples of qualified medical expenses include hospital costs, doctor’s office visits, prescription drugs, lab tests, eyeglasses, hearing aids, counseling fees, health insurance deductibles, and co-payments. Premiums for health insurance do not constitute ‘qualified’ medical expenses unless the health insurance purchased is continuation coverage provided under COBRA, qualified long-term-care coverage provided through a long-term-care contract under section 7702B(b) of the Tax Code, or health coverage provided while the individual is receiving unemployment compensation under any federal or state law. IRS Publication 502 generally describes the types of medical expenses that may be paid or reimbursed with distributions from your MSA, with the exceptions described above. You should note carefully that the range of qualified medical expenses for which tax-favored MSA distributions are allowed may be broader than the expenses that count toward the deductible under your high deductible plan. For example, expenses for eyeglasses that are a qualified medical expense under MSA rules may not count toward your high deductible health insurance policy deductible. You are responsible for determining if expenses are ‘qualified’ medical expenses and for properly reporting all distributions on your tax return. Merrill Lynch is responsible for reporting the amount of distributions in a year from an MSA but is not responsible for determining whether or not distributions are excludable from income or are subject to the additional 15% tax described below.”

**Medical Savings Insurance:** “MSA funds cover everything most traditional health care plans don’t: Dental, Vision, Chiropractic, Psychological, Acupuncture.”
3. WHAT IS A QUALIFIED “HIGH-DEDUCTIBLE PLAN”?  

Golden Rule: “A health insurance plan that has minimum and maximum annual deductible limits.

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<th>Minimum</th>
<th>Maximum</th>
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<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$2,250</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

Future limits. After 1998, minimum and maximum deductible limits are adjusted based on changed in the Consumer Price Index (CPI).”

Time: Does not address this issue.

Blue Cross/Blue Shield of Texas: Like Time, BCBS Texas does not explicitly address this issue. It says only that “Not every health plan offering a high-deductible will qualify for use with an MSA. The plan must be qualified to be eligible for the financial portion of the MSA. Ask your independent tax agent or tax advisor for specific information about your health plan, or call us at 1-888-MSA-BLUE.”

NYLCare: Does not address this issue except to say that “[its] policies are designed to meet the requirements established by HIPAA for a ‘high deductible health plan.’”

Merrill Lynch: “A high-deductible plan is a health plan with an annual deductible equal to: (a) At least $1,500 and no more than $2,250, with maximum out-of-pocket expenses no more than $3,000, for individual coverage; or (b) At least $3,000 and no more than $4,500, with maximum out-of-pocket expenses no more than $5,500 for family coverage.”

Medical Savings Insurance: Does not address this issue.

4. ELIGIBILITY REQUIREMENTS

Golden Rule: “The program is open to the self-employed and employer groups with 50 or fewer employees. The individual must be: (1) Covered by qualified major medical insurance; (2) Not covered under other health insurance; and (3) Under the age of 65. Other health insurance does not
include coverage for: accidents, dental care, disability, long-term care, and vision care. Workers' compensation, specified disease, and fixed indemnity coverage is also permitted.”

**Time:** Indicates that product is available to self-employed, but otherwise does not address this issue.

**Blue Cross/Blue Shield of Texas:** “To open an MSA, you must: (a) be self-employed or an employee of a small group employer; (b) establish, or have your employer establish, a qualifying high-deductible health insurance plan; and (c) have no other duplicate health coverage.”

**NYLCare:** “Who is eligible for an MSA? (a) Small business owners: Self-employed persons can be either a sole proprietor or an owner in a partnership-type arrangement. Generally, owners in partnership type arrangements include members of a limited liability company, partners in a partnership, or employees/shareholders that own more than 2% of an S-corporation; (b) Employees of small employers: The IRS defines small employers as those that had an average of 50 or fewer employees during either of the two preceding years. An employer will continue to be eligible as long as it sponsors a high-deductible health plan and does not grow beyond 200 employees. Note: Individuals eligible for Medicare are not eligible for the MSA program.”

**Merrill Lynch:** “You are eligible to establish and contribute to an MSA if you are: (a) A self-employed person (or the spouse of a self-employed person) maintaining an individual or family high-deductible health plan; or (b) An employee (or the spouse of an employee) of a small employer that maintains an individual or family high-deductible health plan. For MSA purposes, a “small employer” generally is an employer that employed, on average, 50 or fewer employees during either of the two preceding calendar years.”

**Medical Savings Insurance:** Does not address this issue.

5. **MSA MANAGEMENT FEES.**

**Golden Rule:** “MSA checking services are provided to you for $3 per month. Management fees will automatically be deducted from your account. The first 25 checks are provided at no cost. Additional orders cost $2.50. Your account will be charged $10 for each bounced check and $15 for each stop-payment request.”
Time: “Time is pleased to provide you with the value of an MSA without any extra administration or user fees.”

Blue Cross/Blue Shield of Texas: Set-up fee of $50 for MSAver Medical Savings Account. Monthly MSAver Medical Savings Account administration fee of $5 per month.

NYLCare: “There is a onetime set-up fee and a small monthly administration fee for each MSAver Medical Savings Account. Please see the enrollment form and rate schedule that accompanies this brochure.” (No enrollment form or rate schedule is included.)

Merrill Lynch: Provides a 20-page prospectus of its CBA Money Fund, including information about management fees, rule 12b-1 fees, transfer agency fees, and other fees.

Medical Savings Insurance: Does not address this issue.

6. WITHDRAWALS AND REIMBURSEMENTS.

Golden Rule: “How do I withdraw money? Write a check. We will send you an MSA checkbook shortly after your insurance becomes effective. You can pay your qualified medical expenses with these checks or write yourself a check and pay the providers from your personal checking account. If you have enough covered expenses to meet the deductible, send us your bills. We will process the expenses under the major medical.”

Time: “Claims submissions are as simple as ever. Claims can be sent to Time by you or your provider. If a claim is submitted by your provider and applied to your Time health plan deductible, you and your provider will be notified. At the time of MSA enrollment, you indicate whether you will pay for claims with out-of-pocket funds and thus maintain a higher balance in your MSA, or have Time pay claims automatically from your account. If you choose to have your account debited you will be reimbursed for your claim from your MSA. Payments will be made directly to you.”

Blue Cross/Blue Shield of Texas: “Q: How do I obtain MSA funds? A: It depends on how the MSA is established. Some may make payments directly to you and others may have debit cards. For specific details, please refer to your insurance representative, tax advisor, or trustee.”
NYLCare: "The MSAver Medical Savings Card. This healthcare-only transaction card can be used to conveniently pay healthcare providers at time of service, directly from your MSAver MSA Account. It does not require a claim and will be honored for healthcare purchases where MasterCard or VISA are accepted." Also provides "convenience checks and vouchers for non-card withdrawals from your MSAver Medical Savings Account."

Merrill Lynch: "You can access your account at any time by using your MSA checks or MSA Visa debit card, which will be provided to you when you open your Merrill Lynch MSA."

Medical Savings Insurance: Does not address this issue.

7. TAX BENEFITS.

Golden Rule: "There are three major tax advantages to your MSA. (1) Cash contributions during a tax year to an MSA are not included in your federal gross income; (2) Interest earnings accumulate tax-deferred; and (3) Withdrawals from an MSA for 'qualified medical expenses' are free from federal income tax."

Time: "If you were to use taxed dollars to pay for your medical expenses, you would be spending from 15% to 39.6% more for your medical expenses based on current federal income tax rates alone. You may save even more if your state income tax laws allow for MSA deductibility. The following chart illustrates the equivalent amount required to be paid with after tax dollars compared to tax deductible dollars (MSA contributions) of $3000. It is based on 1997 federal income tax rates for a married individual filing a joint return. For example, if a family had taxable income of $75,000 and had a health plan with a $4000 deductible, 75% or $3000 could be contributed to their MSA. On the other hand, earnings would have to be $4167 to buy $3000 worth of services with after tax dollars" (chart omitted here).

BlueCross BlueShield of Texas: "MSA contributions are deducted from gross income, building your retirement savings. MSA funds and interest earned can accumulate each year on a tax-deferred basis. Money can be withdrawn tax-free to pay for qualified health care expenses; The new law gives MSAs very favorable tax treatment. In fact, the IRS treats MSAs very much like an IRA. Unlike an IRA, however, funds can be withdrawn on a tax-free basis to pay for qualified medical expenses."
NYLCare: “The new law gives MSAs very favorable tax treatment. In fact, the IRS treats MSAs very much like an IRA. Unlike an IRA, however, funds can be withdrawn on a tax-free basis to pay for qualified medical expenses.”

Merrill Lynch: “If the other requirements and limitations described herein are satisfied, contributions to an MSA may be made by you or by your employer. For federal income tax purposes, MSA contributions made by you or your spouse that meet the requirements set forth above may be deducted from your gross income for the tax year with respect to which they are made. These contributions are deductible whether or not you itemize deductions. Contributions made by your employer during the tax year to your MSA (or your spouse’s MSA) will generally be excluded from your gross income for the tax year, are not subject to withholding for income tax and are not subject to employment taxes, including Social Security and Medicare taxes. State income tax treatment may differ from the federal tax rules…”

Medical Savings Insurance: Does not address this issue except to note that the MSA is tax deductible.

8. HOW MUCH CAN BE DEPOSITED IN THE MSA?

Golden Rule: “Monthly contribution limits are based on: (1) The major medical deductible amount; and (2) The number of dependents you are entitled to claim on your tax return that are also covered under the major medical. Following are the monthly maximum contributions for 1997 and 1998.

<table>
<thead>
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<th>Monthly Maximum Contributions for 1997 and 1998</th>
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<tr>
<td>Dependents</td>
</tr>
<tr>
<td>None (0)</td>
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<tr>
<td>One or more</td>
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</table>

Golden Rule minimums. A minimum of $25 each month is required to open and continue your MSA with Golden Rule.”

Time: “Maximum MSA contributions are 65% of the deductible for an individual policy and 75% of the deductible for a family policy. These maximums have been established by law.”
BlueCross BlueShield of Texas: “Although there is no minimum MSA contribution required, the maximum annual contribution will depend on the size of the health plan’s deductible...” Includes a table showing that the maximum annual MSA contribution is $1,462.50 for an individual policy with a deductible of $2,250 and $3,375.00 for a family policy with a deductible of $4,500.

NYLCare: “Although there is no minimum MSA contribution required, the maximum annual contribution will depend on the size your NYLCare health plan’s deductible...” Includes a table showing that the maximum annual MSA contribution is $1,300.00 for an individual policy with a deductible of $2,000 and $3,000.00 for a family policy with a deductible of $4,000.

Merrill Lynch: “Each tax year you (or your employer on your behalf) are permitted to have a portion of your compensation, up to the maximum amount described below, contributed to an MSA...If you have single coverage as of the first day of the money, the monthly amount is equal to 1/12 of 65% of the annual deductible applicable to your coverage under the high deductible health plan. Therefore, if the applicable annual deductible under your high deductible health plan is $2,250 (which is the maximum annual deductible permitted for 1997), then the most that you can “earn” toward your annual deduction amount for any one month is $121.88 (which is 1/12 of 65% of $2,250)...If you have family coverage as of the first day of the month, the monthly amount is equal to 1/12 of 75% of the annual deductible applicable to your coverage under the high deductible health plan...”

Medical Savings Insurance: Notes on the application for insurance that the annual maximum for a single person is the deductible x .65 and the annual maximum deductible for more than one person is the deductible x .75.
4. OPTIONS FOR MINIMUM DEDUCTIBLE

BACKGROUND

The idea of MSAs is to reward people for spending less, so it is reasonable to set a minimum deductible amount needed to qualify. In the under 65 legislation, the minimum deductible was $1500. Private insurers use other methods besides deductibles to cut costs: cost-sharing above the deductible up to some limit, PPO networks with negotiated low prices for patients that stay in the network, or managed care networks that reduce utilization from the supply side. For example, BCBS of New Jersey has a PPO plan with a $1500 or a $2250 deductible, with 20% cost-sharing above the deductible up to an annual limit. Unfortunately, the law rules out cost-sharing above the deductible, and restricts the ability of MSAs to form a PPO style networked MSA (as discussed below). But the issue of the minimum deductible size remains. Older people typically spend more on health care than the under 65 which argues for larger deductibles, but are not particularly rich which argues against deductibles that expose them to more financial risk.

I have taken some numbers from computations by Chris Hogan in a chapter written for the 1996 PPRC annual report.7 As Chris explains, spending by beneficiaries is highly skewed (for example, the top 31% of beneficiaries in 1995 spent more than $3000 a year, and their spending (Medicare payments + their cost-sharing) made up 92% of the total. In that year, Medicare paid $5000 on average and copays and deductibles averaged $970, for a total of $5,970 in spending. The $5,970 can be split into the parts that would be less than a hypothetical catastrophic deductible and the parts over a catastrophic deductible. For example, spending after the first $3000 in a year averaged $4,540 (for all beneficiaries, not just those who exceeded

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7In these computations, he and I assume no balance billing. Not many providers now balance bill, or alternately the insurance company might put together a network of providers that agree to charge just the original Medicare amounts.
$3000), and spending under $3000 averaged only $1,430 or about .25
(=1430/5970) of the total. So, unless there are reductions in volume or price,
premium savings from a $3000 deductible are limited to $1,430, even if
Medicare contributes the full $5,000 and loading fees are zero. There was a
lot of talk at the Alpha center meeting about the MSA funds, but fund
deposits will typically be small—the major benefit from the MSA plan has to
come from the restructuring of insurance payments. The AAPCC varies
widely, and in locations where it is high, there might be more to put in the
MSA, if the MSA could figure out a way to reduce local spending to national
averages.

Options include:

1. No restriction on minimum deductible.\textsuperscript{8} Perhaps HMOs could offer
no-frills prepaid care with no cost-sharing. By qualifying as MSAs, they
could avoid the ACR process and get rebates for their enrollees in areas
where the HCFA contribution was large relative to their costs. (This would
be a way to evade ACR and other HMO regulation). The law on over the
deductible payments discussed below requires such plans to offer a full
coverage point of service plan, so they are probably infeasible. Also they may
be contrary to the intent of the law.

2. A low minimum deductible, for example $1500, as in the under 65
legislation.\textsuperscript{9} The premium for such a policy would be slightly (~$100) more
than the average contribution, according to Chris Hogan's base case
calculations based on the 1993 Current Beneficiary Survey inflated to 1995$.
These calculations assume Medicare contributes 100% of what it paid on
average in FFS, no changes in spending, no biased selection, no loading fees
(so the average spending above the deductible = catastrophic insurance
premium).\textsuperscript{10} Such a deductible might be an attractive competitor for Medigap

\textsuperscript{8}HCFA has not yet imposed a minimum deductible. It is still seeking comment on this matter.

\textsuperscript{9}HCFA is considering a minimum deductible based on the actuarial value of the average per
capita cost sharing under original Medicare (Health Care Financing Administration 1998, 35033). For 1999, this amount is $1,000, which is slightly lower than the amount suggested in Option 2.

\textsuperscript{10}Our alternate, more realistic but more complicated set of assumptions is to assume enrollee
drops generous Medigap policy with premium of $1,160, the catastrophic plan has 20% loading fees
(these policies are sold individually), the deductible and network induces a 20% reduction in spending
for a wide variety of beneficiaries, as the financial exposure is not much larger than the Medigap premium, and in a good year enrollees might save some of the premium. In such a case, no money would go into the MSA account. The law says that any additional premium that the company would charge must be the same for each enrollee. Even if the law specified a low minimum, plans would not offer a minimum deductible if a larger deductible were more attractive to the beneficiaries they wanted to enroll.

3. A medium minimum deductible, for example $3000. This would ensure that plans would be putting some money into the MSA fund. In Chris Hogan’s base case, $460 (= $5000 - $4540) would be deposited, to go along with $970 on average of former cost-sharing. So the additional annual exposure for someone not with Medigap is $3000 - 460 - 970 = $1570. In the alternate, more realistic case, $610 would be deposited into the MSA, with additional exposure of approximately 1,230. Adverse selection would be more of a problem than with smaller deductibles because sick people would have more incentive to buy out of cost-sharing for $1160.

4. A large minimum deductible, for example $5000. This would lead to substantial savings ($1000 per year in the Chris Hogan base case) that could be deposited in the MSA. Because of the financial exposure, such plans would be attractive only to rich, healthy enrollees, because most of the welfare gains from reduced low value spending can be achieved with smaller deductibles. Ultimately, HCFA will develop risk adjustment methods to compensate somewhat for the adverse selection, but probably not completely. Also, the market for such policies will be very small, and insurance companies may feel it is not worth the effort to develop and market such a product.

Plans with larger deductibles might choose to include other spending such as drugs not currently covered by Medicare. This might be beneficial

(as was seen in the HIE). We discuss the effects of different assumptions under the $3000 deductible section.

If the enrollee had generous Medigap that eliminated cost sharing for a premium of $1,160 (= $970 x 1.2), the exposure would be less by the $190 Medigap premium loading.
because such drugs can be substitutes for other types of care, and may add to
financial exposure. If drugs were covered, expected expenses in the
calculations above would be higher, and amounts deposited in the MSA
account would be smaller.

If zero or very small deductibles are not in the spirit of the law, then we
can concentrate on minimums between $1500 and $5000. There are two
issues here—which deductible size seems most attractive to us, and whether
we should mandate that size as a minimum. A smaller minimum allows the
market to pick whatever catastrophic deductible seems attractive to them. In
the under 65 market, the limits on policies sold made firms unwilling to
make major changes in their products. Going from under 65 to over 65
enrollees is a major change in any event, but plans might be favorably
influenced by the ability to offer the same form of product. Smaller
deductibles would be more attractive to sicker enrollees, as a way to limit
coinsurance and if in a network, balance billing. However, they would lead
to zero or small contributions to the MSA, which might be considered as
against the spirit of the law. With the under 65, there are tax incentives for
people to deposit funds in MSA, but the law states that only the Secretary
can contribute to the MSA, so these small funds will not be attractive to fund
holders. Larger deductibles would lead to a greater reduction in low value
care, and might make it somewhat easier to organize networks as more care
would fall in the region where some price discretion were possible. Also they
would lead to larger contributions to the MSA fund. However, because of
their financial exposure, they would be attractive only to a very narrow group
of rich healthy beneficiaries. The most desirable minimums are between
$1500 and $3000, with $1500 best if we want to see what the market will
offer, and larger minimums better if we want to ensure positive deposits into
the MSA.

The law mentions networked MSAs, but are these really viable?
Could an HMO or PPO qualify as an MSA? The law mandates that
MSAs must "pay for at least all Medicare covered items and services after the
enrollee meets the annual deductible... (and) pays the lesser of 100% of
specified expenses or 100% of amounts that would have been payable under
original fee-for service..(1859 b 2 A iii I and II).” This payment rule makes it difficult for plans to give incentives to enrollees that have met the deductible to stay within the network or to forego any care they wanted. The plan could pay less to the doctors and hospitals in its own network, and make them agree not to balance bill, but if the enrollees went outside, the plan would have to pay at least the original amount. This escape hatch would also put the plan in a weaker bargaining position with the doctors and hospitals it might want to include in its network. However, it would probably not be hard to put together a network that at least agrees not to balance bill, especially if the minimum deductible is large.

HMOs with zero deductibles would founder on these “no cost-sharing over the MSA deductible” rules, but how about HMOs with say a $5,000 deductible which forgive cost-sharing if enrollees stay inside the plan? The HMO would have to keep track of nominal spending and tell the enrollee when the deductible is met. The HMO could then manage the care below the deductible. However, in FFS spending in 1995, about $1,970 was below $5,000 per year, and $4000 was above $5,000, so they would be managing only about 1/3 of the care. This would be a major handicap compared to regular Medicare HMOs, which the lightened regulatory burden would probably not offset.

For expenses under the deductible, the plan could have its doctors and hospitals charge some fraction of the original Medicare charge, but must “count towards the deductible at least all amounts that would have been paid Medicare and the beneficiary.” They could not effectively manage care in the sense of refusing to pay for some services, because they are not paying for them anyway. If the enrollee sent in the bills, they would have to count towards the deductible. Perhaps some disease management is possible. For example, they could offer to pay for drugs if patients kept to a certain regular limited schedule of visits.
If the government wanted to encourage network MSAs, it should relax the rules about cost-sharing over the deductible.\textsuperscript{12} This would lead to products that would be more attractive and more like commercial POS, HMOs, or big deductible PPO plans. Such plans could have cost-sharing up to much larger spending levels, some of which could be waived to encourage in plan use.

\textsuperscript{12}HCFA finally decided not to let insurance companies charge beneficiaries the Medicare 20\% cost-sharing requirement on spending over the deductible.
5. DESCRIPTION OF STATE LAWS REGULATING HEALTH INSURANCE PLANS

OBJECTIVE
The purpose of this memorandum is to provide a brief review of how states regulate health insurance plans.

METHODS
Given the time and resources available for this task, a comprehensive evaluation of how all 50 states regulate health insurance was not feasible. Instead, we focused mainly on two discrete areas of regulatory policy that are relevant to MSAs: (1) state mandated benefits and providers and (2) state Medical Savings Accounts laws. In addition, we provide an overview of other state health insurance regulations using several states for illustrative purposes.

RESULTS

State-mandated benefits
All 50 states require companies selling health insurance plans to cover specified services and/or services provided by specified providers. The Blue Cross and Blue Shield Association divides mandates into three categories: (1) treatment mandates, (2) provider mandates and (3) persons covered mandates. Treatment mandates require insurance companies to require treatment for certain conditions, such as chemical dependency. Provider mandates require payment for specific types of providers, such as chiropractors. Persons covered mandates require payment for specific groups, such as handicapped dependents.

The Blue Cross and Blue Shield Association tracks mandates in all 50 states. These data are based on a survey of Blue Cross and Blue Shield plans, and therefore exclude mandates that are limited to other types of health plans, such as HMOs. However, because state mandates typically apply to all companies selling health plans, this distinction is of little importance in practice.

13RAND Medicare MSA Team memo to HCFA 12/9/97
MSA-qualifying health insurance plans are compatible with the overwhelming majority of state-mandated benefits. The major area of concern is mandates that require insurance plans to provide "first dollar" coverage of certain benefits. Congress was cognizant of this issue when it passed the Health Insurance Portability and Accountability Act last year; that legislation allows a "safe harbor" for first-dollar preventive coverage that is mandated by state laws. Thus, a high deductible plan that offers first-dollar coverage for preventive coverage such as mammograms or pap smears could qualify for the federal MSA tax break.

There were, however, a few states that mandated first-dollar coverage for non-preventive services. Problems began cropping up in these states earlier this year because such mandates made it illegal for insurers to sell health insurance plans that qualified for the federal MSA tax break. "This is a real problem. At the state level, you can't legally sell a health insurance policy unless you offer certain coverage. Yet, the Treasury Department says, if you offer that coverage, the policy does not qualify for favorable tax benefits," said Tom Wildsmith, policy research actuary with the Health Insurance Association of America in Washington, D.C. "It puts you between a rock and a hard place" (Geisel 1997). Three states have been identified by press accounts as having problems:

Until July 1, 1997, Kansas required policies sold to groups to have first dollar coverage for the treatment of mental illness. That meant insurers could not require patients to first pay out-of-pocket costs or a deductible to cover mental illness. Since insurance policies that charge a deductible for any coverage other than preventive care do not qualify for the MSA tax break, policies that were in compliance with the federal rules violated state law. Kansas officials asked the U.S. Treasury Department whether its mental health mandate could be shuttered under the "safe harbor" federal exclusion for high deductible plans by classifying mental treatment as preventive care. After two months of discussions, Treasury officials determined that high deductible health insurance issued in Kansas probably would not receive favorable tax treatment. In light of that determination, Kansas decided to halt the sales of MSAs to groups (Insurance Regulator 1997).

Wisconsin has a mental health care mandate similar to the one in Kansas. It also has a law mandating first dollar coverage of drug and alcohol abuse treatment. Unlike Kansas, Wisconsin did not
halt the sale of MSAs because the Office of the Insurance Commissioner concluded it did not have jurisdiction over them. Peter Farrow, a spokesman, told the Capital Times newspaper that, although MSAs are packaged with high deductible insurance policies, technically they are savings accounts and not insurance (Wendling 1997). But although MSAs can be sold in Wisconsin, they cannot be packaged with a high-deductible policy that qualifies for the federal tax break. This prompted a decision by Blue Cross & Blue Shield United of Wisconsin to stop marketing the MSA product to the group market in July. “At this point, we are not selling MSAs to groups,” spokesman Tom Luljak said. “One of the selling points is that they were tax deductible and if that is in question, we want to act in the best interest of our customers. At this point it would appear the plan would not provide the tax benefits they are seeking” (Wendling 1997). Another carrier, Employers Health Insurance Co. in Green Bay, also stopped writing insurance policies linked to tax-favored MSAs and will not renew already-issued policies when they come up for renewal. The health insurer, a unit of Humana Inc., cited regulatory policies as well as sluggish sales for its decision to leave the MSA market (Geisel 1997).

Connecticut also has had trouble with federal rules governing MSAs and a state-mandated $50 home health care deductible. Earlier this year, the insurance commissioner advised companies that the home health care mandate may prevent policies from qualifying as MSAs because of the accounts' high deductible requirements. In addition, the Commissioner warned companies that advertisements for the policies in Connecticut should be sufficiently clear and complete to avoid a "tendency to mislead or deceive" about whether the MSAs were eligible for a federal tax break (Insurance Regulator 1997).

Despite the experiences of these states, state-mandated benefits do not appear to be a major obstacle to the sale of high-deductible health insurance policies. In the few states where it was a problem, it was relatively easy to fix it. Wisconsin, for example, passed a law this fall allowing insurers to charge a deductible for mental health care and for treatment of drug and alcohol abuse. The law will go into effect next spring. Kansas and Connecticut passed similar fixes in the spring. Those laws went into effect July 1. In theory, states hostile to the MSA concept could pass laws
mandating first-dollar coverage of nonpreventive services so that residents would not be eligible for the federal tax break. To date, this has not occurred. Of course, Congress could preempt state laws that interfere with MSAs, though it appears that such action is unnecessary (Geisel 1997; Wendling 1997).

State MSA laws

Many states have laws dealing with MSAs. Among other things, these laws address the agency responsible for overseeing MSAs, who can establish MSAs, the maximum annual contribution, allowable uses of MSA funds, and state tax treatment:

- **Governing agency.** Typically, a state Department of Revenue, Department or Labor or Insurance Commissioner—or some combination of agencies—is responsible for overseeing state MSA rules and regulations.

- **Who establishes.** In most states, either the employer or employee may establish an MSA. However, some states—e.g., Indiana, Missouri and Nevada—require that the MSA be set up by the employer. Others—e.g., Arizona and California—require that the account be set up by the employee.

- **Maximum annual contribution.** There is wide variation in the maximum amount that be contributed to an MSA. Indiana, for example, allows each MSA-holder to deposit as much as $5,000 in his or her MSA. Utah, on the other hand, sets the limit at $2,000. Because limits generally differ from those set established in federal legislation, the amount of money deposited in an MSA that can be deducted from federal income taxes is not usually the same as the amount of money that can be deducted from state income taxes.

- **Allowable uses.** The definition of an “allowable use” varies from state to state. For example, several states permit MSA funds to be spent on health insurance premiums. Federal rules, by contrast, do not permit MSA funds to be spent on insurance premiums, except for COBRA coverage, long-term care insurance, and insurance purchased when receiving unemployment compensation. Penalties for non-medical uses of MSA funds also vary. Many (but not all) states impose a 10% penalty for withdrawals spent on non-medical items. Some states allow individuals to withdraw funds
accumulated that exceed the deductible (or some other threshold) without penalty.

- **Tax treatment.** The federal MSA law allows individuals to establish MSAs that are tax-favored at the federal level. It is up to states, however, to decide whether to allow tax breaks at the state level. According to information compiled by the National Association of Insurance Commissioners, many states have done so. (Many of the states that have not done so—including New Hampshire, South Dakota, Wyoming, Texas, and Washington—have no income tax and, therefore, cannot confer state income tax benefits to holders of MSAs.) Funds deposited into a Medicare MSA will be excluded from federal taxable income. Typically, states follow the federal definition of taxable income, but there is no requirement that they do so, according to Stephen Entin of the Institute for Research and Education on Taxation in Washington, D.C. If a state decides it wants to tax the money deposited into a Medicare MSA, it is unclear whether HCFA could prevent it from doing so.

**Overview of State Health Insurance Regulations**

Under the McCarran-Ferguson Act of 1945, Congress vested in state government jurisdiction over the regulation of health insurance (Courtney 1997). State regulations address a wide variety of issues, including: the application procedure, net worth and deposit requirements, investment restrictions, disclosure rules, and individual and small group insurance reform. These regulations are discussed below.

**Application procedure.** In most states, an organization or group wanting to sell health coverage must receive a certificate of authority from the state insurance commissioner or some other regulatory official. The information required to obtain a certificate of authority to form a Health Maintenance Organization in Minnesota appears to be typical:

- copy of the basic organizational document, if any, of the applicant (such as articles of incorporation);

- copy of the bylaws, rules or regulations that regulate the affairs of the applicant;

- list of the names, addresses, and official positions of members of the board of directors, principal officers, and major shareholders of the
applicant organization; a full disclosure of the extent and nature of any contract or financial arrangements between the health plan and the members of the board of directors, principal officers, and major shareholders of the applicant organization;

- the name and address of each participating entity and the agreed upon duration of each contract or agreement;

- copy of the contract binding the participating entities and the health maintenance organization;

- detailed financial projections;

- statement generally describing the health maintenance organization, its health maintenance contracts and separate health service contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services and separate health services;

- copy of the form of each evidence of coverage to be issued to the enrollees;

- copy of the form of each individual or group health maintenance contract and each separate health service contract which is to be issued to enrollees or their representatives; financial statements showing the applicant's assets, liabilities, and sources of financial support;

- description of the proposed method of marketing the plan, a schedule of proposed charges, and a financial plan which includes a three-year projection of the expenses and income and other sources of future capital;

- statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served;

- description of the complaint procedures to be utilized;

- description of the procedures and programs to be implemented to monitor the quality of health care provided to enrollees;
• description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

• copy of any agreement between the HMO and an insurer or nonprofit health service corporation regarding reinsurance, stop-loss coverage, insolvency coverage, or any other type of coverage for potential costs of health services;

• copy of the conflict of interest policy which applies to all members of the board of directors and the principal officers of the HMO;

• copy of the statement that describes the HMO's prior authorization administrative procedures;

• copy of the agreement between the guaranteeing organization and the health maintenance organization;

• and other information as the state commissioner of health may reasonably require to be provided.

**Net worth and deposit requirements.** The regulation of insurance company solvency is a function of the state. State regulators monitor the financial health of companies licensed to do business in their state through analysis of the detailed annual financial statements that insurers are required to file. State insurance departments also conduct periodic on-site examinations.

Typically states require insurance plans to set aside funds to protect enrollees in the event of an insolvency. In Minnesota, for example, a new HMO must maintain net worth of at least of at least 8.33 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or $1.5 million whichever is greater. In Washington State, every health care service contractor¹⁴ and HMO must have and maintain a minimum net worth equal to the greater of: (a) $3 million; or (b) 2% of the annual revenues on the first $150 million of

¹⁴Health care service contractor means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services.
premium and 1% of premium in excess of $150 million; or (c) an amount equal to three months of uncovered expenditures. HMO net worth and deposit requirements for all 50 states are provided in Appendix C.

**Investment restrictions.** States generally restrict the types of investments that insurers may make with their reserves. In general, funds of health insurers may be invested only in securities and property designated by law for investment by life insurance companies, except under certain narrow conditions.

**Disclosure requirements.** States give health insurance enrollees the right to view evidence of their coverage or contract. Such contracts generally must contain a clear and complete statement of:

- the health care services to which the enrollee is entitled;

- any exclusions or limitations on the services to be provided, including any deductible or copayment feature and requirements for referrals, prior authorizations, and second opinions;

- where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

- the total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

- a description of the health insurer's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom grievances may be registered.

Some states require health insurers to provide a statement of enrollees' rights as consumers. In Minnesota, for example, HMOs must provide a statement, entitled "Important Consumer Information and Enrollee Bill of Rights," that includes the following provisions:

**CONSUMER INFORMATION**

(1) COVERED SERVICES: Services provided by (name of health maintenance organization) will be covered only if
services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

(2) PROVIDERS: Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of (name of health maintenance organization), you must choose among remaining (name of the health maintenance organization) providers.

(3) REFERRALS: Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non-(name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).

(4) EMERGENCY SERVICES: Emergency services from providers who are not affiliated with (name of health maintenance organization) will be covered only if proper procedures are followed. Your contract explains the procedures and benefits associated with emergency care from (name of health maintenance organization) and non-(name of health maintenance organization) providers.

(5) EXCLUSIONS: Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.

(6) CONTINUATION: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

(7) CANCELLATION: Your coverage may be canceled by you or (name of health maintenance organization) only under certain conditions. Your contract describes all reasons for cancellation of coverage.

ENROLLEE BILL OF RIGHTS

(1) Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week;
(2) Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

(3) Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

(4) Enrollees have the right to file a grievance with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers;

(5) Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force;

(6) Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law; and

(7) Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

**Individual and small group reform.** Compared to large employers, individuals and small groups often face higher premiums for similar insurance and these premiums may fluctuate dramatically from year-to-year for several reasons:

- Per capita administrative and marketing expenses are usually higher for individuals and small groups than they are for large groups;
- Claims risk is more volatile and uncertain with smaller groups and individuals. Consequently, medical underwriting has been used by health insurers to determine insurability and monthly premiums in the individual and small group markets;
- The preferred tax treatment accorded employer premium contributions means individuals purchasing insurance outside
the workplace pay higher after-tax premiums. The self-employed may deduct a portion of their premium, but not 100 percent.

Because of these problems, many states have reformed their under-65 individual and small group markets through regulation. In general, these regulations do not apply to Medicare and Medicare supplemental insurance policies, which are governed primarily at the federal level.

Nonetheless, individual and small group regulations are relevant to this discussion insofar as they may influence suppliers' decision to enter a state. If the cost of establishing a presence in a state is high, then carriers which are not already in that state may not want to begin selling Medicare MSAs there. In other words, the benefits of selling Medicare MSAs in a new state may be outweighed by the cost of hiring agents, opening new offices, establishing name recognition and obtaining approval from state regulatory authorities to sell insurance. Therefore, Medicare MSAs may be slow to catch on in states with the most heavily regulated under-65 individual and small group markets.

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15The most common reforms in under-65 individual and small group markets are: guaranteed issue (a law requiring carriers selling health insurance to offer at least one plan to all applicants regardless of health status or claims experience); community rating (in the most extreme version, requiring the insurer to charge the same premium for all the participants in a plan, regardless of differences in age, sex or health status); and limits on pre-existing condition exclusions (requiring carriers to limit pre-existing condition waiting periods to a specified number of months [usually 12] following the effective date of coverage).

16The experience of the under-65 MSA market suggests that that insurers tend to avoid states with both guaranteed issue and community rating in their individual and small group markets. Humana, for example, marketed MSAs in 15 states during the first half of 1997 but did not offer an MSA product in its home state, attributing its decision to "the complexities of reform in Kentucky" (Howlington 1997). The Chairman of Medical Savings Insurance, Patrick Rooney, cited Washington's regulatory environment as his reason for not selling MSAs in that state (Malkin 1997). Central States Health & Life Co. said it would not sell an MSA product in New York due to "regulations that make offering any type of indemnity-type plan prohibitive" (Temes 1997).

17States with the most heavily regulated insurance markets include (but are not limited to) New York, Washington, Kentucky, New Jersey, New Hampshire, Vermont, and Maine. All of these states have guaranteed issue and some form of community rating in both the individual and small group markets. An overview of individual and small group reforms in all 50 states is available in BlueCross BlueShield Association (1996).
6. TRANSFERRING FUNDS TO INSURERS AND FINANCIAL INSTITUTIONS18

BACKGROUND
To implement Medicare MSAs, HCFA will need to figure out a way to get funds to insurers and financial institutions. The law states that insurance premiums will be transferred each month, while the MSA funds will be deposited in a lump sum at the beginning of the year. We have identified five options:

1. HCFA transfers premiums to insurer; HCFA transfers MSA funds to financial institution. Under this system, HCFA would send checks (or transfer money electronically) to both the insurer and the financial institution for each MSA beneficiary.19 The advantage of this approach is that it cuts down on middle-men: Money would flow directly from HCFA to its final destination. The disadvantage is that it adds to HCFA’s administrative burden insofar as checks would have to be sent to two parties per beneficiary rather than just one.

2. HCFA transfers both premiums and MSA funds to insurer. Under this approach, the insurer would receive both premiums and the MSA deposit. It would keep the premiums, but forward the MSA deposit to the beneficiary’s financial institution. The problem with this approach is that many insurers have neither the capacity nor interest in taking on this administrative task. Banks and insurers with whom we spoke agreed that this is a bad idea.

3. HCFA transfers both premiums and MSA funds to financial institution. Under this approach, the bank or brokerage would receive both premiums and the MSA deposit. It would keep the MSA deposit, but would forward the insurance premiums each month to beneficiaries’ insurers. Financial institutions and insurers agreed that this is preferable to option #2. Banks do this sort of thing all the time. All they would need is the account number of the beneficiary’s insurance company and the amount to be transferred each month. In contrast to carriers, banks want to take on this

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19HCFA chose this option, i.e., it will pay into the MSA at the beginning of the calendar year and pay premiums once a month to the insurer.
administrative task, provided, of course, that they be paid a transaction fee for doing so.

4. HCFA transfers both premiums and MSA funds to "MSA administrator." Under this approach, an "MSA administrator" such as MSAver or American Value Health would receive both premiums and the MSA deposit. The "MSA administrator" would send the MSA deposit to the beneficiary's financial institution and would forward the insurance premiums each month to the beneficiary's insurer. Financial institutions such as banks and brokerages could apply to serve as MSA administrators if they wished. This option is similar to option #3, except that it opens up administration duties to a new category of firms, as opposed to restricting it to banks and brokerages.

5. HCFA sends all the Medicare MSA money to one financial institution in one lump sum at the beginning of each quarter. Under this option, which was suggested by an attorney for Fifth Third Street Bank in Cincinnati, a financial institution would be responsible for transferring funds to the MSA accounts and insurance companies. This is similar to option #1, except that a private financial institution rather than HCFA is responsible for transferring funds to the appropriate parties. The advantage of this approach is that it would shift administrative burdens from HCFA to the private sector. Rather than hundreds of thousands of transactions, HCFA would need to make only four transfers per year. The disadvantage is cost.

**Recommendation:** We are not qualified to evaluate which of these options is best. That depends largely on how much work HCFA wants to do in-house and how much it wants to farm out to the private sector. We do believe, however, that option #2 should be avoided. That is not just our opinion, but the view of the insurers, banks and MSA administrators with whom we spoke (Golden Rule, Time, Fifth Third Street, Merrill Lynch, BCBS Texas, and American Value Health).
7. OPTIONS FOR BUNDLING

BACKGROUND
Medical Savings Accounts have two components: the MSA account itself (a trust created for the purpose of paying medical expenses) and the high deductible health insurance plan. These two parts work in conjunction with one another, but they need not be sold in a unified package. In the under-65 MSA market, carriers and financial institutions have developed a variety of methods of packaging (or not packaging) the two products. At one extreme is Time Insurance Company, which offers both a MSA and a health insurance plan in a single seamless package. A consumer cannot purchase a Time MSA without also buying a Time MSA-qualifying health insurance plan. At the other extreme is Merrill Lynch, which offers an MSA account but leaves it up to consumers to find an MSA-qualified high deductible plan. Most carriers and financial institutions fall somewhere between these two poles. Golden Rule Insurance Co., for example, recommends that consumers set up their MSA account with Northern Trust Co., but allows consumers to choose another financial institution if they prefer.

It would appear that HCFA has three options with regard to bundling in the senior MSA market:

1. Require all products to be open (that is, unbundled). This approach, which one financial institution referred to as an "open architecture" system, would allow Medicare beneficiaries to choose any health insurance plan sold in their area and pair it with an MSA from any financial institution. Bundled offerings such as the one offered by Time Insurance Co. in the under-65 market would be prohibited. The open architecture system would give consumers flexibility in designing a package that meets their needs, but most insurers would object to not being allowed to offer a bundled plan. Time and Golden Rule, for example, said they would oppose such an approach.

2. Require all products to be bundled. Under this system, open architecture products would be prohibited. The Medicare beneficiary would choose from a list of insurer-bank combinations. This system would probably be easiest for HCFA since there would be relatively few insurer-bank combinations to send money to and collect data from. But there are

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significant costs. First, since there are probably going to be more financial institutions than insurers in the Medicare MSA market, some financial institutions -- particularly those without close ties to the health insurance industry -- will get locked out. Second, of the three options being considered, this one results in the least consumer choice. Third, those insurers that do not now have a close relationship with a financial institution, such as Blue Cross Blue Shield of Texas, may not enter the senior MSA market if it has to offer a bundled product. Fourth, locking out plans with open architecture may seem contrary to the intent and spirit of the law.

3. Allow products to be either open or bundled. This approach is what we have now in the under-65 system. Insurers and financial institutions are free to partner with each other if they want to do so, but open-architecture plans are not be prohibited. The advantage of this system is that it relies on the market, that is, consumers, carriers and financial institutions rather than the government to sort out desirable bundling arrangements. The system is admittedly complicated. Designing enrollment forms showing both bundled and unbundled options, for example, could be tricky.

We recommend the third option. This gives consumers, insurers and financial institutions an opportunity to choose/offer a bundled product without forcing them to do so. It is the only option that is acceptable to all three insurer—BlueCross BlueShield of Texas, Time Insurance and Golden Rule—with whom we spoke. Explaining bundled and unbundled options in simple language will be challenging, but this does not strike us as an insurmountable barrier.

21They will neither prohibit nor require bundling of the MSA and insurance plan.
8. INSURANCE ACCOUNTING AND "BALANCE BILLING"\textsuperscript{22}

OBJECTIVE
This memorandum examines the issues and options surrounding "balance billing" procedures for MSAs.

BACKGROUND
The Medicare+Choice legislation\textsuperscript{23} imposes requirements on providers' billing practices and insurers' procedures for resolving claims. To understand the legislation, it is useful to first define two dollar amounts associated with any service rendered.

Let $B$ denote the amount a provider would like to charge a beneficiary for services rendered. ($B$ denotes the "bill").

Let $M$ denote the "Medicare fee schedule" for participating providers (i.e., the amount covered by Medicare under Part A or Part B for that service). $M$ is the maximum that a Medicare-participating provider can charge. If the service is \textit{NOT} covered by Medicare Parts A or B, then we assume $M=0$.

Table 1 summarizes the rules governing MSA billing procedures. Two cases are considered: first, when the provider is charging more than the Medicare-covered rate ($B>M$), and second, when the provider charges less or the same as the covered rate. When the provider bills for more than the covered rate, the MSA rules vary depending on whether the service is also covered by Medicare. Scenario (1) in Table 1 corresponds to the situation where the services are covered by both the MSA health insurance plan and Medicare, but in scenario (2) the services are not covered by Medicare. These would be "Supplemental Benefits" covered by Sec. 1852(a)(3). Scenarios (1) and (2) are potential "balance-billing" situations, as we will discuss later. (Note: the BBA requires all MSA health insurance plans to cover Medicare Part A and Part B services, so there is no scenario governing the case in which services are covered by Medicare Parts A and B but not the MSA health insurance plan.)

\textsuperscript{22}Memo 12/15/98
\textsuperscript{23}Title IV, Subtitle A, of the Balanced Budget Act of 1997.
Scenario (3) is similar to the first scenario in that the services are covered by both the MSA health insurance plan and Medicare, but in this case the “bill” $B$ is less than the covered Medicare amount. Scenario (4) corresponds to the case where the expenses are covered by neither Medicare nor the MSA health insurance plan.

### Table 1.
**Summary of MSA Billing Rules**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Type of Benefit</th>
<th>Covered by MSA Health Plan?</th>
<th>Covered by Medicare?</th>
<th>Amount to Credit Towards Deductible</th>
<th>Amount Paid By Plan After Deductible Is Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. $B &gt; M &gt; 0$</td>
<td>Basic</td>
<td>Yes #</td>
<td>Yes</td>
<td>At least $M^@$</td>
<td>At least $.80M^*?</td>
</tr>
<tr>
<td>2. $B = M = 0$</td>
<td>Supplemental</td>
<td>Yes</td>
<td>No</td>
<td>At plan’s discretion</td>
<td>At plan’s discretion</td>
</tr>
<tr>
<td>3. $B &lt; M$</td>
<td>Basic</td>
<td>Yes #</td>
<td>Yes</td>
<td>At least $M^@$</td>
<td>At least $.80B^?</td>
</tr>
<tr>
<td>4. $B = M = 0$</td>
<td>Not Covered</td>
<td>No</td>
<td>No</td>
<td>$0$</td>
<td>$0$</td>
</tr>
</tbody>
</table>

*#Insurers are required to cover all services covered by Medicare as per Sections 1852(a)(1) and 1859(b)(3)(A)(ii).  
1859(b)(3)(A)(ii)  
1859(b)(3)(A)(iii)  
1859(b)(3)(A)(iv)  
\?This assumes (a) that cost-sharing above the deductible is allowed and (b) that the coinsurance rate can be no higher than 20 percent. If coinsurance is not allowed then top box should be “at least $M$” and “$B$,” respectively.

As Table 1 indicates, if the provider bills more than the Medicare rate, then the MSA health insurance plan is only required to credit the beneficiary at Medicare rates. The MSA health insurance plan is also only required to pay at least $M$ if the beneficiary has exceeded the deductible. This raises the issue of whether the provider can charge the beneficiary for the balance.\(^{24}\)

Providers who participate in the Medicare program must agree to accept $M$ as full payment for services they provide to Medicare beneficiaries. No charges to the patient beyond the deductible and a copayment are permitted. In the discussion of options that follows, we assume that participating providers can bill no more than $M$ to patients with Medicare MSAs.

\(^{24}\)The phrase “balance billing” makes the most sense once the beneficiary has exceeded the deductible, since only then will the insurer be reimbursing the provider for services. For services that fall under the deductible, we are really talking about whether providers can collect more than the standard Medicare rate from the beneficiary.
Non-participating providers can bill Medicare patients for no more than 15% above \( M \) without suffering penalties or exclusion from the Medicare program. It is unclear what balanced billing rules will apply when this group of providers treats MSA patients.

The BBA contains a provision allowing seniors to bypass balanced billing limits and pay higher fees out of their own pockets (Section 4507(b)(1)). However, the BBA also contains a deterrent to doctors: Those who accept such payments from seniors must sign a affidavit not to take any Medicare patients for two years (Section 4507(b)(C)(3)). Doctors who violate the ban face a $2,000 fine and possible expulsion from the Medicare program.\(^{25}\) HCFA will have to decide whether physicians who opt out of the Medicare program altogether can treat patients with Medicare MSAs, and, if so, how much they can charge. That issue is not addressed in this options paper.

**OPTIONS FOR BALANCE-BILLING**

HCFA has many choices as to how it might regulate providers' billing practices. Three of these options strike us as choices that merit serious discussion. We summarize these options in Table 2, and discuss some of the advantages and disadvantages of each in the text that follows. Note that these rules only apply to those situations where the services are covered under traditional Medicare (i.e., Scenario (1) above).

\(^{25}\)Senator Jon Kyl's "Medicare Beneficiary Freedom to Contract Act" would eliminate the two-year ban and allow doctors to charge seniors more than Medicare pays, if the patient agrees. Under Kyl's proposal, the patient would pay the entire bill, and the doctor would not submit a claim to Medicare.
Table 2

<table>
<thead>
<tr>
<th>Maximum Billable Amount by Type of Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare-Participating Provider</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Option 1</td>
</tr>
<tr>
<td>Option 2</td>
</tr>
<tr>
<td>Option 3</td>
</tr>
</tbody>
</table>

*Nonparticipating providers are providers who agree not to bill more than 115% of M. They are distinct from noncompliant providers, i.e., providers who disregard Medicare’s limits on balanced billing and opt out of the Medicare program altogether. Noncompliant providers are not discussed here.*

**Option 1: Providers Cannot Exceed Their Medicare Rate**

Under this option, all providers would be subject to the same balance-billing restrictions when treating Medicare MSA patients that apply to them now.

*Advantages:* Consistent with intent of balance billing rules. Does not require the provider to distinguish between an MSA beneficiary and a FFS beneficiary. May not require new regulations from HCFA.

*Disadvantages:* Undermines the rationale for the MSA, which is to let consumers take control of their health-care purchasing decisions without interference from government price controls. It is questionable whether HCFA can legally limit the charges to the beneficiary. BBA section 1854(a)(5)(B) states that "the Secretary shall not review, approve, or disapprove the amounts submitted under MSA plans."

**Option 2: Nonparticipating Providers Can Negotiate Whatever Rate They Want**

This option would give nonparticipating providers complete freedom to negotiate rates with MSA beneficiaries. If HCFA chooses this option, new regulations would have to be issued clarifying that a transaction between an MSA beneficiary and a Medicare provider would not preclude future participation in the Medicare program. Because such transactions are restricted with a traditional FFS beneficiary, there needs to be some way for providers to make sure that the beneficiary is really in an MSA. For

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26HCFA chose this option, i.e., it did not provide for any limits on balance billing under Medicare MSAs. Unless explicitly included in the terms of the Medicare+Choice MSA plan, any amount billed in excess of 100 percent of the Medicare allowed limit would be the responsibility of the enrollee (Health Care Financing Administration 1998, 35035).
example, HCFA might require the beneficiary's financial institution to issue a Medicare MSA debit card with an "expiration date" (alternatively, the insurer would issue an insurance card). The beneficiary would have to show the card even if he or she was not going to pay from the MSA.

Advantages: Beneficiary has maximum flexibility to access to providers and negotiate contracts. Seems consistent with BBA section 1854(a)(5) (B), which states that "the Secretary shall not review, approve, or disapprove the amounts submitted under MSA plans."

Disadvantages: Appears to be a clear violation of balance billing rules. Standard arguments against balance billing would be raised, e.g., possibility of price-gouging, development of "two-tier" system of Medicare. Turns MSAs into a vehicle for wealthy seniors to bypass Medicare rules limiting private contracting.

Option 3: Mixed Rule Which Depends on Whether Patient Is Below Deductible.

Under this option, HCFA might say that nonparticipating providers cannot exceed their Medicare rate when the patient is above his deductible, but nonparticipating providers can negotiate whatever rate they want when the patient is paying privately or out of his MSA for the transaction.

Effectively, this means *nonparticipating* providers would be able to charge whatever they want as long as the transaction falls completely below the deductible.

Advantages: Allows patient flexibility to negotiate with nonparticipating providers when he or she is using MSA money but keeps balanced billing safeguards in place once insurance starts paying the bills. Provides some of the benefits of Option 2 without completely undermining balanced billing safeguards.

Disadvantages: Requires nonparticipating provider to base decision about how much to bill (and whether to treat at all) on where patient is in relation to his or her deductible. This seems highly impractical. There is a danger that a mixed rule would be perceived as absurd.
9. RISK ADJUSTMENT ISSUES

OBJECTIVE
The purpose of this memo is to discuss options related to risk adjustment for MSAs and options related to obtaining data for risk adjustment and for the evaluation of selection into MSAs.

RISK ADJUSTMENT OPTIONS
Section 1853(a)(3)(D) mandates that the same risk adjustment methodology be used for all Medicare+Choice plans, except for religious fraternal benefit society plans. A plausible inference would be that the same capitation rate would be paid for the same individual to any plan (except the benefit society plan) that he or she joined—including an MSA plan.

There are good reasons to want to risk adjust HCFA’s payment for those who elect MSAs in addition to the mandate. First, those who choose MSAs will most likely be younger and healthier, and therefore spend less on health care, than the average Medicare beneficiary. Beneficiaries who are at high risk for substantial expenditures will be better off purchasing a Medigap policy. Thus risk adjustment will reduce the amount that the trust funds pay for the care of these beneficiaries. Although most retirees with employer paid Medigap policies, who also tend to be healthier than average, would be foolish to choose an MSA, this is unlikely to reverse the expected balance of selection into MSAs in the favorable direction.

A second important reason for risk adjusting the MSA capitation rate concerns allowing all beneficiaries, including older and frailer beneficiaries, to join MSAs and therefore to benefit financially from eliminating care of low value (i.e. care whose value to the beneficiary is less than its costs.) In the absence of risk adjustment, these beneficiaries would receive a substantially lower reward from joining an MSA plan because they have higher expected costs and risk adjustment can equalize the playing field. We found scant evidence that the decrease in utilization from cost sharing has a disproportionate effect on the health of sicker enrollees than of healthy enrollees in the HIE, although the importance of this finding may be discounted because the elderly were not included in the HIE. Because sicker enrollees use more care, they likely use more care of low value and thus the

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efficiency gain from enrolling such persons in MSAs is likely higher than that for healthy enrollees.

An important decision concerns the amount that is to be risk adjusted—the MSA plan premium, the deposit in the MSA account, or both. The law does not directly address this issue, but might, depending on one's interpretation of the law, seriously constrain choices.

From the point of view of matching payments for an individual to expected costs, and from the point of view of the trust funds, the best risk adjustment would be of the total amount—so that the total payment made for a person enrolling in the MSA would equal that which would be paid for the same individual to join a coordinated care plan. The best division of these funds, from the point of view of fairness to the MSA insurer and beneficiary, would be based on an actuarial examination of expenditures above and below the deductible for each beneficiary risk category. It is likely that a simple arithmetic rule for splitting the risk adjusted payments in a way, which is actuarial fair, could be devised. A sensitivity analysis could consider expenditures for non-Medicare covered medical expenses that are covered by the insurance plan.

Such a payment might not be allowed, however, depending on one's interpretation of the BBA. One problem is whether the mandate to use the same risk adjustment methodology applies to the entire MSA payment (i.e. the catastrophic insurance plan and the savings account) or to the catastrophic plan considered alone. Another major problem is that the Medicare +Choice monthly MSA premium is to be submitted by the plan (Section 1854(a)(3)(A)) and is not even subject to review by the Secretary (Sec 1854(a)(5)(B)). This is the premium paid by HCFA to the insurance plan to cover services covered by Parts A and B. These problems are summarized in the comments on Option 1 in the attached Table 1.

How can the Secretary apply a risk adjustment methodology to a premium that she can't review? If the Secretary determined that the mandate to use the same risk adjustment methodology for all plans applied only to the entire MSA payment, then she could allow the MSA insurers to choose their own premium. The provisions that demand equal treatment of all beneficiaries in the same geographic area might not apply to the MSA premium, which is paid by HCFA, and thus the plans might even risk adjust the MSA monthly premium. In order to avoid discrimination, the regulations

Additional optional services may be covered by the plans' monthly supplemental beneficiary premium, if any (Sec 1854(b)(1)(B)).
for this option 2 should forbid variation in each plan's MSA monthly premium among persons in the same payment area in the same risk group identified by the Secretary, but allow the MSA plan to decide how to set premiums for each risk group.

Option 2 maximizes the free market aspects of the MSA and minimizes regulatory interference with the insurer. However, the residual deposit into the MSA account might not always be equitable to beneficiaries in the sense that it may not be proportional to expected costs below the deductible. This option could allow plans to set their premiums in a way that would make MSAs unattractive to some risk groups. Since MSAs would likely be unattractive to the more expensive risk groups anyway, this might not have a large effect, but might still be viewed as an appearance problem.

Another possible way to reconcile the mandate for similar risk adjustment of all plans with the freedom of the insurer to set the premium is for the Secretary to insist that the insurers submit a monthly MSA premium for a "typical Medicare beneficiary" (or a beneficiary in a particular class—say 65 to 69, male with Medicare as primary payer, not institutionalized, without specific chronic diseases) and then have the Secretary apply individual risk factor weights to this premium amount in calculating payment to the MSA plan.

The risk factor weights applied to the monthly MSA premium might be the same ones used for coordinated care plans, option 3. If so, the fit of payments to costs would not be optimum, but might be quite good. A few simulations should enable one to find out how good. Alternatively, in option 4, the risk factor weights would be specially calculated for the high deductible plans to obtain actuarially fair weights, if this were deemed allowed by the law.

If the monthly MSA premium is risk adjusted as in either option 3 or option 4, the payment to the beneficiary's MSA could be automatically risk adjusted. The difference between the Medicare capitation rate and the Medicare +Choice monthly MSA premium is deposited into the MSA (section 1853(e)). If the Medicare capitation rate is risk adjusted (i.e. equal to the amount that would be given to a coordinated care plan for the same beneficiary) and the risk adjusted MSA premium subtracted, then the MSA deposit is automatically risk adjusted. However, the language of section 1853(e) refers to the capitation rate "for the area and year involved" without
mention of individual risk factors and thus might be construed as requiring that the deposits not be adjusted for individual risk factors.  

Table 7  
Options for Risk Adjusting  

<table>
<thead>
<tr>
<th>Option</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Apply risk adjustment to total capitation payment, divide between premium and MSA so as to be actuarially fair</td>
<td>Technically best match of costs to payments and therefore most equitable method. Monthly MSA premium calculated rather than supplied by plan and thus probably not legal. Does not apply same risk adjustment methodology to insurance part of MSA as to HMOs. Complex calculations may be needed.</td>
</tr>
<tr>
<td>2. Apply risk adjustment only to the total capitation payment. Allow plans to assign and risk adjust premiums. Calculate MSA deposit from residual.</td>
<td>Maximizes freedom of MSA insurer to set premiums. Interprets mandate to apply same risk adjustment methodology to refer only to risk groups, not factors, for MSA insurer. May be inequitable to some beneficiaries. Allows gaming of premiums, but effect of such gaming may be small.</td>
</tr>
<tr>
<td>3. Apply risk adjustment weights to total capitation payment and to monthly MSA premium specified by plan for specific beneficiary risk category. Calculate MSA deposit from residual.</td>
<td>Probably good match of costs to payments. Constrains MSA plan to accept HCFA risk adjustment method rather than freely setting premiums.</td>
</tr>
<tr>
<td>4. Apply risk adjustment to total capitation payment and actuarially fair risk adjustment weights to monthly MSA premium for specified beneficiary risk category. Calculate MSA deposit from residual.</td>
<td>Same best match of costs to payments as option 1. Constrains MSA plan to accept HCFA risk adjustment method rather than freely setting premiums. Does not apply same risk adjustment methodology to insurance part of MSA as to HMOs.</td>
</tr>
<tr>
<td>5. Risk adjust only the monthly MSA premium, not the MSA deposit.</td>
<td>Easier to explain. Not actuarially fair to older, sicker beneficiaries. Lower efficiency for MSA program.</td>
</tr>
</tbody>
</table>

Some people might argue that the payment into the MSA account should be the same for all beneficiaries. This last option is somewhat in

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29The provisions that demand equal treatment of all beneficiaries in the same area do not appear to apply to this deposit. In MSAs they appear to apply only to the premium for the plans' optional supplemental benefits.

30Ultimately, risk adjustment option 5 was chosen. Plans were asked to bid by stating the amount (the same for everyone in a geographic area) they would put in the beneficiaries MSA account. In effect, the premium for each person was the contribution minus this amount.
keeping with the mandates that other premiums be equal for all beneficiaries in the same geographic area. Uniform premiums would make it easier to explain the beneficiary's choices, although we believe that the concept of extra medical expenses for those who are older or have chronic diseases would be easily grasped by most Medicare beneficiaries. A uniform account payment would not be actuarially fair to older or sicker beneficiaries who would have an even greater reason not to join (or remain in) an MSA. Consequently the social gain in efficiency of the MSA program will be smaller than if the MSA deposit was risk adjusted.

**DATA**

**Background**

Data are needed for two purposes related to risk adjustment—first to calibrate the payment rates and, second, to calculate payment—i.e. assign a risk factor weight to each individual.

The secretary must provide a proposal for risk adjustment that accounts for health status by March 1, 1999 and implement beginning Jan. 1, 2000. We expect that, at least eventually, the risk adjustment system will be similar to the DCG-HCC system and require knowledge of all covered transactions in order to calibrate the system and require knowledge of all diagnoses for which a person sought professional or hospital services in order to calculate payment rates. However, HCFA might decide to use a risk adjustment system based solely on diagnoses found on hospital records for some interim period. In this case, full transaction records for a representative population would be needed for calibration, but only hospital records would be needed to assign a payment amount.

An additional need for data related to the cost of health care arises because MSAs are authorized as part of a demonstration. The Secretary must evaluate the impact of MSAs on:

- selection (including adverse selection),
- use of preventive care,
- access to care, and
- financial status of the trust funds.

The evaluation must be sufficient so that the Secretary can provide a recommendation by March 1, 2002 on whether MSAs should continue.
Data Option 1

The first option would require only that the MSA insurer mail HCFA copies of all transactions that it either counted toward the deductible or paid for Part A or Part B services. In many MSAs for the under 65, the beneficiary pays bills out of the savings account or pocket and then saves the bills and mails them to the insurer only when convenient or desirable such as when the deductible might be exceeded. If such a policy were allowed by HCFA, it would produce one of the benefits claimed for MSAs, viz., savings on administrative expenses. Because bills less than the deductible need not be processed by the insurance company and because such bills are much more frequent under the high deductibles associated with the MSA plan, the administrative savings might be substantial.

The MSA insurer would then forward the bills that it received from the beneficiary to HCFA. In some cases the insurer would receive bills directly from providers which it would also forward to HCFA. HCFA needs these bills so it can calculate the health status adjusted payment amount for the following year for the MSA beneficiary. However, because the bills might not be complete, the risk adjustment payment might be too low.31,32

According to the BBA, all +Choice plans must submit data on all services delivered during periods starting July 1, 1998 and therefore MSA plans must submit such data throughout their operational period. But there is still the question of the penalty, if any, to be assessed for incomplete data. HCFA might allow the self-interest of MSA plans and their beneficiaries to enforce this BBA requirement. It is in their interest to forward any bills that might affect payment. Given the complexity of a risk adjustment system such as the DCG-HCC system, the easiest rule might be to forward all bills since any bill might provide a new diagnosis that might increase payment.

Although this option might be sufficient for an operational MSA plan, it is unlikely that it would be sufficient to meet the evaluation requirement for the MSA demonstration. In order to reach an accurate judgment on the amount of selection into MSAs, the use of preventive care, access, and the effect of MSAs on the trust fund, additional data would be needed. However, such data could be collected solely for a sample of MSA enrollees. It could be collected through interviews with the beneficiary, perhaps with a sample of

31No reasonable risk adjustment system would pay more because a patient did not receive a service.
32If the risk adjustment health status information comes only from hospital data this will be less of a concern because most beneficiaries who are hospitalized will exceed the deductible.
the survey data confirmed from provider records. In addition to the cost of the care and the use of preventive services, data analyses would show the fraction of expenses not received by HCFA that were for conditions that affect the payment rate and that were not detected in the expenses that were received by HCFA.

This separation of collection of data needed for evaluation from that needed for the operational MSA program minimizes the data requirement of the operational program. This will allow a subsequent MSA program, if any, to achieve maximum efficiency and will allow the evaluation to estimate more accurately the effect of MSAs on administrative costs.

During the first demonstration years, it would be wise not to use data on MSA enrollees in calibrating the risk adjustment payment rates because of the possibility that costs are seriously underestimated. Because of the limit on the number of MSA enrollees this is unlikely to affect rates measurably. The results of the demonstration evaluation would be used to determine if these data should be included in the last demonstration year(s) and in an operational program, if any.

Data Option 2
A second option would be to mandate that the insurer receive transaction data on all services received by its Medicare enrollees and forward it to HCFA, with penalties for non-compliance. A network MSA would presumably find this a not unreasonable burden, and perhaps would have its own uses for the data. Other insurers might find this to be a very distasteful proposition, since it might be expensive and would require substantial cooperation from its enrollees.

A sub option here would allow the insurers to offer payments to beneficiaries for sending in their below the deductible claims, as was done in the HIE. This might obviate the problem of the insurer requiring cooperation from the beneficiary, but would only aggravate the expense involved because the insurer would have to pay beneficiaries who might otherwise file the claims for free.

Data Option 3
HCFA might require that all providers and suppliers who provide services to MSA enrollees mail HCFA (or its intermediary) a bill just as if the patient were enrolled in the regular Medicare FFS plan. Because these bills would not be audited financially by HCFA, this might be somewhat cheaper
than the administrative expense associated with the FFS program. However, because they are not audited, one might also expect less accuracy in the description of diagnoses and procedures.

This option would probably incur less resistance than option 2 because it involves using procedures that are now standard for most providers and suppliers. In this option, one would need to make some provision for providers and other suppliers who do not now submit bills Medicare. On balance, in most areas of the country the data would be more complete than in option 1, although accuracy must be a concern.

As a sub-option of this option, HCFA could forward the bill to the catastrophic insurer so that the provider need only send one copy of the bill. However, it is not at all clear that this would be cheaper than having the provider send 2 copies.

Other data options
We considered and rejected options that involved the MSA custodian forwarding transaction information to HCFA when funds are expended from the savings account. Most, perhaps all, MSA custodians are financial organizations who do not currently collect information about diagnoses and procedures and whose computer systems would find it difficult to accommodate such information. Further, many expenditures below the deductible will occur after the MSA has been exhausted and so this is not a source of complete data in any case.

We also considered making the beneficiary responsible for mailing all bills to HCFA, but this seems like a non-starter.

\(^{33}\)Although MSA holders could restrict payment to classes of organizations that provide medical services, most allow the beneficiary to completely control expenditures and allow cash withdrawals which presumably cover expenses that the beneficiary paid through other means.
10. DEDUCTIBLE FOR MID-YEAR ENROLLEES

How should HCFA handle deductibles for people who sign up for Medicare+Choice MSAs upon turning 65 mid-year?

BACKGROUND

We begin by reviewing current Medicare rules:

The Medicare Part A deductible is $764 per benefit period. If someone is hospitalized and then 60 or more days after being discharged re-enters the hospital, a new benefit period applies, and he or she will have to pay the $764 deductible again.

The Medicare Part B deductible is $100 per year. If someone turns 65 on December 1, 1997, and spends a few hundred dollars on Part B items, the deductible re-starts at $100 on January 1, 1998.

Medicare+Choice MSAs will operate like Medicare Part B after the first partial year. That is, it will have a deductible that operates on a calendar-year basis. However, rules governing the first partial year deserve closer attention since the deductible is in effect for less than 12 months.

The extent to which a deductible imposes risk on a beneficiary increases as the length of time during which the deductible is in effect declines. For example, a plan that has a $6,000 deductible for an entire year is effectively less stingy than a plan that has a $6,000 deductible for one month. (If a person has two large episodes separated by 2 months they only have to pay $6000 with an annual deductible).

Under traditional Medicare, the part B deductible is small, so it is not much of a problem to have a partial year with the same deductible. Under Medicare+Choice MSAs, by contrast, the deductible will typically be large, and in a partial year the risk to the beneficiary may be substantially higher than for a full year plan.

Increasing the cost-sharing burden on beneficiaries is not entirely bad. The whole point of MSAs, after all, is to increase the degree to which consumers pay for their medical care out of pocket. On the other hand, the

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fact that the BBA caps the MSA deductible at $6,000 seems to reflect a sense among legislators that consumers should not be exposed to too much risk.

If nothing is done to reduce the risk to mid-year enrollees, people turning 65 will probably avoid Medicare+Choice MSAs late in their first partial year. For example, if someone turns 65 on October 1, they will probably prefer traditional Medicare to a Medicare+Choice MSA that has a large deductible for the remaining three months of the year.

One way to reduce the cost-sharing burden for mid-year enrollees during the first partial year is to "pro-rate" the deductible. That means that the deductible would be reduced in proportion to the amount of the calendar year remaining. For example, if the plan's deductible is $X per calendar year, then someone who enrolls on July 1 would be assigned a deductible of $0.5X. Someone who enrolls on October 1 would be assigned a deductible of $0.25X.

Few if any carriers pro-rate their deductibles for mid-year enrollees, according to several sources familiar with the health insurance industry. However, most health insurance plans have deductibles that are much lower than those being contemplated for Medicare+Choice MSAs do. It is possible that carriers would consider pro-rating the deductible for plans with higher deductibles.

Another way to reduce risk to mid-year enrollees is to implement a "carry-over" procedure. Under such a procedure, bills incurred during the last three months of one year would be carried over to the following year and applied to the next year's deductible. Many insurers use a carry-over procedure for all of their enrollees: both those who enroll mid-year and those who are enrolled for the entire year.

OPTIONS
We identified two regulatory options with regard to this issue:

**Option #1:** Require all plans to pro-rate the deductible for mid-year enrollees or implement a carry-over procedure.

*Pro:* Reduces cost-sharing burden on beneficiaries during the first partial year. Makes MSAs more competitive with other insurance choices.
Con: Carriers handle deductibles for mid-year enrollees in a variety of different ways. Forcing all carriers to implement a single approach may be seen as heavy-handed. Also, the cost to insurers of implementing whatever system is mandated may exceed the benefit to beneficiaries in terms of reduced risk. Finally, since the BBA does not address the matter, this may be viewed as being contrary to legislative intent.

Option #2: Let insurers decide how to handle partial year enrollees.  

Pro: Allows decision to be made on a decentralized basis, based on carriers' perception of the cost of implementation and the benefits to them in terms of attracting prospective enrollees. Insurers may decide to pro-rate the deductible to entice applicants to choose their MSA plan, but because the contribution is also pro-rated, partial year MSA enrollments do not cost the government extra.

Con: If insurers choose to neither pro-rate the deductible nor adopt a carry-over procedure, the risk to mid-year enrollees during the first partial year will be high. Consequently, individuals will probably be disinclined to choose MSAs during their first partial year. This might be one more thing to have to increase the information overload on beneficiaries. In general, universal rules only have to be explained once—rules that are at the insurers discretion have to be explained for each plan.

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35 HCFA chose this option (Health Care Financing Administration 1998, 35035).
11. 390,000-ENROLLEE CAP\textsuperscript{36}

According to Section 1851(b)(4) of the BBA, an individual is not eligible to enroll in a Medicare+Choice MSA "as of any date if the number of such individuals so enrolled as of such date has reached 390,000."

Based on lackluster demand for MSAs in the under-65 market, we believe the chances that the cap will be exceeded in November are slim. Nevertheless, the possibility that the number of applications will exceed 390,000 exists. The purpose of this memo is to summarize the rules relating to the enrollment cap in the under-65 market and outline some options for dealing with overenrollment if it occurs.

\textbf{Rules used in under-65 market}

Congress set a cap of 750,000 MSA policies (not including individuals who were previously uninsured; such individuals did not count toward the cap). Because enrollment was neither reported nor counted immediately, there was no simple way to determine when 750,000 policies were sold. So Congress set up an elaborate system of "dates and gates." The first date was June 30, 1997. That's when MSA trustees reported to the Internal Revenue Service how many policies they had established up until April 30, 1997.

If 375,000 or more policies (not including MSAs established for previously uninsured individuals) had been sold nationwide at that point, the IRS would have set a cut-off date of Sept. 1 for the sale of MSA policies to small businesses and Oct. 1 for sales to individuals. Of course, it was possible that 3 million policies would be sold by September, in which case all 3 million would have been valid policies. So the cap in the under-65 market was not really binding. Some observers have suggested that the cap in the Medicare market is intended to be firmer than the cap in the under-65 was.

\textbf{OPTIONS FOR MEDICARE+CHOICE MSAS}

You informed us that HCFA will be able to count Medicare+Choice MSA applications as they come in. That means that a system of dates and gates is unnecessary. After November, 1998 (or any open enrollment period), if enrollment rises above 390,000, HCFA should simply implement a waiting list. Still, there is a chance that enrollment will exceed 390,000 during an

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open enrollment. How should HCFA deal with this? RAND has identified four options:

**Option #1: Open door policy.**

*Description:* Permit everyone who wants an MSA to sign up for one in November regardless of the number of applicants.

*Pro:* Administratively simple. Everyone who wants a Medicare MSA gets one. Given the lackluster demand for MSAs in the under-65 MSA market, it seems unlikely that the cap will be exceeded. There is a precedent for this type of approach in regulations governing the under-65 MSA market, which left open the possibility that the 750,000-person cap could be exceeded.

*Con:* Risk of violating legislation, which—after considerable negotiation between supporters and opponents of MSAs—placed a cap on the number of MSA enrollees at 390,000. If the cap is exceeded by a large amount, policymakers who oppose MSAs will be furious; they may even take legal or legislative steps to ensure that the cap is implemented rigidly.

**Option #2: First come, first served.**

*Description:* Allow the first 390,000 applicants to enroll. Deny entrance to everyone who applies (or possibly whose application has been mailed) after the cap has been reached.

*Pro:* Relatively simple. Ensures that cap won't be exceeded. Fair. Allows people who really want an MSA to improve their chances by sending in their application early.

*Con:* If the cap is exceeded, MSA applicants who apply late will be turned away. They will either have to designate a second choice or go through the Medicare application process a second time. MSA applicants may rush their decision in order to improve their chances.

*Caveat:* If this approach is used, it is important to ensure that beneficiaries receive their applications at roughly the same time. It may make sense to send applications from HCFA's regional offices rather than Washington, D.C. Entry should be granted on the basis of a postmark rather than arrival of the application to prevent an advantage to those who use express mail.

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37 HCFA chose this option (Health Care Financing Administration 1998, 35034).
Option #3: Randomization.

Description: Wait until the end of the month. If the number of applicants exceeds 390,000, then randomly pick 390,000 and deny entrance to the rest.

Pro: Relatively simple. Ensures that cap won't be exceeded. May improve evaluation by laying the groundwork for a randomized controlled experiment.

Con: Applicants have no way to increase their chances of getting in. Applicants who don't get in an MSA will either have to designate a second choice or go through the Medicare application process a second time. May be perceived as unfair, e.g., "I filled in my form just like my neighbor; but he got in and I didn't."

Option #4: Mixed strategy.

Description: Permit everyone who wants an MSA to sign up for one during the first two weeks of November then limit enrollment thereafter (through first-come-first-served or randomization) if enrollment after 2 weeks exceeds 195,000 (half of 390,000).

Pro: Less risky than option #1 since it reduces the probability that the cap will be exceeded.

Con: Riskier than options #2 and #3 since it leaves open the possibility that the cap will be exceeded. Administratively complex and may be difficult for applicants to understand.

Regardless of which option is selected, HCFA should notify prospective applicants of enrollment rules on or before November 1, 1998.
12. IRS CONFLICTS AND ISSUES

Withdrawals from a Medicare+Choice MSA are taxable under certain circumstances. While tax treatment and enforcement issues will largely be resolved by IRS, HCFA should familiarize itself with—and be prepared to help untangle—the regulatory framework under which Medicare+Choice MSAs will operate. IRS enforcement will pose at least two dilemmas:

1. **Conflicting definitions of "medical expense."**

   According to a HCFA memorandum dated January 6, 1998, "IRC, Section 213(d), defines which medical items are 'qualified medical expenses,' and the IRS uses the same definition to assess the tax deferral status of MSA expenditures."

   There may be a conflict between the IRS definition of "qualified medical expense" and the BBA's definition. The former includes medical expenditures made on behalf of dependents (e.g., a son, daughter, brother, sister, father, mother, niece, nephew, uncle or aunt). The BBA, by contrast, states specifically that "qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder."

   To avoid confusion, HCFA may want to alert the IRS to this discrepancy.  

2. **Documenting enrollees.**

   IRS will want to know who is enrolled in a Medicare+Choice MSA. Relying exclusively on self-reporting by individuals (e.g., on their 1040 forms) may work in the under-65 MSA market but is problematic in the senior market due to a difference in incentives: Declaring an MSA reduces taxes for people who are under 65 but potentially increases them for seniors. In lieu of self-reporting, here are three ways the IRS might be able to determine who is enrolled in a Medicare+Choice MSA:

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38 Memo 2/6/98  
39 HCFA calls attention to this discrepancy in the Federal Register (Health Care Financing Administration 1998, 35038).
(1) HCFA could inform the IRS who has signed up for Medicare+Choice MSAs and the amount contributed to each beneficiary's account;
(2) IRS may require the beneficiary's financial institution to send a form to the IRS alerting the IRS of the MSA's existence. Such a system already exists in the under-65 market.\textsuperscript{40}
(3) The Department of the Treasury, which will be printing and sending checks to beneficiaries, might provide the IRS with information about Medicare+Choice MSA enrollees directly.

\textsuperscript{40}HCFA chose this option. IRS knows who is enrolled in a Medicare MSA from the 1099 forms submitted by the trustee financial institution.
13. WHAT PROSPECTIVE BUYERS MIGHT WANT TO KNOW\textsuperscript{41}

BACKGROUND:

For MSAs, as for other Medicare + Choice plans, Section 1851 d of the BBA says the Secretary will provide for activities to disseminate information to beneficiaries to promote informed choice. It also prescribes particular items that are supposed to be “available”. For example, 1851 d 2 A ii requires a list of plans that are available to residents of an area, with information presented in comparative form, and 1851 d 2 A iii adds any other information the Secretary determines will help the beneficiary make a choice. While many of the specific required data items are specified in 1851 d 4, there are options relating to both who is responsible for collecting the information, and to what parts are mailed to everyone, and what is only available to those who ask. As always in presenting information, there is a tension between giving people what they need to know, and overwhelming them with details.

People should be able to get signed up without having to go through too many hoops. Those who request more information might be sent a package including data from 2, 3, 4, 5. The probably small number of insurers offering Medicare MSAs in an area should make this feasible. You can put the packet together in modules—with 2 going nationwide, and 3, 4 and 5 customized to area. Although lists of financial institutions will be unwieldy for individuals, they should be able to hook up with one, using either insurers, yellow pages, ads, or their current banks.

This memo has three parts: a list of the various domains of information with options for making them available, proposed items for each domain, and examples of such items. To determine these items, we read the bill and the report language, and thought about what we would like to know before purchasing an MSA plan.

LIST OF DIFFERENT TYPES OF INFORMATION NEEDED TO MAKE A DECISION ON MSAS:

1. Introduction to the concept\textsuperscript{42}

\textsuperscript{41}Memo 2/23/98
2. Details of relevant Medicare rules
3. The HMO contribution amount or MSA deposit for each plan
4. The list of insurance plans in their area and contact numbers
5. Brief comparative information on plans
6. Required details to be made available by plans
7. Financial institutions offering to handle MSA accounts and contact numbers
8. Required information to be made available by them

OPTIONS FOR DISSEMINATING THE INFORMATION

1. A short introduction would include a general description of how MSA works, i.e. the catastrophic insurance plan, and the account deposit\(^\text{43}\) and general Pros and Cons. Should also include phone number, URL and probably a post card to mail in for those interested.

This is planned to be mailed out to everyone, which is a good idea. It is in conformance with the report language. If it is mailed out earlier than the 15 days prior to enrollment specified in the law, people will have more time to gather the information needed to make a decision.

2. Details of relevant Medicare rules applying to all MSAs:
   - What sorts of supplemental coverage are legal? Prices for services are not controlled by Medicare: Negotiations are up to you and your insurer (if it has a network).
   - Are some doctors not covered (those who opted out of Medicare?)
   - Who is not eligible (DOD, VA etc. rules)?
   - Minimum enrollment for a company and area?

\(^{42}\)The MSA brochure will be a general description of how Medicare MSAs work, and their pros and cons. On the Medicare Website, and the 800 information number, beneficiaries will be able to get phone numbers of potential insurance plans and of trustees, but no descriptive information about their offers or past performance in this startup year.

\(^{43}\)To what extent should this language reflect the report language on giving people more control over spending, and the assumption that money will be there to be deposited. These imply a large deductible. Should the description say a MSA is a combination of a large deductible plan with an account in which the difference between the premium and the amount the government would pay an HMO to take care of a beneficiary for the year is deposited.
• Special rules on enrollment and disenrollment for MSAs
  390,000 limit and how it will be implemented, ends in 2003;
  Restrictions on disenrollment: only annual changes permitted;
  Special mid-year enrollment rules? (maybe just a sentence on
  what should ask insurers)

• What can I spend MSA money on without tax penalty? (IRS rules)

• Tax treatment of MSA contributions by Feds and my state?

Options:
Make up longer general brochure and

A. Mail it out to everyone.
   This option seems wasteful, and does not appear to be required
   by law, so the lower cost alternatives B and C are preferable.

B. Mail it to everyone asking for information or signing up for
   MSAs.

C. Put on Web site, or toll-free phone bank with FAQs.
   A Web site is a good idea no matter what. It is inexpensive, can
   contain massive amounts of information, and is specifically
   called for in the BBA. Even if the beneficiaries themselves don’t
   use it, their families or paid advisors might.

3. Inform each person of his or her HMO contribution amount? The
   conference report said this does not have to be provided, senate amendment
   liii at bottom of 589, but it (or the size of the MSA deposit for each plan) is
   necessary for an informed choice.

Options:
A. HCFA does not report to beneficiary, but delegates
   responsibility to the insurance company to say the amount
   deposited in the MSA for each person.
B. HCFA calculates and mails the contribution amount to
   beneficiary as part of information package.

In our conversation 2/20/97, you said that someone was arguing for the
same contribution for every person in an area that picks a particular plan.
This is a good idea from the viewpoint of making it easy to inform participants, and it seems fair. (It will work much better than the earlier proposal to make everyone pay the same premium). If this idea prevails, informing the patient is easy, either through option A or by modifying option B so that the deposit is one data item in the brief comparison of plans. Informing them of the contribution and the implicit premium (= contribution-deposit) would be unnecessary and confusing.

4. List of insurers offering MSA plans in my area with contact numbers. In 1999 and later, this information can be collected as plans sign up by May 1.

Options:
A. Mail it out to all with initial brochure: this would seem to be the minimum that the law requires.
B. Mail it out with the packet for those who request more.
   Depending on how many ask for it, this could save some money, but would require the initial brochure to go out earlier to give time for requests to be fulfilled.

5,6. The information listed below should be collected from insurance plans and made available to potential enrollees. Also these enrollees might be primed to ask questions to get that information. In the conference agreement, plans are supposed to give much of this information by May 1 of each year for the end of year enrollment period (p625).

   a. Scope of coverage: what services besides basic Medicare are covered in the basic plan? Is there a supplemental plan, and if so, what does it cover in addition?
   b. What is the premium for the basic plan? for the supplemental plan? Example of how much money would go into MSA.
   c. Cost-sharing: could be described by
      i. Rules: deductible, copayments above deductible and out-of-pocket maximum.
      ii. Scenarios
      iii. Actuarial approach: experienced distribution of cost-sharing for people like you--quantity of care compared to traditional FFS?
      iv. Worst case, best case financially compared to traditional FFS?
   d. Managed care features:  
      Pre-authorization requirements?
Is it a network—if so, see list below? Presumably you can borrow all regulations from what is required from non-MSA coordinated care plans.

(Coordinated care) factors: CAHPS, HEDIS, and other quality information
Who is in panel—How can I find out this information?
Availability of primary physician
Control over your treatment. How are disagreement handled?
Point of Service options and penalties: i.e. what happens if I go to someone not in the network?
Timeliness of access to care
    Referral rules? Which specialist can I self-refer to?
Administrative efficiency
Other managed care rules: limits, bonuses etc.

Options for distributing\(^{44}\) information:
    a. Mail out all this information to everyone, or
    b. Mail out a subset to everyone, or
        b) to everyone who wants to know more about MSAs.
    c. Keep the information for those who ask by phone or WWW.
    d. Make insurance companies responsible for this information.

The law 1851 d 2 A says the Secretary shall mail out general information 1851 d (3), and comparative plan specific information 1851 d (4). Thus it appears to mandate option A or B.\(^{45}\) (For part B, “brief” might include: cost-sharing arrangements, any significant expansions in coverage, the premium for a representative case, whether it is a network, and how out of network use is handled.) Option A would be very expensive and discouragingly poor in informing beneficiaries, and even A’ might be excessive. For example, in a trial survey for CAHPS, only 40% remembered seeing materials. Those who did complained about their length. This makes options B, C and D more appealing. C should be done in any event.

\(^{44}\)Some information may be difficult to collect. For example, potential enrollees might want to know the average out-of-pocket spending with a plan for two reasons. It is a measure of the risk in choosing the MSA, and also of how much medical care people with the plan buy—one disadvantage of choosing an MSA is that less generous insurance will lead you to buy less care. Average out-of-pocket spending could be collected from a sample of enrollees at the plan by asking them to file all bills or by a survey. As discussed in the risk adjustment memo, this information will also be needed for the more complete risk adjustment that is supposed to be used starting in 2000.

\(^{45}\)The report language from the House, page 868 of report 105-149, confirms this, talking of the Secretary mailing comparative information on each plan at least 30 days (later amended to 15 days) before the enrollment period. For MSAs, information on coverage and exposure should be included.
Presumably the information would be collected as part of insurance plan sign-up, what might be done next.

HCFA must decide how much information to send each Medicare Beneficiary. To make an informed choice, they need detail about the plans available to them. Because there are few constraints on the form of these MSAs, it is not sufficient to describe MSAs in general. However, it would be very expensive, and perhaps overwhelming to send a complete brochure (including a list of network providers) for each MSA insurer to each beneficiary. How is this handled for other coordinated care choices?

7. List of financial institutions offering MSA custodial accounts in an area.

Options:
A. Provide a list of companies offering this service and a national toll-free number for each. Also give information on what to ask the companies.
B. Make the plans responsible for informing beneficiaries about this and require them to list plan to which deposit is to be sent on application.
C. Provide information on how to use local yellow pages to get this information.

Information on which plans are offering to handle MSAs or their terms is not specifically mandated in law, and there may be a huge number of bank branches offering this service. There are still many small regional bank companies, so there would be some work involved in making a list that is tailored to each beneficiary. Maybe a selected list could be sent, but there are advantages to having the people with incentives to get this information (option B) responsible for transmitting it. Option C might also be possible, but in itself might not be considered enough.

8. Details beneficiaries should know. These include

- Custodial Fees, how calculated and levied?
- Minimum balances?
- How do I withdraw money from MSA (check, debit card etc.)?
- What investment options do I have?

Options:
A. A little booklet explaining these details and recommending questions might be part of the initial brochure or the detailed packet sent out to those wanting to know more about MSAs.
B. Insurers might be responsible for providing this information to those who ask for more details about their plans.

Examples of 5,6:

It is challenging to try to write these to be both understandable and accurate. (Letters refer to information in parts 5,6 above.)

a. In addition to the basic Medicare coverage, this plan covers prescribed drugs from a formulary.

b. The annual deposit into your Medical Savings Account if you sign up with our plan is given by Table 1 (contains age-sex-county cells). (Possibly omit the following text) The entry in Table 1 is the difference between the premium charged by this company and the contribution that would be made to a coordinated care plan that enrolls such a person.

b. (alternate). The premium for the basic plan is $300 a month. For a 70 year old man living in Los Angeles County, HCFA pays any coordinated care plan in which he enrolls $350 a month. For such a man, the annual deposit into his Medical Savings account would be twelve times the reduced monthly government payments or $350-300 = $600.

b. (alternate) The premium for the basic plan for each type of enrollee is given in Table 1. The contribution for each enrollee is given in Table 2. The annual deposit into the Medical Savings Account is given in Table 3. (All 3 tables have age-sex-county cells.)

c-i. The plan has a $1500 deductible in any year. This means that the enrollee pays the first $1500 in covered medical bills in any year, and the insurance company pays 100% of all medical bills in excess of $1500 in any year. Insurance payments are made only for services covered by traditional Medicare and only to the amounts allowed by Medicare rules.

c- The plan has a $1500 deductible with 20% coinsurance above the deductible up to a maximum of $2500 in out-of-pocket payments in any year. This means that the enrollee pays the first $1500 in covered medical bills in
any year, and 20% of the bills between $1500 and $6500 in any year. The maximum that any enrollee must pay for medical services covered by Medicare in any year is $2500. So, the insurance company pays 80% of the bills between $1500 and $6500, and 100% of all medical bills over $6500 in any year. The coinsurance is waived for enrollees that use providers in our network. Insurance payments are made only for services covered by traditional Medicare and only to the amounts allowed by Medicare rules.

   c-ii. Suppose a person with $400 in his Medical Savings Account has doctor bills and drugs totaling $2000 in a given year. That person would have to pay $1500, with $400 from his Medical Savings Account and then $1100 ($1500- $400 = $1100) of his own money. We would pay the remaining $500 ($2000-$1500 = $500). [Written by an insurance company with a $1500 deductible.]

   c-iii. Last year, people insured by this plan had $700 in out-of-pocket expenses on average, and the insurance company paid $3200 on behalf of the 27% of enrollees who had more than $1500 in medical bills. The total premium + out-of-pocket expenses was on average $xxx less than estimated total spending by those with traditional FFS Medicare (which includes bills paid by the government, Medigap, and out-of-pocket spending).

   c-iv. The people who had some bills paid by the plan all had $1500 in out-of-pocket expenses, which was the largest amount possible for people in this plan. 39% had no expenses at all, so were able to save the full difference between the contribution and the premium. (This information might be tabulated for a few age-sex-county cells?)
14. MEDIGAP POLICIES AND MSAS

A question was raised during our last conference call about whether Medigap plans could be used in conjunction with Medicare+Choice MSAs. The purpose of this memorandum is to answer that question.

Restrictions on the use of Medigap plans in conjunction with an MSA

According to the BBA, "it is unlawful for a person to sell or issue a policy that...provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan." Exceptions are as follows:

(a) policies that provide coverage for accidents, disability, dental care, vision care, or long-term care;
(b) policies that relate to liabilities incurred under workers' compensation laws, and tort liabilities;
(c) policies that provide coverage for a specified disease or illness; and
(d) policies that pay a fixed amount per day (or other period) of hospitalization.

Ten standard Medicare supplemental plans

Prior to enactment of the BBA, there were ten standard Medicare supplemental plans. Nine out of ten of these plans provide coverage for the Medicare Part A inpatient hospital deductible ($764 per benefit period in 1997) and, therefore, are incompatible with Medicare+Choice MSAs. A description of each of these plans is provided in Appendix A.

Plan A (the basic policy) is the only standard Medicare supplemental plan that doesn't cover the Medicare Part A inpatient hospital deductible. It provides the following benefits:

- Coverage for the Part A coinsurance amount ($190 per day in 1997) for the 61st through the 90th day of hospitalization in each Medicare benefit period.

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- Coverage for the Part A coinsurance amount ($380 per day in 1997) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health services) after $100 annual deductible is met.

Since none of these benefits "provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan," Plan A might be legally permitted in conjunction with a Medicare+Choice MSA. But even if it is legally permitted, this plan may have no practical value in the Medicare+Choice MSA context since copayments of the MSA insurance plan will probably differ from those used in Medicare Parts A and B. For example, coverage for the Part A coinsurance amount ($190 per day in 1997) for the 61st through the 90th day of hospitalization, would be of little help to an enrollee if the Medicare+Choice MSA plan does not charge a copayment or coinsurance for such hospitalization.

Two new Medicare supplemental plans

The BBA adds two new Medigap policies which kick in after a deductible of $1,500 has been reached. These two policies are identical to Plans F and J, except that they cover out-of-pocket expenses above the $1,500 deductible and cover nothing below it.

Let \( X \) equal the deductible of the enrollee's MSA insurance plan.

If \( X \) is greater than $1,500, then the Medigap policy would pay for the portion of expenses incurred between $1,500 and \( X \). This would mean that
the Medigap plan "provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan" and, therefore, is not legally permitted.

If $X$ is less than or equal to $1,500$, then the Medigap policy would not pay for any expenses that would otherwise be applied toward the MSA plan's deductible. In this case, then, the Medigap policy could be used in combination with the enrollee's MSA.

**Conclusion**

The two new Medigap policies created by the BBA could be used in conjunction with a Medicare+Choice MSA if and only if the deductible of the MSA insurance plan is less than or equal to $1,500.

Plan A, the only one of the ten current standard policies that might be legal for those choosing Medicare and choice MSAs will have little value for them.
15. HOSPICE CARE AND END-STAGE RENAL DISEASE\(^{47}\)

POLICY ISSUE
You informed us that when an enrollee in a Medicare HMO chooses hospice care or is diagnosed with ESRD, his hospice and/or ESRD expenses are paid by HCFA, not the risk HMO. That raises a question as to whether MSA enrollees would have to pay for these services out of their MSAs.

BACKGROUND

End-Stage Renal Disease
In 1972, Medicare coverage was extended to individuals with end-stage renal disease (ESRD). Medicare’s definition is "that stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life." Currently over 200,000 patients in the United States receive some form of life-saving kidney (renal) dialysis treatment.

Hospice
Hospice is a way of caring for a person whose disease cannot be cured. It is available as a benefit under Medicare Part A to beneficiaries with a very limited life expectancy. A Medicare beneficiary who chooses hospice care receives non-curtative medical and support services for his or her terminal illness. Home care is provided along with necessary inpatient care and a variety of services not otherwise covered by Medicare.

Medicare coverage for hospice care is available if the following criteria are met:

- The patient is eligible for Medicare Part A;
- The patient’s doctor and the hospice medical director certify that the patient is terminally ill with a life expectancy of six months or less;
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness; and
- The patient receives care from a Medicare-approved hospice program.

\(^{47}\)Memo 4/17/98
OPTIONS

Our understanding is that two options are currently under consideration:

1. HCFA pays for all ESRD and hospice care except minor copayments.\footnote{HCFA finally decided that, if beneficiaries sign up for hospice, they resign from MSA and HCFA recoups the rest of the year payments. If they become eligible for ESRD, the insurance plan gets a much larger payment for them, but their MSA status, both the MSA deposit and cost-sharing requirements are unchanged.}

2. HCFA pays for all ESRD and hospice care except minor copayments, but only after the individual's MSA has been depleted.

PROS AND CONS

The argument for Option 2 is simple: If people have money in their MSA, they should be required to use that money to pay for hospice and ESRD bills. After all, the point of the MSA is to pay for unexpected medical expenses.

There are two arguments against Option 2.

First, it is not equitable. HCFA pays for ESRD and hospice care of individuals in traditional FFS and in Medicare HMOs (except minor copayments). If HCFA does not pay for such care for beneficiaries enrolled in MSAs, then the playing field will be tilted against the MSA/high-deductible package.

Second, it is unworkable. Terminally-ill patients will have an incentive to cash out their MSAs before being diagnosed with ESRD or entering hospice care since they know that once their MSA is depleted, their care will be paid for by HCFA. Even if an individual uses the money for non-medical expenses and has to pay a penalty, he will be better off than if he had left the money in the MSA only to have all of it taken away.

If beneficiaries with MSAs are transferred to hospice care, then presumably they would not continue to get their MSA deposits for the difference between the catastrophic premium and the contribution. The monthly payments for MSA deposits are paid as a lump sum at the beginning of the year. According to the law, 1853 e 3, the secretary shall provide for a procedure for recovering MSA deposits attributable to the remaining months.
of the year. The issues are similar to recovering payments when a person dies mid-year.
16. MEDICARE SUPPLEMENTAL POLICY ISSUES

Over 90 percent of Medicare beneficiaries in the traditional fee-for-service program have supplemental coverage today. About 78 percent of beneficiaries have private coverage, and another 12 percent are covered by Medicaid, which pays for Medicare copayments and deductibles for dual Medicare and Medicaid eligible individuals and qualified Medicare beneficiaries. Of those with private coverage, about one-half receive these benefits from their employers under their retiree benefits and another one-half purchase individual Medigap policies.

Supplemental policies raise several issues for implementation of the Medicare MSA demonstration project that need to be worked through.

1. Is it legal to keep an existing policy that covers a portion of the deductible?

The BBA makes it illegal to "sell" or "issue" insurance policies which buy out a portion of the MSA's deductible (see Appendix B). However, as Ken Thorpe noted at the RWJ conference, the BBA does not specifically address the ability of Medicare beneficiaries to use existing Medigap policies or employer-based policies in buying out the deductible. While the wording of the law is ambiguous, legislators probably intended to prohibit retention of any comprehensive health insurance policy that buys out any portion of the MSA deductible.50

This has implications for all Medicare eligible people who may be eligible for other insurance policies, either by virtue of poverty (Medicaid) or through an employer. If it is illegal to have policies covering the deductible and an MSA, then either the supplier of the other policy must be dissuaded from offering it, or the beneficiary holding such a policy prevented from choosing an MSA. This will probably be easy to enforce with Medigap policies, but employers unfamiliar with the latest details of Medicare law may unwittingly offer such policies.

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50HCFA imposed a rule that individuals with supplemental policies that cover expenses which would count toward a MSA health insurance plan's deductible are not eligible to elect an MSA plan (Health Care Financing Administration 1998, 35036).
Implications for the Medicaid Eligible. Since Medicare beneficiaries who are covered by Medicaid receive coverage that buys out the deductible, relatively few low-income beneficiaries will be eligible for MSAs (unless they turn down Medicaid benefits, which would exchange essentially free care for a very risky insurance contract and a small MSA contribution). HCFA might want to be paternalistic in this case and not allow people eligible for Medicaid to turn it down and sign up for MSAs.


If someone is over 65 and is still working, and their employer has more than 20 employees in its medical plan, then the employer's health plan is the primary insurer and Medicare is a secondary payer.

People for whom Medicare is currently secondary, i.e. if Medicare is not now responsible for most of their health care, should probably not be eligible for MSAs. For example, if they had a high deductible plan with the company, the letter of the law allows them to choose an identical high deductible plan that qualified them to get an MSA, and simply pocket the MSA payments, but presumably Congress was not trying to allow this. Typically the company will also be offering some financial incentive to get workers to choose catastrophic insurance.

There are steps HCFA can take to improve compliance.

Steve Coppock, a consultant with Hewitt Associates LLC in Rowayton, CT, suggests that HCFA release a fact sheet for employers who offer primary coverage to people 65 or older. This information might be placed on the Internet or distributed to groups representing employers, such as the Chamber of Commerce and the National Federation of Independent Business.

Alternatively, HCFA could try to shift responsibility for compliance to the beneficiary or insurance company by having the enrollment form for MSAs include a statement that Medicare is the primary insurer.

3. Even if Medicare is primary, some employers may unwittingly violate the BBA by offering low-deductible policies to employees and retirees who are enrolled in MSAs.

In 1987 approximately 8.4 million people in the United States aged 65 or older had employer-sponsored health insurance. This number includes
nearly one-third of the Medicare population. Most employer-provided plans offered to people 65 or older are coordinated with conventional Medicare. If a beneficiary signs up for an MSA and has an employer-provided supplemental plan, the plan may pay for some benefits below MSA deductible. This violates the BBA.

If the employer has 20 or fewer employees in its medical plan, then the employer's health plan is the secondary insurer and Medicare is the primary payer for workers over 65. Employers may also offer secondary coverage for retirees. In either case, the employer is not permitted to sell or issue the plan to a beneficiary that has opted for an MSA unless the plan does not provide "for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan."

The only exceptions to this are policies that provide coverage for accidents, disability, dental care, vision care, or long-term care; policies that relate to liabilities incurred under workers' compensation laws and tort liabilities; policies that provide coverage for a specified disease or illness; and policies that pay a fixed amount per day (or other period) of hospitalization. Thus, it appears that the BBA rules out the sale or issuance of any comprehensive health insurance plan--primary or otherwise--that covers any of the benefits (Part A, Part B, and any supplemental benefits) that would count toward the MSA plan's deductible.

Technically, the employer, not the beneficiary, is in violation of the law (see #1, above). Yet, few employers know which Medicare program employees and retirees select each year. For example, many employers do not know whether an employee is enrolled in conventional Medicare or a risk HMO.

Again, HCFA could release a fact sheet for employers that offer coverage to people 65 or over. Alternately, in the enrollment process, the beneficiary or insurance company might have to affirm that the beneficiary does not have insurance that covers expenses below the deductible.

4. Can Medicare beneficiaries who do not enroll in MSAs buy the two new Medigap policies created by the BBA?

This issue was raised by Ken Thorpe at the RWJ conference. The BBA appears to allow Medicare beneficiaries who are not in MSA plans to buy the two new Medigap policies.
5. Must supplemental policies be community rated?

In answering this question, it is useful to distinguish between two types of supplemental policies:

First, there are the "supplemental" policies that can be sold along with the basic MSA policy. These are supplements that add additional benefits to the basic Medicare package, such as eyeglasses, prescription drugs and hearing aids. My understanding is that this type of supplemental coverage can be wrapped into the basic plan or sold separately as an additional option.

However, it appears that such supplemental policies—that add benefits to the basic plan—must be community rated. Section 1854(c) of the BBA, for example, reads: "UNIFORM PREMIUM. The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in a plan."

If premiums for the basic plan are not community rated, then the insurer may be able to wrap the supplemental benefits into the basic plan—in which case the supplemental benefits also would not be community rated. We must stress, however, that this an assumption on our part, as there is nothing in the BBA that speaks to this issue.

Second, there are Medigap policies. These are the 10 standardized policies that existed prior to enactment of the BBA (Plans A through J), plus the two new high-deductible policies created by the BBA.

There is nothing in the BBA that indicates that Medigap policies must be community rated. Such policies have generally been experience rated in the past, and it appears that this will continue. Must an MSA provider who also offers one of the new Medigap high-deductible policies community rate them? We guess not, but the issue is unclear.
17. REQUIRED CLAIMS DATA

**Question:** Will insurers considering selling Medicare MSAs have difficulty complying with HCFA requirements for claims data?

**Methods:** Called 5 insurers—Golden Rule, Medical Savings Insurance, Blue Cross Blue Shield of Texas, Mutual of Omaha, Time—that are considering entering the Medicare MSA market.

**Results:** 4 insurers returned my calls.

1. *Golden Rule* uses standard HCFA Form 92 for hospitals and HCFA Form 1500 for physicians.
2. *Medical Savings Insurance* uses CPT4 to code services and ICD-9 for diagnoses. Our informant was not aware of whether claims came in EDI or paper.
3. *BCBS Texas’ Medicare Division* complies with all HCFA mandates, meaning that they use CPT4 for services and ICD-9 for diagnoses. Their physicians are encouraged to use EDI, but they can file claims by paper as well.
4. *Mutual of Omaha* said its physicians use CPT4 to code services and ICD-9 for diagnoses.

**Conclusion:** Overall, data incompatibility does not appear to be a problem.

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*Memo 1/5/98.*
Appendix A

OUTLINE OF IMPLEMENTATION AND EVALUATION ISSUES

A. Enrollment

1. Eligibility Cap. How will the legal limit of 390,000 beneficiaries who can enroll in the MSA option be tracked, and how will the limits be applied?\textsuperscript{52}

2. Enrollment Process. Should MSA enrollment be treated symmetrically with other Medicare+Choices plans? Will modified procedures be necessary to handle enrollment with insurers as well as MSA custodians? Will mid-year enrollment into MSAs be permitted for those who just turned 65? If so, what will the deductible be?\textsuperscript{53}

3. Beneficiary Education. What marketing materials and information should be made available to beneficiaries to inform their choices? How should these materials be evaluated?\textsuperscript{54}

4. Disenrollment.

5. Beneficiary Protection. What sort of appeals processes and beneficiary protections should be instituted?

6. Eligibility. Is the eligibility the same as for other Medicare+Choice beneficiaries? What beneficiaries are excluded because they have additional insurance already?\textsuperscript{55}

B. Benefits

1. Benefit Package. All MSA Catastrophic policies are required to include the full Medicare benefit package. Does this mean first $ coverage of such items as flu shots, and other federal preventive mandated services? (Federal

\textsuperscript{52}Memo 1/30/97.
\textsuperscript{53}Memo 1/30/97.
\textsuperscript{54}Memo 12/8/97
\textsuperscript{55}Memos 2/23/98 and 4/17/98.
laws supercede state laws, so state mandates are not a problem.) Supplemental insurance may not cover the deductible (sec 4003 b).

2. Insurers can offer expanded benefits such as prescription drugs and annual physical examinations. What services will count against the deductible? Only covered services, or the full range of IRS allowed services? What will the cost-sharing and accounting requirements be on such services? 56

3. What kind of cost-sharing is allowed? Will plans be allowed to charge cost-sharing above the deductible? What is the lowest deductible allowed or required to qualify for an MSA? 57

4. Apportioning Savings. How much money will be deposited into the medical savings account, a standard amount for all beneficiaries in a given plan, or a different amount depending on the AAPCC cell? This becomes even more important when risk adjustment is implemented.

C. Plan Selection and Certification.

1. Memo on who is in <65 market and whether they will go into Medicare MSAs. 58

2. Types of Insurers. Fee for service, indemnity plans or networks (including HMOs) or both. If networks, how will the networks be qualified? Will this require a full evaluation similar to the inspections of managed care plans? Will networks that are currently certified for the managed care options be automatically qualified for the MSA networks if they meet restrictions in coinsurance rates and a cap on cost-sharing? 60

3. State Issues. What state license requirements must be met by the insurer? Are there additional or standard federal requirements that need to be met by the insurers? 61

56 Memo 12/17/97.
57 Memo 12/8/97 also discusses impact of not allowing cost-sharing over the deductible on feasibility of forming networks.
58 Issue discussed in conference calls and at Robert Wood Johnson conference.
59 Memo 12/1/97.
60 Memo sent 12/8/97 also discusses whether there should be a minimum deductible.
61 Memo on current state regulations sent 12/8/97.
4. Quality. What types of quality standards, if any, are required of plans that wish to participate in the program. What remedies are available if the plan does not maintain high quality standards?

5. Selection Process. What application is required, and how will it be reviewed? How will applications be solicited? Will all qualified applicants be accepted, or will there be limits? Currently, geographic limits will not be applied.

6. How can insurers be encouraged to participate? What effect will the rules for splitting the contribution have?

D. Plan Payment and Provider Payments

1. Methods for Risk Adjustment. What will be the basis for risk adjustment? What will be the basis for the premium payment? HCFA's total contribution is mandated to be the same for MSAs as non-MSA plans. When will advanced risk assessments be available and implemented? 62,63

2. What premiums from the plans will be allowed? Will there be reviews of the premiums, or will the premiums be offered to the beneficiaries as a bid process, with any savings available to the beneficiary as a contribution to the MSA account? The law says the ACR process is not required for MSAs.

3. Doctors can charge MSA patients whatever they want, but insurers only have to pay Medicare amounts. 64

4. Accepting MSA funds does not constitute a private contract. Non-Medicare providers: IRS will view their bills as medical, but HCFA will not require that such bills be covered, or count against the deductible. 65

E., F. The Medical Savings Account and Custodian, Taxes and Withdrawals

62 Memo on risk adjustment also discusses the impact of different rules for splitting contribution.
63 Memo on risk adjustment sent 12/19/97.
64 Memo on balance billing sent 12/17/97 also discusses insurance accounting.
65 Memo on insurance accounting sent 12/17/97 also discusses balance billing.
1. Relation to the Insurer. Is the MSA custodian independent of the insurer, or chosen by the insurer and directly tied into the insurance account?\(^{66}\)

2. Qualifications. What are the qualifications of the MSA custodian? Must it be a bank or trust company, or are other financial institutions such as brokers also allowed?

3. Reporting and Payment. If the MSA custodian is not tied to the insurer, who will calculate the payment amounts and make the payments of the varying amounts to the fund holders? Law 1853 e 1 says secretary will make payments of contribution—premium into an account established by the individual. Who will recoup funds if the MSA account is terminated?\(^{67}\)

4. How will MSA custodians be solicited and approved if the custodian is not tied to the insurer? Will there be a limited number of custodians, or will any qualified applicant be approved?

5. How may withdrawals be made? Credit card, check, or debit card?

6. MSA Fees. May custodians charge fees, or will any fees come out of the MSA account balance?

7. How will withdrawals of funds from the MSA accounts be reported for tax purposes, and what will the role of HCFA be in this process? (probably limited.)

MSA Spending and Taxes. MSA account withdrawals ("Medicare dollars") will be permitted for any use, but tax consequences vary. IRS qualifying medical services are not taxed. Other uses invoke a large tax penalty, except for funds in excess of 60% of the deductible as of the end of the preceding year. Sec 4006 of BBA amends IR code Chapter 1 B III Sec 138 with rules on Medicare MSA funds.\(^{68}\)

G. Data and Evaluation

1. The BBA requires an evaluation of the MSA program, and OSP is already planning to operate an evaluation. Can the demonstration be designed to

\(^{66}\)Memo on bundling sent 12/11/97.
\(^{67}\)Memo on transfer of funds sent 12/11/97.
\(^{68}\)Memo on IRS issues sent 2/6/98.
facilitate monitoring? (HCFA decided against limiting implementation to a certain geographical area.) If so, what should the demonstration look like?

2. What data will be required for the evaluation and for program monitoring from the beneficiaries, from the insurers, and from the MSA custodians? Will these data be gathered on a sample or on a population basis?  

3. Types of data will include claims data processed by the insurer, tracking of the balances in the MSAs, and information on the services paid out of the MSA accounts (on a sample or on a population basis.)

4. What types of additional data will be required for the evaluation?

5. What will be the penalty for noncompliance?

6. What data will be needed for risk adjustment and how will they be collected?  

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69 Memo sent on 12/19/97 also discusses risk adjustment.  
70 Memo on claims data processed by the insurer sent on 1/5/98.  
71 Memo on risk adjustment sent 12/19/97.
Appendix B

RESTRICTIONS ON CERTAIN LOW-DEDUCTIBLE SUPPLEMENTAL POLICIES FOR MEDICARE+CHOICE MSA ENROLLEES (FROM BBA)

SEC. 4003. CONFORMING CHANGES IN MEDIGAP PROGRAM...
(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS AND PRIVATE FEE-FOR-SERVICE PLANS- Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

“(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan or a Medicare+Choice private fee-for-service plan.”

“(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.”

“(B) A policy described in this subparagraph is any of the following: `\(i\) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. `\(ii\) A policy of insurance to which substantially all of the coverage relates to—\(i\) liabilities incurred under workers' compensation laws, \(ii\) tort liabilities, \(iii\) liabilities relating to ownership or use of property, or \(iv\) such other similar liabilities as the Secretary may specify by regulations. `\(iii\) A policy of insurance that provides coverage for a specified disease or illness. `\(iv\) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.”"
C. ORAL PROPOSAL FOR CONTRACT TO PREPARE OPTIONS ON MSAS
Medicare and MSAs

- HCFA has used supply reforms to control costs—now trying out demand reforms.
- RAND HIE showed that HMOs and big deductible plans had much lower spending than free FFS.
- Medical Savings Accounts (MSAs) concept:
  - big deductible insurance plan +
  - deposit into MSA account for out-of-pocket spending
  - designed to encourage people to economize on health care
- MSA option is the first to give cash to Medicare beneficiaries in exchange for less expensive plans.
  - other plans have to add services until costs match AAPCC
  - most MSA money will eventually be spent on medical services, but spending will go down for those with MSAs.

1. HCFA has successfully used supply reforms to control soaring Medicare costs. Prospective payment DRGs have changed the game for inpatient spending. Maybe some day there will be a city willing to accept competitive bidding for HMOs. Competitive bidding could get some excess profits out of HMOs but the savings goes to government, not beneficiaries.

2. HCFA is now shifting to demand reforms, and a lot of what we know about demand comes from The RAND HIE. This was a large RCT of alternate insurance arrangements. It showed people on big deductible plans and in HMOs had spending about 70% of those with free care, with few bad effects on their health. These results have led employers to toughen up cost-sharing requirements, and encourage their employees to join HMOs. Similar to the MSA concept, we paid people up front to induce them to accept big deductible plans, and they still spent much less than people with free care.

3. Medical Savings Account or MSA as implemented in Health Insurance Portability and Accountability Act (HIPAA) and Medicare Choice + are a newly popular idea—as a reward for accepting a big deductible plan that gives them incentives to economize on care, people are given some tax advantaged money in an account that can be used to pay for out-of-pocket spending. Why does a big deductible plan reduce costs? Most people most of the time will be in a situation where they pay 100% of the costs of care. From the HIE, we know they will sometimes not buy treatment for some episodes of illness in that case, even though they would get it if it were free. Through the rest of this talk, I will call such care "low-value" care. Economists believe that it is wasteful to provide such care because its value to beneficiary is less than costs.

4. Other choice + plans don't give back money—if it costs an HMO less to provide basic services than what traditional FFS spends in an area, they have to keep adding services such as drugs, eyeglasses, etc. until they burn up the difference. Obviously beneficiaries in HMOs can avoid cost-sharing or Medigap payments, but they may still be stuck with a more generous plan than they want in areas where the AAPCC is high.

Most MSA money will eventually be spent on medical care when you are 65, ill health is coming, but for a while, people will spend less than they would otherwise and also save Medigap $.
Medicare Choice +

- Most Medicare beneficiaries can choose
  - traditional Medicare FFS
  - coordinated care plans (risk HMOs, ...)
  - Private FFS
  - MSAs
- Informed consumer choice in November
  - based on plan data filtered through HCFA on regular and supplemental coverage, liability, premiums, quality and performance
- Plans must accept all eligible beneficiaries until full
- Coverage rules: at least as good as traditional
  - but MSAs somewhat less restricted -> coverage options
- Contribution based on area costs gradually moving to national rates, same for all Choice + plans.
  - attractiveness depends on local differences, which persist
  - Risk adjustment based on use beginning in 2000

1. In choice+, THE BBA of 1997 gives beneficiaries 4 choices: All prior HMOs will be rolled into coordinated care plans two new options MSAs and Private FFS (doctors get together to escape from balance billing and other Medicare limits.) The non-MSA networks are like PPO to beneficiaries, but like capitated to plan (like a lot of private Medical group networks in LA). How the plan pays doctors is up to the plan.

2. Informed choice in November 1998 for January 1 start. MSAs have to enroll for calendar year. Choice will be based on lots of required information. CAHPS administered by HCFA, HEDIS for clinical quality, other data from plans filtered through and sent out by HCFA. Some options about whether there should be special MSA information perhaps on risks. Marketing material needs 45 day advance notice.

3. There will be no underwriting or preexisting condition clauses. Unlike an HMO, MSA insurer can't do much post enrollment to make it difficult for sick people to get the care they want, and induce them to quit.

4. Coverage rules: in general at least as good as traditional in terms of coverage and cost-sharing. But MSAs less restricted so may have coverage options. MSAs can be network or not, can offer supplemental package. Indeed, although MSA advocates talk about the cost-savings from private shopping, insurers have much more clout, and people wanting to save money need help. Health care is a field where you don't want to pay list.

Contribution has been based on 95% of AAPCC (age, sex, disability status location)--lots of literature on problems with AAPCC, and 1997 law contains a lot of changes: new contribution is the max of ($367, 1.02% x last year, or blend): gradual shift to national system rather than local. However, AAPCC is not rising (GME phasing out, costs not up much) blend not factor yet and local differences will persist. Size of contribution important to attractiveness of MSA, which could work in rural areas without an active HMO.

Risk adjustment to begin in 2000 which is not that far away.
Legal limits on Choice + MSAs

- MSA plan rules:
  - demonstration project: so more discretion on rules.
  - catastrophic deductible must be < $6000.
  - MSA deposit = contribution + premium
  - payment and accounting rules

- Some differences from the under 65 MSAs
  - less tax benefit
  - can't be spent on family members
  - minimum deductible, medical expenses not defined
    - options: What should they be?
  - less competition from FFS or HMOs.

- Law solves some potential problems
  - no giveaway to people with other sources of care
  - risk adjustment for biased selection?
  - forbids Medigap for deductible

A lot is spelled out in legal summary—a lot of possibility and ambiguity remains. Obviously, if we get the contract we will figure out, with your help, what is specified and what are options.

Talk about demonstration limits later—but important point is that we have options about whether to write rules to play up demonstration, learning aspect, or to just write rules that we now think are best for an ongoing program—this initial choice affects many later decisions.

The choice+ MSA plan: must have a less than $6000 deductible plan that satisfies some other rules such as paying the lesser of original Medicare fees, bills after deductible is met, counts at least those amounts towards meeting deductible, etc. is eligible to get difference between premium for that plan and contribution put in Medical Savings Account. The rules leave options for example, for bills under deductible that are larger than Medicare payments, and for how to enforce them.

There are some differences from the under 65 MSAs that we looked at in our DOL projects and were part of (HIPAA). Beneficiaries don't pay income taxes on Choice + deposits (they don't pay taxes on other HCFA payments to MDs or to HMOs, but their out-of-pocket cost-sharing or Medigap plan premia does come from after-tax funds) AND they gain from less generous insurance. But under 65 workers get an additional 15% tax advantage for not having to pay FICA—MSA funded out-of-pocket spending has the same advantage as employer paid premiums.

Choice+ is clearly individual following Medicare culture—under 65 MSA had more of a family orientation, like most employer sponsored insurance.
Choice + didn't define minimum deductible or medical expenses: minimum DEDUCTIBLE not in legal summary: for under 65, it had to be at least $1500. There are options: Probably want to set some minimum but it could be much smaller than $6000--in 1995, about 1/2 Medicare beneficiaries had spending less than $1000. Medium big deductibles give you most of the incentive benefits of huge deductibles, while limiting financial exposure. Typically, with even medium sized deductible, the issue is whether you went to the hospital. IRS definition of Medical expenses in HIPAA law--tax enforcement primarily through the income tax system. We often have option of using same rules as under 65 or not.

In last 10 years, big changes towards increased cost-sharing, managed care, HMOs for under 65--this has already squeezed a lot of profit and excess services out of system. Medicare is last bastion of old-fashioned generous FFS. So choice+ might do better.

Chris Hogan of MEDPAC gave a good talk on Medicare MSAs at a session on MSAs I chaired last year (it went in 1996 report). His bottom line was that they were a slightly good deal for healthy beneficiaries--with not too much costs for others if you solve certain problems. Law has done so. Medicaid, retired military of federal employees with other sources of care. Risk adjustment to deal with biased selection (same problem as with HMOs). IRONIC Medigap not allowed for deductibles in MSAs or new private FFS in Choice +, but still ok in original Medicare.
To choose between options, need criteria. In our notes and comments on options, we will be using these or others you suggest to make suggestions.

1. The excess spending of free FFS did not improve health compared to HMOs or big deductible plans. So the US probably benefits from reducing lower valued care, and HCFA is also interested in its own costs. As in any reform, we start with Budget neutrality. Hope that with time if premiums go down, MSA balances go up; Government can save money—or at least not lose any, as they might have done with HMOs according to the research.

Rules ensure beneficiaries have real access around the clock to sufficient numbers of MDs in networks.

2. Adverse selection by the healthy is a bigger problem for Medicare than we predicted would be the case for those under 65. Medigap offers a not very expensive way for sick people to get rid of cost-sharing altogether—by law anyone can sign up at 65, and a recent GAO report notes that by paying $5 a year you can sign up for AARP and be eligible for their plan at any time without any underwriting or exclusions.

3. Well informed choice is good in its own right and is the market approach to ensuring quality of care and satisfied customers. There is some tension between more traditional regulated approaches to quality, good provider service, and the market approaches. The MSA is more of a market model, but we have options to try to improve the market through information or do these tasks in a more regulated way. HCFA can also be leader in consumer information which is desperately needed in the rest of the health care system (CAHPS, etc.).

4. Ease of implementation both to HCFA and companies in the field—I have heard that supply response is main reason why MSAs have done so poorly—agents don’t want to sell, or banks to set up accounts for such piddley amounts of business. Easy administration keeps down costs: Medicare costs are currently very low because of economies of scale, and not much resources put into management of care system. For MSA program, need to monitor compliance and prevent fraud, and collect data for other purposes—can be done many ways—but which are easy and cheap?

After this introduction, I'm now going to talk about some of the most important issues to HCFA, such as who can choose MSAs, which entities can participate, the impact of risk adjustment, and how to fulfill data requirements.
Who Can Choose MSAs?

- **Background:**
  - Demonstration of 1st 390,000 non-ESRD with no other insurance, entitled to part A, enrolled in part B. Annual enrollment.

- **Issue:** How to enforce enrollment cap of 390,000
  - Options: enforce cap year by year with overflow, or
  - Keep strictly to 390,000 by some rationing of overflow

- **Issue:** Those with other insurance can’t enroll
  - Options: CBS, insurer to enforce
  - General or very specific lists of those who can’t enroll

- **Issues:** Enforcing special MSA enrollment rules
  - How to design enrollment/disenrollment procedures
  - Penalties for disenrollment? other termination?

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The Medicare+Choice legislation sets criteria for which providers, insurers, and patients can participate in MSAs, and the process by which they are accredited. Still, the Secretary maintains broad discretion, and it is useful to consider the policy options relating to participation.

1. By law, MSAs are open to up to 390,000 beneficiaries without ESRD who are entitled to Part A and enrolled in Part B. Medicaid eligibles are explicitly excluded, as are Federal annuitants and military retirees unless OMB certifies it will not increase costs to the FEHBP.

2. So there are options on how to implement the 390K cap. The problem is that enrollment comes in big annual open enrollment lumps. Eligible beneficiaries sign up for a MSA starting in the November 1998 open enrollment period. At the end of the month, HCFA could determine how many people enrolled. If the number of beneficiaries exceeds the cap, HCFA has options: it could probably allow all of them to join MSAs. (This is essentially how it works in the under-65 MSA demonstration). HCFA could then declare the MSA program closed to new beneficiaries until the number of MSAs falls below the cap. Other options to explore, which we think are less attractive, would be to randomly exclude some eligibles who chose that option during open enrollment, exclude some geographic areas after open enrollment, or track enrollment on a first-come, first-served basis. If HCFA were interested in studying effects on markets, they should limit geographic areas from the start. One problem with under 65 evaluation design was that the program was scattered across all the country making any market effects too dilute to see. The report was asked to study effects on others’ premiums--from 1/2% leaving the pool! The 390K limit may be non-issue: 750K cap has not close to reached with under 65, and older people are generally more risk averse.

3. The legislation also gives the Secretary latitude in determining enrollment and disenrollment procedures. Midyear disenrollment from a MSA might be forbidden except for by cause, or financial penalties for early disenrollment worked out. Law says money is recovered after termination. (If there is no penalty for disenrolling, healthy beneficiaries could enter MSAs until they get sick and then go back to traditional Medicare FFS.) HCFA will also have to determine if those with other public coverage such as CHAMPUS are eligible. If these beneficiaries are not excluded, then HCFA has to coordinate eligibility with DoD. All of these choices affect who enrolls in MSAs, how hard it is for HCFA to set up and administer the MSA program, and the efficiency of the program.
Who Can Offer MSAs?

- Background:
  Insurers must be state-licensed; must meet antidiscrimination, disclosure, access, grievance, confidentiality, advance directives, and beneficiary protection requirements; must contract with Secretary: must meet QA and minimum enrollment requirements.

- Issue: How extensive should the quality review be?
- Issue: What about minimum enrollment? (Waive, make national)
- Issues: How to regulate MSA accounts?
  - Who will be custodians? (Insurer, bank, HCFA, or even brokerage house)
  - What can be done with balance? (Savings account or IRA-type account)
  - Who handles disbursements? (TPA, carrier or beneficiary)

The Medicare+Choice legislation mandates that offerors of catastrophic policies ("the MSA plan") must be state-licensed. In addition, they must meet requirements relating to antidiscrimination, disclosure, access to services, grievance process, confidentiality, and accuracy of records, advance directives, and beneficiary protection. This language is standard and covers managed care plans as well. Despite these requirements, there are many possible options for rules with the legal framework. MSAs will also be subject to quality review by the Secretary, but this review will be very different than for managed care plans. HCFA needs to consider options for this review, with one option clearly being extremely streamlined (i.e., see if consumer demands for quality let the market work). These are some of the restrictions, but will anyone want to sell them? Market response has been meager--Council Affordable HI (a good source for MSA info) told Jesse that three groups are interested: Medigap insurers, classic MSA firms like Golden Rule, LTC insurers.

2. Plans must also meet minimum enrollment requirements. These were designed with HMOs in mind, since they must cover at least 5000 lives (1500 in rural areas). Given the lack of enthusiasm for MSAs in the under-65 population, this may be a tough requirement, which for non-network MSAs HCFA might consider waiving (this was explicitly allowed for in the law) or having standards based on nationwide enrollment, because geographic density doesn’t matter so much with catastrophic insurers. If there is a minimum, HCFA will need to consider how to handle plans which are certified to offer MSAs, but are not selected by enough beneficiaries during open enrollment. How will the beneficiaries pick again?

3. The legislation does not impose many restrictions on the Medical Savings account. Who will be the custodian? Many insurers will track these accounts themselves or with a financial intermediary or TPA, but others will not. HCFA might consider whether to manage the account itself (as with Social Security). This would simplify tracking of disbursements, but would it violate the legislative intent? May be specially interested in data because it’s a demo--later relax requirements? In the under-65 market, various banks, Savings & Loans, and brokerage houses have expressed interest in offering MSA accounts. If this is allowed in the Medicare market, then HCFA has to regulate how the balance is managed. Stock market gyrations bring up the issue of what if people can’t pay? MSA balance doesn’t cover all the deductible--HCFA has option of not worrying about it--there are a lot of people without full coverage elsewhere in system--or maybe they should worry? Should these accounts be like IRAs and allow MSA holders to invest in the stock market? There would need to be regulations whether and how these funds are invested. Such regulations affect the desirability of MSAs to some beneficiaries, and hence who selects into them.
Risk Adjustment Issues

Background: Risk adjustment reduces incentives for and bad effects of adverse selection. HCFA Contribution $H(x)$ for people with characteristics x, starts from area contribution. Adjustment could be based on diagnoses, age and sex. Data to be collected starting 1998, for system implemented in 2000. $H(x) = MSA \text{ Deposit} + MSA \text{ premium}$

Issue: How should HCFA determine x and compute $H(x)$?
- Is x based on current calendar year or some other period?

Issue: When $H(x)$ varies, who gets the extra $ for sicker people?
- unlike HMOs, FFS insurer and beneficiary split extra costs
  Options: insurance company, beneficiary, or divided
    » division could be simple or $d(x)$ based on study
    » these options implemented through rules on premiums
- if insurer can only base premiums on age, sex, location $\rightarrow$ Beneficiary
- If insurer can base premiums on x $\rightarrow$ insurer or both get $.
  » but how can choices then be presented?

The more the beneficiary gets, the more attractive MSAs will be to sicker people, and incentives to file BD claims increase.

A big question for all capitated payment systems is whether plans do well because they provide a better product more efficiently, or because they can select low-cost people. Risk adjustment is one way of limiting the attractiveness of selection, because there is no gain if payment matches expected costs. So lots of interest in risk adjustment in both public and private insurers, as it is vital to managed competition: without risk adjustment or some cross-subsidy system, adverse selection kills the market. We recently wrote a paper on market impacts of various payment systems using a market simulation that shows this (Keeler et al., JHE 1998). It was part of a HCFA project on clinically detailed risk system. At a recent HCFA coordinated lunch in Chicago, there was a large table of people, all with risk adjustment projects.

Given characteristics x, let $H(x)$ be the HCFA contribution now aimed at risk HMOs. It starts with the area contribution which is based on the complicated rules discussed above and spelled out in law. Here and elsewhere there are potential administrative simplicity gains from MSAs riding on HMO regulations.

I can rewrite the earlier equation to emphasize what happens to the contribution. But first, the contribution has to be calculated. In addition to choosing a system for predicting costs, or making payments, the government has many other options to consider—many are not special to MSAs, but we'd be happy to list and comment on them.

The choice of a system leads to a # of cells for which contributions are calculated with perhaps some continuous adjustments for variables like age.

As a practical matter, What is the lead time needed to determine x, the cell the person is in? what use data to use, can it be retrospective after signup?
(Cont'd.)

H(x) varies slightly by personal characteristics x, and will vary much more if a
good risk adjustment system is developed. If H(x) varies from person to person,
the other parts of the equation must also vary. Who gets the extra $? In the
Dutch system, for example, the insurer gets more for sicker person, but all people
choosing a plan pay the same premium. The split is not an issue for HMOs who
bear all the costs, but with big deductibles, the costs of sickness are shared by
beneficiaries and insurance plan, and maybe deposit should vary.

These options on the split are equivalent to rules about how the insurer can set
the premiums charged to HCFA and the resulting deposits. (We read the text that
“premiums have to be the same” to apply only to premiums charged directly to
beneficiaries. For MSAs, this is just the supplemental premium.)

We might say premium has to be the same except for age, gender, location, or we
could follow Wynand vd Ven’s suggestion of personalized vouchers and let the
insurance company set an individualized premiums--government lists cells,
calculates the contribution H(x) and says who is in each one.

This might be hard to explain in the consumer report? But maybe not if HCFA, or
eventually the broker, could have software that would make the calculation
automatically and produce customized materials.

If deposit is the same, MSAs will be bad for sicker people, and there will be a lot
of adverse selection. MSAs will be a small part of the market, but even so, we
probably don’t want to encourage that. Indeed there is scant evidence that cost-
sharing affects sick and well disproportionately either on use or health, so we do
not want to discourage frail people from choosing MSAs. The efficiency gains
from reducing low value care from those who get a lot of it are larger. Also having
the contribution larger for sick encourages people to report their illness.

There are some special MSA risk adjustment issues: person’s costs may vary
disproportionately in different systems: Do we want to base factors just on
traditional FFS? Reporting may also be a problem--HMOs have been crying that
they keep people out of hospitals, so would be gypped by hospital based DCGs.
Finally, may want to do simulation of how much spending is above or below the
deductible to divvy up varying H(x).
Other Data Collection Issues

Issue: Use data is needed for compliance with rules such as deductible accounting, special MSA reports, general reports on Choice + plans, risk adjustment, other research, demo. evaluation.

Options: Just require specific mandated data
  » Rely on audits for monitoring
  » or, require full transactions submitted to insurer
  » Beneficiary may not submit below deductible claims
  » or, set up other system to capture all beneficiary spending

Issue: No penalty for withdrawals if used to pay personal medical bills, or if minimum balance (fungibility threshold) maintained

Options: Use IRS, make beneficiary responsible for tax compliance
  » this is how <65 law works.
  » or, make financial institution verify bills are legit.

Options: Minimum balance could be deductible or other amount

Issue: Basis of Mandated MSA reports on numbers, preventive services.

Options: Special or routinely collected data

All these purposes lead to data needs—so there are options about who provides data in what detail. With data particularly, the tension between demonstration objectives and ongoing program is strongest. See options in slide above. They range from minimum data to save $, or requiring insurance to submit all transactions. Even this doesn’t work.

Dummy claims for bills below the deductible could also be used in other research. This adds to administrative expense, but may be needed. Medicare data has been a great resource for health services research, but will be less so if many people disappear when they elect choice + plans.

It will be in beneficiaries interest to get full credit for being sick—-if extra contributions are split between insurance company and beneficiaries, insurer will help to educate beneficiary. Would they be allowed to offer filing fees, as we did in HIE?

If insurer can’t do it, how about MSAccount? Even if the financial institution reports all withdrawals, this won’t cover it after MSA runs out. If HCFA wants to use accounts to track payments to providers, they might try to handle them through a fiscal intermediary. However, balances might be used for medical expenses that are not typically covered by Medicare (e.g., paying a masseur for a massage) and people may not want the government involved. Only person who really could provide is beneficiary.

For tax compliance, one option is minimal regulation as with under 65. People in their tax returns have to certify withdrawals were for medical purposes, as defined by IRS, just as with medical deduction from income tax. Alternatively, financial institutions might have list of providers—but the costs of MSA management should be low and that implies low administrative burden. The minimum balance could be deductible or possibly higher based on some simulation of multiyear spending.

Language on numbers, use of preventive services, impact on trust funds! Seems to come intact from the under 65 bill—the numbers are easy enough, but the other parts of the report are extremely hard to do in the under 65 because of the difficulty of locating who has an MSA. Here we could probably use Medicare data (not as sensitive as IRS), but there is a question of how much more data to collect.
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