URGENT

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OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001
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LEGISLATIVE REFERRAL MEMORANDUM

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TO: Legislative Liaison Officer - See Distribution below:

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SUBJECT: Office of Personnel Management Proposed Testimony on medical savings accounts under the Federal Employees Health Benefits Program

DEADLINE: 2:00 p.m. Thursday, December 28,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: The attachment document will be handed out at tomorrow morning's briefing by OPM for the House Government Reform and Oversight Subcommittee on Civil Service on medical savings accounts under FEHBP. The briefing begins at 9:30 a.m tomorrow, December 29th.

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RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: **3347**

FILE NO: **1493**

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.
If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.
You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI 395-4871
Office of Management and Budget
Fax Number: 395-6148
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FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: Office of Personnel Management Proposed Testimony on medical savings accounts under the Federal Employees Health Benefits Program

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

ONE HUNDRED FOURTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6143

December 21, 1995

The Honorable James B. King
Director
Office of Personnel Management
1900 E Street, N.W.
Washington, D.C. 20415

Dear Director King:

The Subcommittee recently held a hearing to explore adding the option of Medical Savings Accounts (MSAs) to the Federal Employee Health Benefit (FEHB) program. I am writing to request information related to the development and implementation of MSAs in the FEHB program.

The Subcommittee would appreciate the Administration providing all nonidentical copies of the following material relating to MSAs in the FEHB program: correspondence (incoming and outgoing), memoranda, briefing papers, talking points, press releases, discussion documents or any other written material relating or referring to the option of adding MSAs to the the FEHB program. This information is requested under Rules X and XI of the Rules of the United States House of Representatives. The Subcommittee would appreciate you providing a briefing on Friday, December 29, at 10:00 a.m. in Room 2203. The briefing should address:

1) Whether the Administration has formulated an official position with regard to MSAs in the FEHB program?

2) Have you done any analysis regarding the assertion that MSAs would cause adverse selection in the FEHB program? Has there been any evidence of adverse selection in the private sector where MSAs are in place? Have you found any evidence that HMOs in the FEHB program have led to adverse selection? If so, what steps have you taken, or should Congress take, to address this problem?

3) Have you done any enrollee surveys of the FEHB population to determine the interest in MSAs as a health care option?

4) The National Treasury Employees Union (NTEU) released a press release the day of the hearing which stated "Enrollees would be tempted to join a traditional health care plan in years which they anticipated high health care needs."

Has OPM conducted any studies regarding the success of the average enrollee to guess what their health care needs will be in the following plan year? Assuming that an enrollee could predict his health care needs accurately, has OPM found that there is a substantial percentage of the FEHB population that changes health plans based strictly on anticipated health care needs?

5) At a previous hearing of the Subcommittee, the President of the American Federation of Government Employees (AFGE), John Sturdivant, testified that "... the FEHBP's relatively high premium costs for employees have left roughly 400,000 federal employees uninsured."

Has OPM conducted any studies to determine the actual number of uninsured federal employees? It has been suggested that the 400,000 figure is exaggerated and that it includes employees who voluntarily opt-out of the FEHB program because they have insurance elsewhere. What number of the supposedly uninsured federal employees are insured elsewhere? If MSAs were introduced into the FEHB program, would MSA enrollees have any health premiums automatically withdrawn from their paychecks? How would MSAs affect the uninsured population?

Please contact, Daniel R. Moll at the Civil Service Subcommittee, if you have any questions. Thank you for your assistance.

Sincerely,

John L. Mica
Chairman
Subcommittee on Civil Service

PROPOSAL TO INCLUDE MEDICAL SAVINGS ACCOUNTS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

a briefing for the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

by

WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

DECEMBER 29, 1995

THANK YOU FOR THE INVITATION TO BRIEF YOU ON THE PROPOSED INCLUSION OF MEDICAL SAVINGS ACCOUNTS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM.

MEDICAL SAVINGS ACCOUNTS (MSA) ARE A RELATIVELY NEW CONCEPT WHICH PROPONENTS DESCRIBE AS A NON-BUREAUCRATIC APPROACH TO HEALTH CARE REFORM. THE IDEA COMBINES RELATIVELY LOW-COST CATASTROPHIC HEALTH INSURANCE, WHICH FEATURES A DEDUCTIBLE OF $1,500 OR MORE BEFORE BENEFITS BEGIN, WITH AN INDIVIDUAL MSA. IDEALLY, MSAs WOULD PERMIT TAX-FREE ACCUMULATION OF FUNDS TO PAY FOR ANY QUALIFIED MEDICAL EXPENSES THAT ARE NOT REIMBURSED BY INSURANCE BECAUSE THEY ARE BELOW THE INSURANCE DEDUCTIBLE OR ARE SIMPLY EXCLUDED UNDER THE POLICY.

UNDER THE MSA SCENARIO, HEALTH CARE COSTS WOULD DECREASE, FIRST, BECAUSE INDIVIDUALS, OR EMPLOYERS ON BEHALF OF EMPLOYEES, WOULD PURCHASE LESS COSTLY INSURANCE POLICIES TO COVER ONLY LARGE, UNBUDGETABLE EXPENSES AND WOULD DEPOSIT RESULTING PREMIUM SAVINGS, AND PERHAPS ADDITIONAL CONTRIBUTIONS, INTO INDIVIDUALLY-OWNED MSAs ON A PRE-TAX BASIS. EACH ACCOUNT OWNER WOULD NOT ONLY HAVE TAX-FREE ACCESS TO ACCUMULATED MSA FUNDS TO PAY OUT-OF-POCKET EXPENSES THE ACCOUNT OWNER INCURS FOR QUALIFYING MEDICAL CARE, BUT WOULD ALSO HAVE AN INCENTIVE TO AVOID ANY UNNECESSARY HEALTH CARE SPENDING IN ORDER TO BUILD SAVINGS. IN ADDITION, TO THE EXTENT THAT CONSUMERS BECOME MORE COST-CONSCIOUS IN SHOPPING FOR MEDICAL SERVICES THEY PAY FOR DIRECTLY, THERE WOULD BE GREATER COMPETITION AMONG HEALTH CARE PROVIDERS TO LIMIT COSTS, AND THE GROWTH OF NATIONAL HEALTH CARE EXPENDITURES WOULD SLOW.

THE U.S. CHAMBER OF COMMERCE HAS ENDORSED MSAs AND AT LEAST A DOZEN STATES PERMIT STATE TAX DEDUCTIONS FOR MSA CONTRIBUTIONS. BUT, WHILE A FEW EMPLOYERS HAVE INTRODUCED PROTOTYPE HIGH-DEDUCTIBLE/MSA HEALTH PLANS, MSAs ARE LARGELY UNTESTED SINCE THEY DON'T CONFER FEDERAL TAX ADVANTAGES FOR EMPLOYERS AND INDIVIDUALS AS DO EMPLOYER-PROVIDED HEALTH INSURANCE, FLEXIBLE

SPENDING ACCOUNTS, OR INDIVIDUAL RETIREMENT ACCOUNTS. THE 1995 BUDGET RECONCILIATION BILL PASSED BY EACH HOUSE OF CONGRESS WOULD ESTABLISH POWERFUL INCENTIVES FOR MSAs BY CHANGING THE FEDERAL TAX CODE TO TREAT MSAs SIMILAR TO 401(k) RETIREMENT SAVINGS PLANS--ALLOWING EMPLOYERS AND EMPLOYEES TO MAKE PRE-TAX CONTRIBUTIONS TO ACCOUNTS THAT WOULD GROW TAX-FREE AND BE INDIVIDUALLY OWNED--AND BY INTRODUCING MSAs AS AN OPTION FOR MEDICARE BENEFICIARIES. ANOTHER BILL, H.R. 2341, WOULD INCLUDE MSAs UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM. OPM IS VERY CONCERNED THAT ANY PUSH FOR WHOLESALE USE OF MSAs, GIVEN THE LIMITED EXPERIENCE WITH THEM, IS PREMATURE.

SOME WHO BELIEVE THAT THE MSA CONCEPT WOULD HELP CONTAIN HEALTH CARE COSTS POINT TO A SCIENTIFIC STUDY DONE BY THE RAND CORPORATION IN THE 1970'S WHICH SHOWED THAT SPENDING FOR MEDICAL SERVICES DECREASED IN RESPONSE TO INCREASED COST-SHARING, WITH NO APPARENT DIFFERENCE IN HEALTH OUTCOMES FOR THE VARIOUS GROUPS. IT IS IMPORTANT TO RECOGNIZE, HOWEVER, THAT COUNTLESS CHANGES HAVE DRAMATICALLY RESHAPED THE HEALTH INSURANCE MARKET IN THE 20 YEARS SINCE THAT STUDY. THEN, FEE-FOR-SERVICE PLANS WITH FIRST-DOLLAR COVERAGE WERE COMMON UNDER HEALTH INSURANCE CONTRACTS AND MANAGED CARE WAS IN ITS INFANCY. THE CONGRESSIONAL BUDGET

OFFICE HAS CONCLUDED THAT THE HIGH-DEDUCTIBLE INSURANCE/MSA OPTION WOULD HAVE LESS POTENTIAL FOR CURBING NATIONAL HEALTH SPENDING THAN THE RAND EXPERIMENT IMPLIES FOR TWO REASONS. FIRST, THE RAND EXPERIMENT INVOLVED ONLY FEE-FOR-SERVICE REIMBURSEMENT, WHEREAS MSAs MAY ATTRACT PEOPLE FROM HEALTH MAINTENANCE ORGANIZATIONS SO THAT THE EFFICIENCIES OF MANAGED CARE WOULD BE LOST. ALSO, UNINSURED MEDICAL EXPENSES WHICH PEOPLE NOW PURCHASE WITH AFTER-TAX INCOME WOULD BECOME TAX-EXEMPT EXPENDITURES WITH AN MSA, SO SPENDING WOULD LIKELY INCREASE FOR SERVICES SUCH AS EYE CARE, ORTHODONTIC CARE, AND OTHER SERVICES WITH LIMITED COVERAGE UNDER CONVENTIONAL HEALTH INSURANCE.

A MAY 1995 REPORT OF THE AMERICAN ACADEMY OF ACTUARIES, ENTITLED MEDICAL SAVINGS ACCOUNTS, COST IMPLICATIONS AND DESIGN ISSUES, IDENTIFIES A WIDE RANGE OF POSSIBLE EFFECTS FROM MSA USE, DEPENDING UPON HOW THIS OPTION IS INTEGRATED WITH EXISTING HEALTH INSURANCE PLANS. THE REPORT NOTES THAT SINCE MSA ELIGIBILITY REQUIRES HEALTH INSURANCE WITH AT LEAST A $1,500 DEDUCTIBLE, THE POTENTIAL INCREASE IN INDIVIDUAL COPAYMENTS WILL EXCEED ANNUAL PREMIUM SAVINGS WHICH WOULD BE GAINED BY CHANGING FROM LOW-DEDUCTIBLE INSURANCE. SO, MSAs WOULD BE MOST ATTRACTIVE TO PERSONS WHO HAVE LITTLE OR NO HEALTH CARE EXPENDITURES AND LEAST ATTRACTIVE

TO THOSE WITH HIGH HEALTH CARE EXPENSES, PARTICULARLY THE ELDERLY. AND, IF MSAs ARE COMPLETELY OPTIONAL, RISK SEGMENTATION COULD RESULT IN A DESTRUCTIVE COST SPIRAL FOR LOW-DEDUCTIBLE COVERAGE.

THE REPORT SUGGESTS THAT AN MSA OPTION OFFERED IN A CONTROLLED SITUATION SUCH AS AN EMPLOYER HEALTH PLAN MIGHT BE DESIGNED TO AVOID THE COST SPIRAL BY MAINTAINING THE SAME RELATIVE LEVEL OF EMPLOYEE CONTRIBUTIONS AMONG THE VARIOUS OPTIONS FROM YEAR TO YEAR. IN CONCLUSION, THE REPORT STRONGLY CAUTIONS THAT ACHIEVING MAXIMUM SAVINGS FROM MSAs WILL DEPEND HEAVILY ON THE DESIGN OF THE ENABLING LEGISLATION TOGETHER WITH INDIVIDUAL ACTIONS UNDERTAKEN BY EMPLOYERS IN REDESIGNING EXISTING HEALTH PLANS AROUND AN MSA. SAVINGS ALSO WILL DEPEND ON THE DEGREE TO WHICH INDIVIDUALS VIEW THEIR MSA AS A PERSONAL SAVINGS ACCOUNT, AS OPPOSED TO ALTERNATIVE INSURANCE. IF INDIVIDUALS VIEW THEIR MSA AS ADDED INSURANCE, UTILIZATION WOULD APPROXIMATE THAT WITH A LOW-DEDUCTIBLE PLAN.

WITH THESE CONCERNS IN MIND, I WISH TO BRIEFLY DISCUSS THE PROPOSAL TO INTRODUCE MSAs UNDER THE FEHB PROGRAM. H.R. 2341 WOULD AUTHORIZE OPM TO CONTRACT WITH GOVERNMENTWIDE INSURERS AND ELIGIBLE EMPLOYEE ORGANIZATIONS, BEGINNING IN 1997, FOR AN

UNSPECIFIED NUMBER OF CATASTROPHIC HEALTH PLANS WHICH OFFER BENEFITS SIMILAR TO OTHER FEHB PLANS, BUT ONLY TO THE EXTENT THAT COVERED EXPENSES EXCEED $3,000 A YEAR. ANYONE WHO ENROLLS IN A CATASTROPHIC HEALTH PLAN WOULD NO LONGER BE SUBJECT TO THE USUAL 75-PERCENT LIMIT ON GOVERNMENT CONTRIBUTIONS TOWARD A PLAN'S ENROLLMENT CHARGE; THEY WOULD ALWAYS RECEIVE THE MAXIMUM GOVERNMENT FEHB CONTRIBUTION AMOUNT. SUCH CONTRIBUTION WOULD FIRST PAY UP TO THE ENTIRE PREMIUM FOR THE CATASTROPHIC PLAN PREMIUM AND ANY REMAINING CONTRIBUTION WOULD GO INTO A MEDICAL SAVINGS ACCOUNT MAINTAINED FOR THE INDIVIDUAL'S BENEFIT IN ACCORDANCE WITH APPLICABLE INTERNAL REVENUE CODE PROVISIONS.

OPM ACTUARIES PROJECT THAT ANNUAL ENROLLMENT CHARGES FOR A TYPICAL FEHB FEE-FOR-SERVICE PLAN FEATURING A DEDUCTIBLE OF $3,000 FOR SELF-ONLY, OR $6,000 FOR SELF-AND-FAMILY, WOULD BE $1,400 AND $3,100, RESPECTIVELY. MAXIMUM GOVERNMENT FEHB CONTRIBUTIONS IN 1996 WILL BE APPROXIMATELY $1,600 FOR SELF-ONLY AND $3,400 FOR FAMILY ENROLLMENTS. SO, IF H.R. 2341 WAS IN EFFECT FOR 1996, ENROLLEES IN CATASTROPHIC HEALTH PLANS WOULD PAY NO FEHB PREMIUMS AND WOULD RECEIVE A $200 TO $300 MSA CONTRIBUTION, WHILE FEHB ENROLLEES IN GENERAL WOULD PAY APPROXIMATELY $570 FOR

SELF AND $1,400 FOR FAMILY COVERAGE. BASED THE WEIGHTED AVERAGE OF ALL FEHB PREMIUMS. EVEN IF ENROLLEES IN CATASTROPHIC PLANS ALSO CONTRIBUTED THEIR PREMIUM SAVINGS TO THEIR MSAs AND MADE NO WITHDRAWALS, IT WOULD TAKE THEM 3 TO 4 YEARS TO ACCUMULATE SUFFICIENT FUNDS TO OFFSET THE $3,000 OR $6,000 CATASTROPHIC DEDUCTIBLE. SO, THIS OPTION WOULD LARGELY APPEAL TO EITHER VERY HEALTHY OR FINANCIALLY WELL-OFF PEOPLE!

CERTAINLY, OPM WANTS THE FEHB PROGRAM TO OFFER EVERY OPPORTUNITY FOR ADDED CHOICE, AFFORDABLE HEALTH CARE, AND QUALITY MEDICAL SERVICES. HOWEVER, EXPERIENCE WITH MSAs TO DATE IS SO LIMITED THAT IT RAISES MORE QUESTIONS THAN IT ANSWERS. THE FEHB PROGRAM IS WIDELY REGARDED AS A HIGHLY SUCCESSFUL EMPLOYER-SPONSORED HEALTH BENEFITS PROGRAM. OVER THE LAST SEVERAL YEARS, MANY HAVE PROMOTED IT AS A USEFUL MODEL FOR EFFORTS TO PROVIDE ACCESS TO QUALITY HEALTH CARE NATIONALLY. OPM BELIEVES THAT MSAs COULD SIGNIFICANTLY ALTER THE WAY THAT THE FEHB PROGRAM DELIVERS ITS BENEFITS AND WE ARE CONCERNED THAT NO HARM BE DONE TO THE PROGRAM OR ITS ENROLLEES.

WE ARE GREATLY CONCERNED THAT THE INCLUSION OF MSAs IN THE FEHB PROGRAM, WHICH OFFERS THE SAME BENEFITS TO BOTH ACTIVE AND

RETIRED PARTICIPANTS, WOULD LEAD TO SEGREGATION OF PEOPLE IN PLANS BY RISK CATEGORIES. HEALTHY INDIVIDUALS WHO CONSIDER THEMSELVES AT LOW RISK FOR OUT-OF-POCKET MEDICAL EXPENSES WOULD TEND TO ELECT THE CATASTROPHIC-PLUS-MSA OPTION. AS A RESULT, OTHER FEHB PLANS WOULD ENROLL A HIGHER PROPORTION OF INDIVIDUALS WHOSE HEALTH PROFILE IS POOR, PARTICULARLY AMONG THE ELDERLY; AVERAGE PER-PERSON COSTS AND ASSOCIATED PREMIUMS FOR THESE PLANS WOULD INCREASE MORE RAPIDLY THAN IF THE RISK POOL WAS REPRESENTATIVE OF THE ENTIRE ELIGIBLE POPULATION; AND MORE OF THE HEALTHIEST ENROLLEES WOULD LEAVE WITH SUCCESSIVE PREMIUM INCREASES. WITHIN A 3 TO 5-YEAR PERIOD, IT IS LIKELY THAT SUCH ADVERSE SELECTION WOULD DRIVE UP THE COST OF CONVENTIONAL TYPES OF COVERAGE SIGNIFICANTLY, PUTTING THEM BEYOND THE REACH OF MANY WHO NEED THEM. INCREASINGLY, EVEN PEOPLE WITH COSTLY, CHRONIC HEALTH CONDITIONS COULD BE FORCED INTO CATASTROPHIC PLANS THAT REQUIRE THEM TO PAY $3,000 OR MORE OUT OF POCKET EVERY YEAR.

MOREOVER, THE COMBINATION OF MSAs WITH THE ANNUAL FEHB OPEN ENROLLMENT SEASON BRINGS THE PROSPECT OF ADVERSE SELECTION AMONG GENERALLY HEALTHY PEOPLE AS WELL. FOR EXAMPLE, MSA PARTICIPANTS WHO CAN ANTICIPATE THE NEED FOR AN EXPENSIVE PROCEDURE WILL HAVE AN INCENTIVE TO JOIN A PLAN THAT PROVIDES THE

MOST COMPREHENSIVE COVERAGE, HAVE THE PROCEDURE PERFORMED, AND RETURN TO CATASTROPHIC, MSA-LINKED COVERAGE IN THE FOLLOWING OPEN SEASON. COMBATING SUCH BEHAVIOR WITH WAITING PERIODS AND BARS TO PRE-EXISTING CONDITIONS WOULD UNDO ONE OF THE FEHB PROGRAM'S MAJOR STRENGTHS. OPM HAS WORKED HARD TO CONTROL THE FEHB PROGRAM'S PREVIOUS PROBLEM WITH ADVERSE SELECTION AFTER THIS CAUSED ONE OF THE TWO GOVERNMENTWIDE PLAN CARRIERS TO QUIT THE PROGRAM IN 1989 AND OUR SENSE IS THAT THE INTRODUCTION OF MSAs ON A PURELY OPTIONAL BASIS WOULD CAUSE THE PROBLEM TO REAPPEAR.

TODAY, ABOUT 30 PERCENT OF ENROLLEES ARE IN HMOs WHICH ALREADY EXERT INSTITUTIONAL CONTROL ON UTILIZATION THAT MSAs ARE INTENDED TO ENCOURAGE AMONG INDIVIDUALS. ANOTHER COMPONENT OF MANAGED CARE THAT COULD BE LOST UNDER MSAs IS THE COST-SAVING POWER OF PREFERRED PROVIDER ORGANIZATION (PPO) NETWORKS. PPO NETWORKS OF HOSPITALS, PHYSICIANS, AND PHARMACIES REDUCED MEDICAL EXPENSES PAID UNDER THE FEHB PROGRAM BY ABOUT $1.3 BILLION IN CONTRACT YEAR 1994. THESE SAVINGS WERE REALIZED BECAUSE PROVIDERS AGREED TO PRACTICE PATTERNS AND/OR OFFERED SUBSTANTIAL DISCOUNTS IN RETURN FOR ACCESS TO A LARGE EMPLOYEE GROUP. THE SIZE OF THE DISCOUNTS WILL ERODE IF THE GROUP IS FRAGMENTED, PARTICULARLY IF THE HEALTHIER LIVES ARE REMOVED FROM THE RISK POOL. MSAs DO NOT TAKE ADVANTAGE

OF THE LARGE MANAGED CARE COMPONENT CURRENTLY AT WORK IN THE FEHB PROGRAM.

IT ALSO APPEARS LIKELY THAT MSAs WOULD UNDERMINE INCENTIVES TO OBTAIN PREVENTIVE HEALTH CARE SERVICES SINCE THE COST OF SUCH CARE WOULD ORDINARILY BE BORNE EXCLUSIVELY BY AN INDIVIDUAL WHO IS SUBJECT TO A CATASTROPHIC DEDUCTIBLE. IGNORING OR DEFERRING PREVENTIVE CARE HAS BEEN DEMONSTRATED TO BE A FACTOR IN THE EMERGENCE OF LATE, MORE EXPENSIVE MEDICAL CONDITIONS.

FINALLY, CATASTROPHIC HEALTH INSURANCE LINKED TO MSAs MAY DO LITTLE TO MODERATE INCREASES IN HEALTH CARE COSTS IN THE LONG RUN SINCE MOST SPENDING IS CONCENTRATED ON A SMALL PERCENTAGE OF PEOPLE WHO ARE BEYOND THE COST-REDUCING INCENTIVES OF EVEN A CATASTROPHIC DEDUCTIBLE. ONCE SOMEONE HAS A CONDITION FOR WHICH TREATMENT COSTS WILL EXCEED THE DEDUCTIBLE, THE INCENTIVE TO ECONOMIZE IS GONE BECAUSE THE ADDITIONAL COST OF MORE CARE IS ZERO.

IN CLOSING, WE THINK THE APPROPRIATE COURSE FOR NOW, AS FAR AS THE FEHB PROGRAM AND MSAs ARE CONCERNED, IS "WAIT-AND-SEE." IF FEDERAL TAX CODE CHANGES AFFORD MSAs TREATMENT COMPARABLE TO

HEALTH INSURANCE AND RETIREMENT SAVINGS ACCOUNTS. WE SHOULD ALLOW A REASONABLE OPPORTUNITY TO CAREFULLY STUDY HOW VARIOUS INSURERS AND EMPLOYERS APPLY THE CONCEPT, AS WELL AS THE RESPONSE OF CONSUMERS AND HEALTH CARE PROVIDERS. THE DEMOGRAPHIC DIVERSITY PRESENT IN THE FEHB PROGRAM AND THE BROAD RANGE OF CHOICE WHICH IS AN INTEGRAL PART OF THE PROGRAM MAKE IT VERY SUSCEPTIBLE TO RISK SEGMENTATION. IT IS UNLIKE ANY OTHER PROGRAM IN THIS RESPECT AND FOR THIS REASON NEW BENEFITS MUST BE APPROACHED WITH EXTREME CAUTION.

I WOULD NOW BE HAPPY TO ANSWER ANY FOLLOW-UP QUESTIONS THE SUBCOMMITTEE MAY HAVE.

Comments on Medical Savings Accounts within the FEHB

Introduction

The Office of Personnel Management (OPM) has learned that the House of Representatives may consider the establishment of Medical Savings Accounts (MSAs) in the Federal Employees Health Benefits Program (FEHBP) as part of its action on the Reconciliation Bill or other legislation this Fall.

The proposed legislation envisions that the Government would:

- provide MSA participants an uncapped Government contribution up to the maximum dollar amount determined under the statutory computation formula (but maintain the 75 percent cap on other insurers and Health Maintenance Organizations participating in the Program);

- pay the entire cost of the catastrophic premium;

- contribute the balance of the Government's contribution into the employee's MSA.

This particular proposal has not been the subject of any hearings in the Congress. Indeed, the House Government Reform and Oversight Committee has scheduled hearings on Medical Savings Accounts for mid-November. The proposed legislation, which is being considered as part of the Reconciliation process has a proposed effective date of January 1, 1996. Implementing such a far-reaching set of changes in the Federal Employees Health Benefits Program on that schedule would be virtually impossible. Even if possible, it would have untold effects on the insurers already in the Program, whose benefit and rate proposals were submitted months ago and upon which negotiations have already been completed.

MSA'S ARE UNTESTED

The OPM believes that MSA's could significantly alter the way that the Program delivers its benefits. The FEHBP is widely regarded as a highly successful employer-sponsored health benefits program. The OPM is concerned about any change in the FEHB that could harm the Program.

There is concern that the inclusion of MSA's in the FEHB Program could segregate people into risk categories. Healthier, generally younger employees would tend to select MSA's over other programs. Individuals whose health profile is poor, particularly the elderly, could tend to become isolated in plans offered by other insurers, driving up the costs of their coverage significantly.

- In a typical year, 17 percent of the elderly covered by Medicare file no claims; the proportion of younger people who have no medical claims is substantially higher.

- Government studies show about 10 percent of all Americans are responsible for about 70 percent of medical expenses. A 1995 study by the American Academy of Actuaries found that if everyone now covered by ordinary medical insurance moved into a system of high deductibles and medical savings accounts, roughly two-thirds--those who need little or no medical treatment-- would gain financially and one-third would lose.

Since healthy people would be most likely to choose the MSA approach, those remaining under low-deductible health insurance policies would tend to be sicker people. As a result, the per-person costs for low-deductible policies could increase more rapidly than if the costs were based on groups representative of the entire population. The cost of conventional health insurance for frail and sick people who continue to want comprehensive coverage may eventually soar out of reach.

The combination of MSA's with the annual FEHB Open Season brings the prospect of adverse selection among the healthy as well. For example, MSA participants who require expensive but elective procedures will have an incentive to join a plan that provides the more comprehensive coverage, have the procedures performed, and return to the MSA during the following open season. Combating such behaviors with waiting periods and bars to pre-existing conditions would undo one of the FEHB Program's major strengths.

The OPM has worked hard to control this problem of adverse risk selection and is concerned that the introduction of MSA's would cause it to reappear.

MANAGED CARE SAVINGS COULD ERODE

Medical Savings Accounts do not take advantage of the large managed care component currently in the FEHBP. Today about 30 percent of enrollees are in HMOs which already exert the control on utilization that MSA's are intended to encourage. Another component of managed care that could be lost under MSA's is the cost saving power of PPO networks. PPO networks of hospitals, physicians and pharmacies reduced medical expenses paid under the FEHBP by about $1.3 billion in contract year 1994. These savings were realized because providers agreed to practice patterns and/or offered substantial discounts in return for access to a large employee group. The size of the discounts will erode if the group is fragmented, particularly if the healthier lives are removed from the risk pool.

REDUCED INCENTIVES FOR PREVENTIVE CARE

It has been suggested that MSA's eliminate incentives to obtain preventive care since the cost of such care would ordinarily be borne exclusively by the individual. Ignoring or deferring preventive care has been demonstrated as a factor in the emergence of later, more expensive medical conditions

POTENTIAL FOR OVERALL SAVINGS UNCLEAR

While MSA's might bring consumers into the health care arena as active players, it is doubtful that MSA's would affect consumption of the more costly medical services since those decisions generally are made by doctors and not patients. Since 70 percent of medical claims occur after $3,000, MSA's will not dramatically reduce the costs of non-elective medical treatments.

Catastrophic health insurance may do little to moderate increases in FEHB costs in the long run since most spending is concentrated on a small percentage of people who are beyond the cost-reducing incentives of a deductible. Once someone has a condition for which treatment costs will exceed the deductible, the incentive to economize is gone because the additional cost of more care is zero.

Conclusion

All of these factors suggest that the Government as an employer should move deliberately in this area. The OPM has a successful track record, forged through a remarkable partnership between the Legislative and Executive branches, in offering a wide variety of health benefit choices which are competitively priced and highly regarded by both employees and health policy commentators.

OPM wants the Federal Employees Health Benefits Program to offer opportunities for added choice, affordable health care and quality medical services. However, many questions exist about how these objectives might be achieved with the introduction of MSA's. In order to carefully consider these matters, the Congress should stick to its plan and hold extensive hearings on the matter. The OPM believes that the Medical Savings Account proposal being considered as part of either the Reconciliation Bill or other legislation should not proceed further until all parties have had adequate opportunity to consider this matter.

1. Has the Administration formulated an official position with regard to MSAs in the FEHB Program?

The Federal Employees Health Benefits (FEHB) Program is widely regarded as a highly successful employer-sponsored health benefits program. Over the last several years, many have promoted it as a useful model for efforts to provide access to quality health care nationally. Certainly, OPM wants the FEHB Program to offer every opportunity for added choice, more affordable health care, and access to quality medical services. But, we are concerned that MSAs could significantly alter the way that the FEHB Program delivers its benefits and we want to be reasonably certain that any change will do no harm to the FEHB Program or its enrollees.

There is relatively little actual experience with the MSA concept to date. As testimony at a Subcommittee hearing on December 13th reflected, such experience involves relatively small groups who typically have a very limited range of plan choices. These groups obviously are not representative of the FEHB Program, which covers more than 9 million people, offers a broad range of options, and has been highly successful in recent years at achieving savings through promotion of prepaid medical plans and a variety of other managed care mechanisms. The MSA proponents who testified conceded that their health plans provided very limited options, with MSAs being the only option in some cases, and that given a wide choice of health plans, adverse selection could be a problem.

As a responsible health plan administrator, OPM wants to know more about the potential consequences of MSAs before endorsing them for the FEHB Program. The Administration has also expressed concern that proposals to offer Medicare beneficiaries the MSA option could lead to fragmentation of the risk pool and increased costs.

options available. If costs increase despite a low cost for the MSA subset, that is an indication of adverse selection in the group as a whole."

c. **Have you found any evidence that HMOs in the FEHB Program have led to adverse selection? If so, what steps have you taken, or should Congress take, to address this problem?**

Adverse selection is a function of the benefits offered by plans and choice. Any time there is a wide array of plan benefit designs with choice there will be differential rates of selection. To eliminate this effect requires standard plan design. OPM, in response to adverse selection in the 1980's, took steps to move toward a more standardized plan design. We set minimum benefit levels to minimize the divergence of plan design and this has led to a stabilization of the Program. MSAs are so different in terms of structure and benefit design that we believe the potential exists for unmanageable levels of adverse selection.

2. a. Have you done any analysis regarding the assertion that MSAs would cause adverse selection in the FEHB Program?

We have not done any quantitative analysis of the effect MSAs would have on the FEHBP with regard to adverse selection. however we have studied adverse selection in the FEHBP.

A 1988 study, commissioned by OPM and performed by the benefits consulting firm of Towers, Perrin, Forster and Crosby, Inc., found the following:

> "The history of FEHBP is a study in the erosion of the group insurance principle by risk selection. The essence of group insurance is to pool together a large group of people representing various levels of risk so that cross subsidies occur between young and old and sick and healthy, and the entire group can be insured at a reasonable charge per individual. The introduction of choice into a group insurance program is always problematic, but the introduction of unfettered choice among plans sponsored by different competing entities, as in the FEHBP, virtually guarantees risk selection.
>
> Risk selection occurs when individuals representing the same level of risk congregate in a given plan or option. Low health risks may know that they are healthy and, given the choice, will likely seek less costly and less comprehensive health benefit plans than higher health risks. Insurers seek to attract these people because, as a group, they usually generate favorable claims experience. This allows premiums to remain low relative to plans that enroll higher risks, thus attracting additional participants who are low health risks."

b. Has there been any evidence of adverse selection in the private sector where MSAs are in place?

We are not aware of adverse selection in the private sector where MSAs are in place, but it is important to realize that selection occurs over a period of time, so little evidence would have emerged by this point in time. Also, the diversity of the FEHBP is much greater than the environment in which MSAs are being introduced in the private sector.

The May 1995 report of the American Academy of Actuaries noted that

> 'Measurement of costs must, by necessity, be on an aggregate basis. If only the healthiest employees are choosing the MSA arrangement than achieving lower costs for the MSA arrangement, as compared to other options, should not be the criterion used for measuring success or reducing costs. Rather, costs should be measured across the entire group and all the

3. Have you done any enrollee surveys of the FEHB population to determine the interest in MSAs as a health care option?

No, OPM has not surveyed FEHB enrollees to determine the level of interest in MSAs. Since there is only limited experience with the MSA concept, and little to rely on for purposes of predicting how the concept would work in a very large environment such as the FEHB Program, we think a survey would be premature. We want to avoid creating unrealistic expectations or confusion for FEHB participants.

4. The National Treasury Employees Union (NTEU) released a press release the day of the hearing which stated "Enrollees would be tempted to join a traditional health care plan in years which they anticipated high health care needs."

   Has OPM conducted any studies regarding the success of the average enrollee to guess what their health care needs will be in the following plan year?

   Assuming that an enrollee could predict his health care needs accurately, has OPM found that there is a substantial percentage of the FEHB population that changes health plans based strictly on anticipated health care needs?

OPM has not conducted any studies focused on the enrollees' ability to guess their health care needs. However, some carriers in the FEHB Program study first-year claims costs for not only FEHB participants, but new enrollees in general, so we have some anecdotal information. Those studies have indicated that first year costs are often higher than in subsequent years, leading to a conclusion that some people do predict their health care needs, and choose on that basis. A 1990 survey, prepared for OPM by Science Management Corporation, found that among employees the third most frequent reason for choosing a plan was the special benefits that it provides.

At the same time, only about 5 percent of FEHB enrollees change health plans during the annual open enrollment period. This, we believe, reflects our efforts to minimize differences in plan design. The situation would likely be different if the Program permitted widely divergent plan designs.

5. a. **At a previous hearing of the Subcommittee, the President of the American Federation of Government Employee (AFGE), John Sturdivant, testified that "...the FEHBP's relatively high premium costs for employees have left roughly 400,000 Federal employees uninsured."**

Has OPM conducted any studies to determine the actual number of uninsured Federal employees? It has been suggested that the 400,000 figure is exaggerated and that it includes employees who voluntarily opt-out of the FEHB Program because they have insurance elsewhere. What number of the supposedly uninsured Federal employees are insured elsewhere?

Our best information, as of September 30, 1994, suggests about 530,000 employees who are eligible are not enrolled. The 1990 Science Management Corporation survey, commissioned by OPM, found people not insured for a variety of reasons. To be more precise, we would have to redo this type of study. However, projecting the survey results to our current enrollment records would indicate about 75,000 eligibles don't participate because of cost and this translates to about 200,000 covered lives. Another 75,000 eligibles say they "don't need" health insurance or have other reasons for non-participation. Of the remaining eligibles not enrolled, about 165,000 are covered by someone else in the FEHBP and 215,000 are covered by a non-FEHBP plan.

b. **If MSAs were introduced into the FEHB Program, would MSA enrollees have any health premiums automatically withdrawn from their paychecks?**

If MSAs were introduced to the FEHBP any health premiums or deductions could be handled through payroll offices in a similar manner to current withholdings.

c. **How would MSAs affect the uninsured population?**

If those uninsured because of cost were offered MSAs without cost, they would likely join and the Government would incur additional cost. Additionally, some of those covered by non-FEHBP plans would join the MSA and the Government would incur further additional cost.

PRESIDENT'S MEDICARE PROPOSAL

The Medicare savings and structural reforms included in the President's balanced budget proposal have been carefully designed to strengthen the Medicare Trust Fund, expand health plan options for beneficiaries and assure that Medicare benefits continue to be affordable for the 37 million elderly and disabled Americans the program serves.

The Medicare Trust Fund is Strengthened through 2011. The savings and structural changes assure the financial health of the Medicare Trust Fund through 2011 -- placing the Fund in a better position than it has been in 18 out of the last 20 years.

We Have Specific and Scorable Savings. The Administration has outlined specific and scorable program policy changes that assure program efficiency and achieve $124 billion in savings. It does this without undermining the structural integrity of the program or imposing new costs on beneficiaries.

Our Cuts are Significantly Less than the Republican Conference Agreement. We propose less cuts for all major categories of the program (i.e., beneficiaries, hospitals, physicians, home health care providers and nursing homes). We have significant differences, in particular, on our beneficiary and hospital cuts. We have about $50 billion less in beneficiary cuts and at least $25 billion less in hospital cuts (as much as $44 billion if the failsafe is included) than the Republican conference agreement. (See attached charts.)

Our Reforms Hold the Medicare Per Person Program Growth Rate to Approximately that of the Private Sector. On a per person level, we hold the Medicare program to a growth rate that is slightly less than the 7.1 percent per person private sector growth rate as estimated by the Congressional Budget Office. In contrast, the Republican Conference agreement's Medicare cuts would constrain Medicare to over 20 percent below the private sector per person growth rate. (See attached chart.)

Republican Cuts Will Lead to Cost Shifting or Access and Quality Problems. We believe cuts of the magnitude advocated by the Republicans would result in either cost-shifting or reduced quality and access to needed health care providers. This is why the American Hospital Association, the Catholic Health Association, the National Association of Public Hospitals and over 40 state hospital associations say: "the reductions in the conference report will jeopardize the ability of hospitals and health systems to delivery quality care, not just to those who rely on Medicare and Medicaid, but to all Americans."

We Expand Choice of Plans Under Medicare in a Pragmatic, Responsible Way. We retain a strong Medicare fee-for-service program and significantly increase choices of alternative health plans, including new managed care options (PPOs and HMOs with point of service options) as well as provider networks. In contrast, the Republican approach — which includes Medical Savings Accounts and other options that rely on managing risk rather than managing costs -- will significantly fragment the Medicare risk pool.

We Improve Medicare by Expanding Preventive Programs, including better mammography coverage, colorectal screening, and a new respite benefit for families of Alzheimer's patients.

MEMORANDUM

TO: Interested Parties September 28, 1995
FROM: Chris Jennings
RE: CBO (Financial Coercion) Reference and Backup to "Managed Care" Scoring Description

Attached you will find a copy of CBO memo to the Senate Finance Committee staff that outlines the breakout of how CBO scores Medicare Choice. This is the memo that no doubt was used by Robert Pear in today's New York Times article.

As you will note, only $7.1 billion out of the total $47.5 billion in savings cited by the Senate Finance Committee would be attributed to managed care savings. $42.6 billion of savings is produced solely by the fact that the Finance Committee plan has placed a cap on the growth of the managed care plans being utilized by the current Medicare population. Another interesting finding worth noting is that CBO scores Medical Savings Account as $2.3 billion coster to the Medicare program as a result of adverse selection.

Lastly, in their analysis, CBO assumes that the elimination of the state requirement to help pay for low-income elderly beneficiaries premiums, co-payments, and deductibles will result in increased enrollment in managed care for these beneficiaries who can no longer afford their fee-for-services plan.

We are trying to get a sense of how many beneficiaries and how much money is assumed in that projection, but the most important fact, of course, is that CBO clearly states that the beneficiaries would move into these plans as a result of negative financial incentives.

You should feel free to use and circulate as you please. Don't hesitate to call me at 456-5560.

MEMORANDUM September 27, 1995

TO: Julie James
Bruce Lesley

FROM: Murray Ross

SUBJECT: Estimating savings from Medicare Choice in the Chairman's Mark

CBO's estimate of savings from Medicare Choice is the net result of changes in spending from three sources:

- lower updates on payments made on behalf of current enrollees (strictly speaking, the share of Medicare beneficiaries enrolled in risk contracts under current law);
- savings associated with new enrollees (the estimated fraction of Medicare beneficiaries moving from traditional fee-for-service to Choice plans other than high deductible plans); and
- payments on behalf of beneficiaries choosing the high deductible insurance/medical savings account option.

Over seven years, CBO estimates that savings on current enrollees would total $42.6 billion (see attached table). Savings on new enrollees would total about $7.1 billion. Payments to Choice enrollees with high deductible plans would cost about $2.3 billion as a result of adverse selection not fully compensated for by risk adjustment. The net savings attributed to Medicare Choice is $47.5 billion.

CBO's estimate assumes that enrollment in Choice plans (including high deductible plans) would reach about 22% of Medicare beneficiaries by 2002, compared with the 14% of beneficiaries projected to be covered by risk plans in the CBO baseline. Most of the increase is attributable to CBO's assumptions about beneficiaries' responses to the new government-coordinated open enrollment process and expanded choices. CBO assumed that there would be a short-run increase in enrollment reflecting these factors, but a slightly lower rate of growth in future enrollment. In addition, CBO assumed that eliminating the entitlement to cost-sharing for Medicaid eligibles and QMBs would increase enrollment as those beneficiaries sought out plans with lower cost-sharing requirements.

CBO ASSUMPTIONS UNDERLYING CALCULATION OF MEDICARE CHOICE SAVINGS

CHANGE IN SPENDING (Billions of dollars)	Fiscal Years 1996	1997	1998	1999	2000	2001	2002	Tota
Baseline Enrollees	-0.4	-1.9	-3.6	-5.4	-7.5	-10.2	-13.7	-42.6
New Enrollees (excluding high deductible plans)	-0.0	-0.1	-0.7	-1.0	-1.3	-1.8	-2.3	-7.1
High-Deductible Plans/MSAs	0.0	0.4	0.4	0.4	0.4	0.4	0.4	2.3
Total	-0.4	-1.5	-3.9	-6.0	-8.4	-11.6	-15.7	-47.5

MANAGED CARE ENROLLMENT (As percent of all Medicare beneficiaries)	1996	1997	1998	1999	2000	2001	2002
CBO Baseline (risk contracts only)	8	9	10	11	12	13	14
Medicare Choice	8	13	17	19	20	21	22
Risk Plans	8	12	16	18	19	20	21
High-Deductible Plans/MSAs	0	1	1	1	1	1	1

Note: Change in spending is difference from Budget Resolution baseline.

Source: Preliminary Congressional Budget Office estimates based on policy in Chairman's mark and discussions with Committee staff.

09/27/9

Medical Savings Accounts (MMAs) have been proposed as an option both for the Medicare system and for the private health insurance market. Since the Medicare version has hit the news most in recent weeks, we begin by examining that concept, and then turn to specific issues regarding the private market. However, the principal issues are the same for both kinds of MMAs.

MEDICARE MEDICAL SAVINGS ACCOUNTS

Giving seniors more choice in choosing health care options has been one of the most touted planks of the GOP's medicare-cutting proposals. Both the House and Senate proposals ostensibly offer seniors more options for coverage. Both would allow seniors to withdraw from the traditional medicare pay-for-service system and join HMOs or, more relevant here, set up "medicare medical savings accounts" ("MMSA").

What is a Medicare Medical Savings Account?

In essence, the Medical Savings Account option would allow a beneficiary to elect to receive a check from the medicare system equal to the average amount the Medicare program spends each year on a beneficiary -- roughly $5,200 per year in 1995. (Under some proposals, this average would be "risk adjusted" to take into account characteristics like age, gender, geography, etc.). The contribution would be used to buy a health insurance policy with a very high deductible -- up to $3000 in the Senate version and up to $10,000 in the House version [check]. And any money remaining after that expense would be deposited into the "medical savings account." Those funds would be used to pay any deductible cost for health care expenses during the year. Beneficiaries would also be able to withdraw some of the funds for other purposes, so long as the account maintained a minimum balance equal to __% or more of the deductible amount.

What are some of the benefits of Medicare Medical Savings Accounts?

Republicans see both practical and ideoligical benefits to the MSA concept.

- Fewer unnecessary procedures. Practically speaking, Republicans see MSA's as a cost-containment method. Since MSA-holders would bear the full cost of any health care procedure up to the deductible limit, particpants would have a strong incentive to cut back on unnecessary tests and procedures. Some claim that MSAs will achieve high savings, but none of the recent studies have been able to reach any definitive conclusions about the magnitude of the savings.

- Less Government. MMSAs also appear to have an ideological appeal, since they embrace a non-governmental approach to

health care coverage. Indeed, for at least some Republicans, MSAs are probably viewed as the opening wedge of a plan to unravel the medicare program once and for all. Once MMAs take hold, it may be just a matter of timne before the whole system collapses.

Given the practical and ideological appeal of the MMSA concept, it is highly likely that some kind of MSA option will be included in the Republican medicare proposal.

What's wrong with the Medicare Medical Savings Account?

Irrespective of the benefits, the MMSA concept has a number of serious drawbacks. It essentially gives a costly subsidy to the healthiest and wealthiest beneficiaries, while putting just about every one else in the medicare system at great risk. For that reason, VHI-Lewin recently concluded that, "the MSA model as currently conceived is actuarilly unsound."

- MSA's will benefit only the healthiest and wealthiest beneficiaries -- those who need help the least. MSAs will attract only the wealthiest beneficiaries -- who will be willing to take a risk on a high deductible program -- and the healthiest ones -- who will be confident of receiving more from the medicare system (based on the average cost of providing health care) than they would pay out in health care costs. CBO projects that only 1% of the medicare population will ultimately open an MSA program. VHI-Lewing predicts that only 3% will join.

- MSA's will cost the Medicare system $3 billion dollars or more -- its a good way to break the bank. While MSA holders would receive from the medicare system a check equal to the average cost of care, they actually cost Medicare far less than this average. As a result, MSAs will cost the medicare big bucks. CBO projects a cost of $3 billion over 7 years. VHI-Lewin puts the cost at between $15 and $20 billion, based on conservative assumptions.

- Everyone else loses -- in higher premiums or less care. With the healthiest beneficiaries in MSA plans, the traditional medicare program will be left both with a pool of the more costly beneficiaries and with significantly less money to go around. If CBO and VHI-Lewin are right that MMSAs increase overall medicare spending, the rigid spending caps set forth in the GOP proposals would force a cut back in payments to traditional fee-for-service providers. That would mean that beneficiaries would likely recieve less care -- or fork over higher premiums -- for everyone left in the traditional medicare system.

- More choice -- or less? Apparently, some Republicans are considering adding a provision that would bar MSA-holders

from later opting back into the traditional fee-for-service medicare plan. This "lock-out" provision is a point of great controversy. On one hand, the lock-out provision would could create hardship on individuals that become chronically ill. These individuals may not have saved enough in their MSA to cover the deductible over a series of years. Many beneficiaries would be extremely unhappy with a lock-out policy. On the other hand, without such a policy, individuals could choose the MSA program during their healthy years and opt back into the traditional program as their health declines. Costs would rise.

Recommendation

The negatives of the Medicare Medical Savings Account ~~is~~ are too great. We recommend that you strongly oppose this measure.

Changes in Medicare Program Spending Under Alternative Medical Savings Account Models

Prepared for

The National Committeee to Preserve Social Security and Medicare

By:

John F. Sheils
Gary J. Claxton
Randall A. Haught

Lewin-VHI, Inc.

September 22, 1995

EXECUTIVE SUMMARY

Under the Medical Savings Account (MSA) plan, beneficiaries would have the option of accepting a Medicare voucher that could be redeemed for MSA coverage with a private insurer. Insurers would offer beneficiaries a catastrophic health plan covering expenses over a high deductible amount (e.g., $3,000) together with a contribution to the beneficiary's MSA account equal to the difference between the Medicare voucher amount and the cost of the catastrophic plan. The MSA contribution could be used by enrollees to pay for medical expenses up to the plan deductible amount or to pay for health services that are not otherwise covered under Medicare. Enrollees are at risk only for health expenditures between the MSA contribution amount and the amount of the plan deductible.

The program creates strong selection incentives that would increase Medicare spending. The MSA program would be likely to attract only Medicare beneficiaries who expect to have low health expenses during the year, leaving the most expensive individuals in the traditional Medicare program. This "selection effect" would lead to a substantial net increase in program costs. This is because plans would be paid an amount equal to average beneficiary costs under the current Medicare program even though the individuals who would be inclined to select the MSA option generally would be those who use substantially less than the average amount of care.

In this analysis, we found that even after adjusting plan payments by age, sex and disability status, Medicare payments to MSA plans would be nearly twice what the predominantly healthy MSA enrollee population would have cost under the current Medicare program. The key findings of our analysis include the following:

- Medicare program costs would increase by about $15.3 billion under the MSA program over the 1996 through 2002 period due to selection effects, even if demographic and geographic adjustments are used to set plan payment amounts.[1] This estimate is before applying the fail-safe mechanism included in some proposals that would eliminate cost increases through reductions in provider payments under the traditional Medicare program. We consider this selection effect estimate to be conservative because we have assumed that only a portion of those who could potentially benefit under the plan actually enroll.
- We estimate that only about three percent of all Medicare beneficiaries (1.1 million persons) would enroll in the MSA program in 1996. Our enrollment estimates reflect the fact that not all of those who could potentially benefit under the program would actually enroll due to the risk of incurring uncovered expenses. These estimates also reflect the fact that in many areas of the

[1] This estimate represents an increase over Medicare spending levels permitted under the recent Congressional budget resolution.

country, the Medicare payment amount would not be high enough to finance both a private catastrophic insurance policy and a substantial MSA contribution.

- Those who enroll in the MSA program would tend to be in better than average health. Enrollment is also likely to be greatest in higher income groups where beneficiaries are more likely to be willing to go at risk for a substantial portion of the catastrophic deductible.

- MSA enrollment would increase to about 1.8 million persons by permitting MSA enrollees to make a tax-deductible contribution to the MSA for use in paying uncovered medical expenses. The increase in enrollment would occur primarily among higher income groups with over half of the tax benefit going to beneficiaries with incomes of $75,000 or more. Allowing this tax deduction would increase the net cost of the MSA model to $20.3 billion over the 1996 through 2002 period.

- Enrollment also could be increased to as many as 1.6 million persons by using a higher deductible amount under the catastrophic plan. Raising the deductible amount would increase the net potential financial benefit of the MSA program for healthier individuals resulting in increased enrollment among higher income groups who can afford to go at risk for the high deductible. This increase in enrollment would be partly offset however, by a loss of enrollment among lower income persons who are less able to go at risk for a large deductible.

- Permitting individuals to cash-out unspent MSA contribution amounts also would increase the appeal of MSAs thus increasing enrollment to 1.7 million persons and increasing the net cost of the MSA model to $17.3 billion.

- In theory, the net increase in Medicare costs could be eliminated by lowering voucher payments to plans to reflect the actual costs for those who enroll. However, this would require lowering the plan payment amount to 55 percent of the AAPCC amount. At this level, however, plans would be able to make only very small contributions to the MSA (if any), thus lowering enrollment to less than 100,000 persons.

- Enrollment in the MSA plan would decline over time if enacted with the spending limits in the recent Congressional budget resolution. Under the resolution, the per-capita payments to plans would be indexed at 4.9 percent per year while private insurance costs are expected to grow at 7.4 percent per year.

Our MSA analysis shows that an optional health coverage program that promises potential cash benefits to persons who are able to keep their health spending low will experience extreme selection bias. Even adjusting MSA plan payments by age, sex, disability status and geography as under the AAPCC method fails to correct for the selection effects that such a program would experience. Moreover it is unclear whether any other risk adjustment methodology could ever fully correct for these selection

problems. Thus, the MSA model would almost certainly result in a net increase in Medicare program costs regardless of the risk adjustment method used.

Our estimates are very sensitive to assumptions concerning behavioral responses by both health plans and beneficiaries. The impacts discussed above would change depending upon how attractive the program is made to health insurers and beneficiaries through: the methods used to pay plans; tax preferences for MSA enrollees; and MSA balance withdrawal policies. Thus, our estimates should be considered illustrative of potential impacts rather than point estimates of actual policy outcomes.

CC:

Laura
Carol
Leon
George
Stiglitz

---

also send to → J. Klein

& cc back here just of my cover note T.

THE PRESIDENT HAS SEEN
11-2-95

THE WHITE HOUSE

WASHINGTON

October 31, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: TODD STERN

SUBJECT: Medical Savings Accounts

The attached Tyson/Rasco memo seeks your guidance on the position we should take toward proposals for medical savings accounts (MSAs), which are included in both the House and Senate budget bills.

MSAs could be introduced in the private market or as a Medicare alternative. In the Medicare context, subscribers would receive an annual voucher equal to the amount Medicare pays for an average beneficiary (about $5,200 in 1995); the voucher would be used to purchase a high-deductible (essentially, catastrophic) insurance policy, with the balance deposited in a Medicare MSA. Withdrawals would be tax free for medical expenses and taxable for other expenses.

Supporters claim MSAs would help control health care costs by forcing individuals to bear more of the direct costs. But there are serious downsides: "adverse selection" -- MSAs would attract healthier, wealthier people (who could risk high deductibles), leaving a pool of poorer and sicker people in comprehensive insurance coverage; a shift of Medicare money to those choosing MSAs, because the "average" voucher would be more than they'd get under Medicare (since they're healthier than average); administrative difficulties; a loss in tax revenues; no expansion of coverage; possible reduced spending on preventive care because of the high deductibles.

NEC, DPC, OMB, HHS and Treasury oppose Medicare MSAs; CEA sees some possible benefit. **Laura and Carol present three options: (A) oppose MSAs and threaten a veto, at most suggesting possibility of private market demonstration project; (B) oppose but leave open possibility of compromise, such as private market or Medicare demonstration project; (C) express preliminary interest in the idea. Leon favors option B. George favors a variation of B -- he would strongly oppose MSAs, but sees no need at this stage either to mention a veto or to suggest a demonstration project.**

A: Oppose, suggesting veto ____
B: Oppose, leaving open possibility of compromise ____
George's variation: Oppose, don't mention veto or compromise ____
(C) Indicate interest ____

THE WHITE HOUSE

WASHINGTON

95 OCT 13 P4:29

October 13, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: LAURA TYSON AND CAROL RASCO

RE: Medical Savings Accounts

PURPOSE:

To reach a decision on an Administration position on the use of Medical Savings Accounts for the private insurance market and the Medicare program.

OVERVIEW AND BACKGROUND:

A few nights ago, CBS News broadcast a scathing attack on Medical Savings Accounts (MSAs), suggesting that their popularity was due largely to the financial contributions of their backers rather than their actual merit. Yet, while concerns about the concept have also been raised by the elite print media, by CBO, and by Lewin-VHI, MSAs continue to ride a wave of support in the Congress.

Both the House and Senate budget bills contain some version of an MSA option. The concept has also received strong support from certain elements of the insurance industry, particularly those firms that once excelled at the traditional underwriting method of "cherry picking" beneficiaries from low-risk populations. While these methods have been rejected by the public and by policy makers, MSAs offer a subtle way of accomplishing much the same effect. Given the depth of financial and Congressional support behind this concept, some form of MSA proposal likely will be included in any reconciliation bill that reaches your desk.

Medical Savings Accounts, as their name suggests, are special accounts used primarily to pay personal medical expenses. Typically, these accounts offer tax benefits or other financial incentives. But, in return, they impose one basic requirement: Participants must switch their health insurance from a "comprehensive" plan to a "catastrophic" plan with a high deductible, sometimes as high as $10,000.

Supporters in Congress contend that, by forcing individuals to bear more of the direct costs of health care, MSAs discourage the use of unnecessary or excessively costly medical procedures, thus reducing medical expenditures. Opponents counter that the plans simply allow healthy and well-to-do populations to self-select out of the traditional insurance pools -- thereby increasing costs for those left behind. Other criticisms are that MSAs: (1) are untested; (2) are extremely difficult to administer; and (3) may discourage use of cost-effective preventive care.

DISCUSSION:

In general, MSAs have been proposed for both the private health insurance market and the Medicare system. These two options are described briefly below. The pros and cons of the MSA concept are then examined in greater detail.

Private Market MSAs

Various MSA proposals have been introduced for the private (under 65) insurance market. One of the most significant, Representative Archer's proposal (H.R. 1818), allows individuals to open an MSA whenever they enroll in a health plan with a minimum deductible of $1,500 for a single plan and $3,000 for a family plan.

H.R. 1818 provides a significant benefit for individuals who open an MSA: Not only are employer and employee contributions into an MSA deemed tax exempt, but withdrawals from an MSA for medical expenses are also tax free. By comparison, under current law, an individual must generally spend after-tax dollars on medical expenses (with a few exceptions).

Medicare MSAs

Both the House and Senate Medicare plans allow beneficiaries to withdraw from the traditional fee-for-service system and set up a Medicare MSA account. When a beneficiary opens an MSA, Medicare gives the subscriber a voucher equal to the amount of money that the Medicare program spends on the average beneficiary per year -- roughly $5,200 per beneficiary in 1995. (Under some proposals, this average would be "risk adjusted" to take into account the beneficiary's demographic characteristics, like age or gender). This voucher can be used only for the purchase of a high deductible insurance policy -- with deductibles ranging from up to $3,000 in the Senate version to up to $10,000 in the House version. Any remaining credit is then deposited into the Medicare MSA.

MSA funds can be used to pay for both medical and non-medical expenses. When used for medical expenses, withdrawals from the account are tax-free. However, when used for non-medical expenses, the withdrawals are taxed as income and, under the House plan, subject to an additional penalty whenever the MSA balance falls below a specified threshold (60% of the deductible amount).

GENERAL PROS AND CONS

Pros -- Private Market and Medicare MSAs

The advantages of the MSA concept for the Medicare and private market system are relatively straightforward:

- More Choice. MSAs may offer new options for private health insurance consumers and Medicare beneficiaries.

- Ideological appeal. MSAs resonate with the anti-government mood of the 104th Congress. Medicare MSAs, for example, appear to eliminate the federal middle-man in the Medicare system -- replacing a government-run insurance program with what seems to be a more market-oriented one. Moreover, MSAs in general enable individuals to decide how to cut costs, rather than imposing institutional rules such as those found in managed care programs.

- Incentives to reduce unnecessary procedures. By requiring individuals to bear more of the direct cost of medical expenses, MSAs probably lead people to become more cost-conscious consumers. A reduction in the use of unnecessary procedures would reduce aggregate health care spending and could benefit the entire economy. As such, MSAs provide an initial attraction to many economists who worry that the existing preferential tax treatment encourages the purchase of excessively comprehensive insurance coverage. Nonetheless, the effect on medical expenditures is unlikely to be as dramatic as some proponents claim: MSAs do not address the principal cause of increased spending -- the rising costs of catastrophic illness. Roughly 20% of individuals account for 70% of all medical spending. MSAs would do little to reduce spending on the small number of very sick individuals responsible for most medical expenditures.

- Popular among certain segments of the population. MSAs appeal particularly to the healthier and wealthier segments of the population, and their inclusion in a final budget package would avoid confrontation with their fierce supporters on Capitol Hill.

Cons -- Private Market MSAs

The MSA concept raises a number of concerns when applied to the private insurance market.

- Untested. The MSA concept is a largely untested concept. It makes little sense to implement the idea nationally without better understanding its implications.

- Adverse Selection. Adverse selection is one of the most significant defects associated with MSAs in general. Adverse selection refers to the fact that MSAs will likely attract wealthier and healthier beneficiaries -- those rich enough to risk a high deductible and healthy enough to be confident that they will do better with their own catastrophic policy than in a comprehensive pool of riskier and sicker individuals. Adverse selection could lead to a situation where people left in comprehensive insurance coverage are sicker than average, leading to increasing costs for such coverage as the risk pool shrinks and becomes less favorable. This problem is a variation on cost-shifting, but it does not necessarily mean that aggregate spending on health care increases. It is unclear how severe the adverse selection problem would be in the private market because employers who provide MSAs as part of a benefit package would have some flexibility to adjust an employee's wages or other fringe benefits in order to limit the amount of adverse selection that occurs. (Existing flexible spending accounts and cafeteria plans are not associated with large adverse selection problems.)

- Possible reduction in preventive care. High deductible policies may discourage families from spending funds on certain services, like preventive care, that have short term costs, but long-term benefits. In many cases, providers may be better positioned to recognize the benefits of cost-conscious and medically effective preventive care.

- Administrative problems. According to the Treasury Department, private market MSAs will lead to significant administrative problems, increase the paper-work burden on taxpayers, and create the potential for significant non-compliance. (Imagine the difficulties in distinguishing between a legitimate medical expense and a feigned one.)

- Loss of federal revenues. Since private market MSAs allow individuals to pay for medical expenses with tax-free dollars, a significant revenue loss for the Treasury can be expected. The Joint Tax Committee projects that H.R. 1818 will cost $1.8 billion over 7 years. The Treasury Department estimates that the seven-year loss would be $3.5 billion.

- No significant increase in coverage. Private market MSAs are unlikely to expand insurance coverage to any significant extent. Although some individuals who are currently uninsured may participate in an MSA plan, others who are currently in comprehensive health insurance plans may drop coverage because of changes in the risk pool. Moreover, by encouraging healthy and wealthy individuals to self-select into segregated insurance groups, MSAs would probably make it more difficult in the future to achieve comprehensive health care reform that depends on large community-rated insurance pools.

Cons -- Additional Concerns about Medicare

While the Medicare MSA has many of the same drawbacks as the private market version, most health policy analysts (including Alain Enthoven and others with influence with the Democratic Leadership Council) have pointed out that adverse selection problems will pose a particularly serious problem for the Medicare system:

- Under both the House and Senate Medicare plans, an MSA subscriber receives a voucher equal to what the average beneficiary costs the Medicare system each year -- even though these healthy subscribers cost the system far less than average. In this way, MSAs boost spending on healthy beneficiaries, thus increasing costs. The only way to address the adverse selection problem is by adjusting the Medicare contribution to more accurately reflect a subscriber's cost. As Lewin-VHI notes, however, such "risk adjustment" methods are "still under development and largely untested." Moreover, modifying Medicare contributions based on factors like gender or age would likely face serious obstacles in the political process. Because it is skeptical about the development of an effective risk-adjustment method, Lewin-VHI projects that Medicare MSAs will cost between $15 and $20 billion over 7 years.

- The GOP Medicare plan imposes an overall entitlement cap on Medicare expenditures. As a result, the higher cost of Medicare MSAs must be offset by cuts of an equal magnitude in Medicare's pay-for-service program.

- The GOP Medicare plan allows MSA-holders to transfer back into the traditional pay-for-service system on an annual basis. As a result, subscribers will be tempted to enroll in MSAs during their healthy years, and then opt back into the traditional pay-for-service program when their health declines. This feature exacerbates the adverse selection problem. To address this problem, some have suggested extending the "lock-out" period beyond one year, but such proposals obviously would prove unpopular with beneficiaries.

Taken together, the negative effects of MSAs should be a concern for the overall health insurance market. But adverse selection problems raise particularly serious questions for the Medicare system. Even Senator Dole has expressed some misgivings about Medicare MSAs. Acknowledging reports about the cost of MSAs, Senator Dole recently said,

> "I picked up the paper this morning, the New York Times said the Medical Savings Accounts are a rip-off, when it costs $2.9 billion. They're only for healthy people. Well, should we spend $2.9 million (sic)? I don't think so. We're going to check it out." (quoted at the Business Week Symposium of Chief Executive Officers, 9/28/95).

CONCLUSION AND RECOMMENDATIONS

There is opposition to the concept of Medicare MSAs throughout the Administration (NEC, DPC, OMB, HHS, Treasury), although the CEA sees some possible benefit. Similar concerns have also been raised about MSAs for the private market, but with the exception of the Treasury Department division with responsibility for administering MSAs, the depth of this opposition is not as great.

In all likelihood, some form of the MSA concept will likely pass the Congress. The question arises how best to position the Administration on this issue to ensure that the final compromise is acceptable. There are a range of options available to the Administration, including the following:

OPTION A: Oppose MSA concept for both Medicare and private industry and suggest that proposals might attract a veto. At most, suggest possibility of establishing a demonstration project for the private market.

OPTION B: Oppose Medicare MSAs and raise concerns about private market MSAs, but leave open the possibility of compromise -- perhaps a demonstration project for MSAs in either the Medicare or private market.

OPTION C: Indicate need for more information to evaluate proposals, but express preliminary interest in MSAs as a concept.

DECISION:

OPTION A __ OPTION B __ OPTION C __ DISCUSS ___

THE WHITE HOUSE

WASHINGTON

October 13, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: LAURA TYSON AND CAROL RASCO

RE: Medical Savings Accounts

PURPOSE:

To reach a decision on an Administration position on the use of Medical Savings Accounts for the private insurance market and the Medicare program.

OVERVIEW AND BACKGROUND:

A few nights ago, CBS News broadcast a scathing attack on Medical Savings Accounts (MSAs), suggesting that their popularity was due largely to the financial contributions of their backers rather than their actual merit. Yet, while concerns about the concept have also been raised by the elite print media, by CBO, and by Lewin-VHI, MSAs continue to ride a wave of support in the Congress.

Both the House and Senate budget bills contain some version of an MSA option. The concept has also received strong support from certain elements of the insurance industry, particularly those firms that once excelled at the traditional underwriting method of "cherry picking" beneficiaries from low-risk populations. While these methods have been rejected by the public and by policy makers, MSAs offer a subtle way of accomplishing much the same effect. Given the depth of financial and Congressional support behind this concept, some form of MSA proposal likely will be included in any reconciliation bill that reaches your desk.

Medical Savings Accounts, as their name suggests, are special accounts used primarily to pay personal medical expenses. Typically, these accounts offer tax benefits or other financial incentives. But, in return, they impose one basic requirement: Participants must switch their health insurance from a "comprehensive" plan to a "catastrophic" plan with a high deductible, sometimes as high as $10,000.

Supporters in Congress contend that, by forcing individuals to bear more of the direct costs of health care, MSAs discourage the use of unnecessary or excessively costly medical procedures, thus reducing medical expenditures. Opponents counter that the plans simply allow healthy and well-to-do populations to self-select out of the traditional insurance pools -- thereby increasing costs for those left behind. Other criticisms are that MSAs: (1) are untested; (2) are extremely difficult to administer; and (3) may discourage use of cost-effective preventive care.

DISCUSSION:

In general, MSAs have been proposed for both the private health insurance market and the Medicare system. These two options are described briefly below. The pros and cons of the MSA concept are then examined in greater detail.

Private Market MSAs

Various MSA proposals have been introduced for the private (under 65) insurance market. One of the most significant, Representative Archer's proposal (H.R. 1818), allows individuals to open an MSA whenever they enroll in a health plan with a minimum deductible of $1,500 for a single plan and $3,000 for a family plan.

H.R. 1818 provides a significant benefit for individuals who open an MSA: Not only are employer and employee contributions into an MSA deemed tax exempt, but withdrawals from an MSA for medical expenses are also tax free. By comparison, under current law, an individual must generally spend after-tax dollars on medical expenses (with a few exceptions).

Medicare MSAs

Both the House and Senate Medicare plans allow beneficiaries to withdraw from the traditional fee-for-service system and set up a Medicare MSA account. When a beneficiary opens an MSA, Medicare gives the subscriber a voucher equal to the amount of money that the Medicare program spends on the average beneficiary per year -- roughly $5,200 per beneficiary in 1995. (Under some proposals, this average would be "risk adjusted" to take into account the beneficiary's demographic characteristics, like age or gender). This voucher can be used only for the purchase of a high deductible insurance policy -- with deductibles ranging from up to $3,000 in the Senate version to up to $10,000 in the House version. Any remaining credit is then deposited into the Medicare MSA.

MSA funds can be used to pay for both medical and non-medical expenses. When used for medical expenses, withdrawals from the account are tax-free. However, when used for non-medical expenses, the withdrawals are taxed as income and, under the House plan, subject to an additional penalty whenever the MSA balance falls below a specified threshold (60% of the deductible amount).

GENERAL PROS AND CONS

Pros -- Private Market and Medicare MSAs

The advantages of the MSA concept for the Medicare and private market system are relatively straightforward:

- More Choice. MSAs may offer new options for private health insurance consumers and Medicare beneficiaries.

- Ideological appeal. MSAs resonate with the anti-government mood of the 104th Congress. Medicare MSAs, for example, appear to eliminate the federal middle-man in the Medicare system -- replacing a government-run insurance program with what seems to be a more market-oriented one. Moreover, MSAs in general enable individuals to decide how to cut costs, rather than imposing institutional rules such as those found in managed care programs.

- Incentives to reduce unnecessary procedures. By requiring individuals to bear more of the direct cost of medical expenses, MSAs probably lead people to become more cost-conscious consumers. A reduction in the use of unnecessary procedures would reduce aggregate health care spending and could benefit the entire economy. As such, MSAs provide an initial attraction to many economists who worry that the existing preferential tax treatment encourages the purchase of excessively comprehensive insurance coverage. Nonetheless, the effect on medical expenditures is unlikely to be as dramatic as some proponents claim: MSAs do not address the principal cause of increased spending -- the rising costs of catastrophic illness. Roughly 20% of individuals account for 70% of all medical spending. MSAs would do little to reduce spending on the small number of very sick individuals responsible for most medical expenditures.

- Popular among certain segments of the population. MSAs appeal particularly to the healthier and wealthier segments of the population, and their inclusion in a final budget package would avoid confrontation with their fierce supporters on Capitol Hill.

Cons -- Private Market MSAs

The MSA concept raises a number of concerns when applied to the private insurance market.

- Untested. The MSA concept is a largely untested concept. It makes little sense to implement the idea nationally without better understanding its implications.

- Adverse Selection. Adverse selection is one of the most significant defects associated with MSAs in general. Adverse selection refers to the fact that MSAs will likely attract wealthier and healthier beneficiaries -- those rich enough to risk a high deductible and healthy enough to be confident that they will do better with their own catastrophic policy than in a comprehensive pool of riskier and sicker individuals. Adverse selection could lead to a situation where people left in comprehensive insurance coverage are sicker than average, leading to increasing costs for such coverage as the risk pool shrinks and becomes less favorable. This problem is a variation on cost-shifting, but it does not necessarily mean that aggregate spending on health care increases. It is unclear how severe the adverse selection problem would be in the private market because employers who provide MSAs as part of a benefit package would have some flexibility to adjust an employee's wages or other fringe benefits in order to limit the amount of adverse selection that occurs. (Existing flexible spending accounts and cafeteria plans are not associated with large adverse selection problems.)

- Possible reduction in preventive care. High deductible policies may discourage families from spending funds on certain services, like preventive care, that have short term costs, but long-term benefits. In many cases, providers may be better positioned to recognize the benefits of cost-conscious and medically effective preventive care.

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DECISION:

OPTION A __ OPTION B __ OPTION C __ DISCUSS ___

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

FAX TRANSMITTAL SHEET

DATE: 9-28-95

NUMBER OF SHEETS TO FOLLOW: 2

TO: Jennifer Klein

ADDRESSEE'S FAX #: 456-2878

ADDRESSEE'S CONFIRMATION #: _____

FROM: Alan Cohen

SENDER'S FAX #: 202-622-0073

SENDER'S CONFIRMATION #: 202-622-1700

SPECIAL INSTRUCTIONS/COMMENTS:

MEMORANDUM September 27, 1995

TO: Julie James
Bruce Lesley

FROM: Murray Ross

SUBJECT: Estimating savings from Medicare Choice in the Chairman's Mark

CBO's estimate of savings from Medicare Choice is the net result of changes in spending from three sources:

- lower updates on payments made on behalf of current enrollees (strictly speaking, the share of Medicare beneficiaries enrolled in risk contracts under current law);
- savings associated with new enrollees (the estimated fraction of Medicare beneficiaries moving from traditional fee-for-service to Choice plans other than high deductible plans); and
- payments on behalf of beneficiaries choosing the high deductible insurance/medical savings account option.

Over seven years, CBO estimates that savings on current enrollees would total $42.6 billion (see attached table). Savings on new enrollees would total about $7.1 billion. Payments to Choice enrollees with high deductible plans would cost about $2.3 billion as a result of adverse selection not fully compensated for by risk adjustment. The net savings attributed to Medicare Choice is $47.5 billion.

CBO's estimate assumes that enrollment in Choice plans (including high deductible plans) would reach about 22% of Medicare beneficiaries by 2002, compared with the 14% of beneficiaries projected to be covered by risk plans in the CBO baseline. Most of the increase is attributable to CBO's assumptions about beneficiaries' responses to the new government-coordinated open enrollment process and expanded choices. CBO assumed that there would be a short-run increase in enrollment reflecting these factors, but a slightly lower rate of growth in future enrollment. In addition, CBO assumed that eliminating the entitlement to cost-sharing for Medicaid eligibles and QMBs would increase enrollment as those beneficiaries sought out plans with lower cost-sharing requirements.

CBO ASSUMPTIONS UNDERLYING CALCULATION OF MEDICARE CHOICE SAVINGS

CHANGE IN SPENDING (Billions of dollars)	Fiscal Years 1996	1997	1998	1999	2000	2001	2002	Tota
Baseline Enrollees	-0.4	-1.9	-3.6	-5.4	-7.5	-10.2	-13.7	-42.6
New Enrollees (excluding high deductible plans)	-0.0	-0.1	-0.7	-1.0	-1.3	-1.8	-2.3	-7.1
High-Deductible Plans/MSAs	0.0	0.4	0.4	0.4	0.4	0.4	0.4	2.3
Total	-0.4	-1.5	-3.9	-6.0	-8.4	-11.6	-15.7	-47.5

MANAGED CARE ENROLLMENT (As percent of all Medicare beneficiaries)	1996	1997	1998	1999	2000	2001	2002
CBO Baseline (risk contracts only)	8	9	10	11	12	13	14
Medicare Choice	8	13	17	19	20	21	22
Risk Plans	8	12	16	18	19	20	21
High-Deductible Plans/MSAs	0	1	1	1	1	1	1

Note: Change in spending is difference from Budget Resolution baseline.

Source: Preliminary Congressional Budget Office estimates based on policy in Chairman's mark and discussions with Committee staff.

National Committee to
Preserve Social Security
and Medicare
2000 K Street, N.W., Suite 800
Washington, D.C. 20006 202-822-9459

NEWS

FOR IMMEDIATE RELEASE
September 25, 1995

Contact: Kris Phillips
703/836-9811

Report Shows Medical Savings Accounts Will Increase Medicare Spending by at Least $15 Billion in 7 Years

WASHINGTON – Medical Savings Accounts (MSAs), the centerpiece of the GOP effort to restructure Medicare and reduce costs, will actually increase costs by at least an additional $15 billion from 1996-2002. That's according to a report released today by the National Committee to Preserve Social Security and Medicare and Lewin-VHI.

"It is alarming that Congress is moving with such speed on an MSA proposal that is actuarially unsound and will likely cost the program money," National Committee President Martha McSteen said. "If the Medicare program is really in crisis, why is a proposal being moved forward that's more expensive and primarily benefits upper income beneficiaries?"

"The MSA model will almost certainly result in a net increase in Medicare program costs regardless of the risk adjustment used," the report says. It also concludes that a revenue-neutral MSA model would only attract an estimated 100,000 beneficiaries, and alternatives to make MSAs more attractive would benefit predominantly higher-income groups, cost Medicare more money, or both.

The study also reveals that:

- Allowing tax deductible contributions for MSAs would increase the net cost to $20.3 billion over the same time period.
- The 'selection bias effect' – attracting mostly beneficiaries who have low health expenses, and leave sicker people in the traditional program – would lead to substantial net increases in program costs, regardless of the risk adjustment method used.
- selection incentives would cause Medicare to pay MSAs roughly twice what the healthy population would have cost under the current Medicare program, even after adjusting payments by age, sex and disability.

"This report raises significant questions," Mrs. McSteen said. "If the leadership insists on implementing an MSA option for all seniors, who will pay for the cost increases to the Medicare program? Will the traditional Medicare program be forced to bear additional cuts under the so-called 'fail safe' provision?"

- 30 -

Changes in Medicare Program Spending Under Alternative Medical Savings Account Models

Prepared for

The National Committeee to Preserve Social Security and Medicare

By:

John F. Sheils
Gary J. Claxton
Randall A. Haught

Lewin-VHI, Inc.

September 22, 1995

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EXECUTIVE SUMMARY

Under the Medical Savings Account (MSA) plan, beneficiaries would have the option of accepting a Medicare voucher that could be redeemed for MSA coverage with a private insurer. Insurers would offer beneficiaries a catastrophic health plan covering expenses over a high deductible amount (e.g., $3,000) together with a contribution to the beneficiary's MSA account equal to the difference between the Medicare voucher amount and the cost of the catastrophic plan. The MSA contribution could be used by enrollees to pay for medical expenses up to the plan deductible amount or to pay for health services that are not otherwise covered under Medicare. Enrollees are at risk only for health expenditures between the MSA contribution amount and the amount of the plan deductible.

The program creates strong selection incentives that would increase Medicare spending. The MSA program would be likely to attract only Medicare beneficiaries who expect to have low health expenses during the year, leaving the most expensive individuals in the traditional Medicare program. This "selection effect" would lead to a substantial net increase in program costs. This is because plans would be paid an amount equal to average beneficiary costs under the current Medicare program even though the individuals who would be inclined to select the MSA option generally would be those who use substantially less than the average amount of care.

In this analysis, we found that even after adjusting plan payments by age, sex and disability status, Medicare payments to MSA plans would be nearly twice what the predominantly healthy MSA enrollee population would have cost under the current Medicare program. The key findings of our analysis include the following:

- Medicare program costs would increase by about $15.3 billion under the MSA program over the 1996 through 2002 period due to selection effects, even if demographic and geographic adjustments are used to set plan payment amounts.[1] This estimate is before applying the fail-safe mechanism included in some proposals that would eliminate cost increases through reductions in provider payments under the traditional Medicare program. We consider this selection effect estimate to be conservative because we have assumed that only a portion of those who could potentially benefit under the plan actually enroll.
- We estimate that only about three percent of all Medicare beneficiaries (1.1 million persons) would enroll in the MSA program in 1996. Our enrollment estimates reflect the fact that not all of those who could potentially benefit under the program would actually enroll due to the risk of incurring uncovered expenses. These estimates also reflect the fact that in many areas of the

[1] This estimate represents an increase over Medicare spending levels permitted under the recent Congressional budget resolution.

country, the Medicare payment amount would not be high enough to finance both a private catastrophic insurance policy and a substantial MSA contribution.

- Those who enroll in the MSA program would tend to be in better than average health. Enrollment is also likely to be greatest in higher income groups where beneficiaries are more likely to be willing to go at risk for a substantial portion of the catastrophic deductible.

- MSA enrollment would increase to about 1.8 million persons by permitting MSA enrollees to make a tax-deductible contribution to the MSA for use in paying uncovered medical expenses. The increase in enrollment would occur primarily among higher income groups with over half of the tax benefit going to beneficiaries with incomes of $75,000 or more. Allowing this tax deduction would increase the net cost of the MSA model to $20.3 billion over the 1996 through 2002 period.

- Enrollment also could be increased to as many as 1.6 million persons by using a higher deductible amount under the catastrophic plan. Raising the deductible amount would increase the net potential financial benefit of the MSA program for healthier individuals resulting in increased enrollment among higher income groups who can afford to go at risk for the high deductible. This increase in enrollment would be partly offset however, by a loss of enrollment among lower income persons who are less able to go at risk for a large deductible.

- Permitting individuals to cash-out unspent MSA contribution amounts also would increase the appeal of MSAs thus increasing enrollment to 1.7 million persons and increasing the net cost of the MSA model to $17.3 billion.

- In theory, the net increase in Medicare costs could be eliminated by lowering voucher payments to plans to reflect the actual costs for those who enroll. However, this would require lowering the plan payment amount to 55 percent of the AAPCC amount. At this level, however, plans would be able to make only very small contributions to the MSA (if any), thus lowering enrollment to less than 100,000 persons.

- Enrollment in the MSA plan would decline over time if enacted with the spending limits in the recent Congressional budget resolution. Under the resolution, the per-capita payments to plans would be indexed at 4.9 percent per year while private insurance costs are expected to grow at 7.4 percent per year.

Our MSA analysis shows that an optional health coverage program that promises potential cash benefits to persons who are able to keep their health spending low will experience extreme selection bias. Even adjusting MSA plan payments by age, sex, disability status and geography as under the AAPCC method fails to correct for the selection effects that such a program would experience. Moreover it is unclear whether any other risk adjustment methodology could ever fully correct for these selection

problems. Thus, the MSA model would almost certainly result in a net increase in Medicare program costs regardless of the risk adjustment method used.

Our estimates are very sensitive to assumptions concerning behavioral responses by both health plans and beneficiaries. The impacts discussed above would change depending upon how attractive the program is made to health insurers and beneficiaries through: the methods used to pay plans; tax preferences for MSA enrollees; and MSA balance withdrawal policies. Thus, our estimates should be considered illustrative of potential impacts rather than point estimates of actual policy outcomes.

A. INTRODUCTION

Medical Savings Accounts (MSAs) have been proposed as a vehicle for reforming the Medicare program. Under the MSA model, beneficiaries would have the option of accepting a Medicare voucher that could be redeemed for MSA coverage with a private insurer. Insurers would offer beneficiaries a catastrophic health insurance plan covering all expenses over a high deductible amount (e.g., $3,000). They would also make a contribution to the beneficiary's MSA account equal to the difference between the Medicare voucher amount and the cost of the catastrophic plan. The MSA contribution could be used by enrollees to pay for medical expenses up to the plan deductible amount or to pay for health services that are not otherwise covered under Medicare (i.e., prescription drugs, etc.). Thus, enrollees are at risk only for health expenditures between the MSA contribution amount and the amount of the plan deductible.

However, the amount of the contribution to the MSA generally would be substantially less than the deductible amount under the catastrophic plan. This is because an increase in the deductible amount would not reduce plan costs for those individuals who would have spent less than that amount. Since many individuals consume little or no health care, the per-capita amount that becomes available for contributions to the MSA is less than the amount of the increase in the deductible itself.[2] Thus, beneficiaries who elect the MSA option would be at risk for a substantial portion of the catastrophic deductible amount. This would tend to discourage enrollment in MSA plans particularly for those who expect to have substantial medical expenses during the year.

In fact, the MSA model creates strong selection incentives that would increase Medicare spending. The MSA program would be likely to attract only Medicare beneficiaries who expect to have low health expenses during the year, leaving the most expensive individuals in the traditional Medicare program. This "selection effect" would lead to a substantial net increase in program costs. This is because plans would be paid an amount equal to average beneficiary costs under the current Medicare program even though the individuals who would be inclined to select the MSA option generally would be individuals who use substantially less than the average amount of care. In fact, we found that even after adjusting plan payments by age, sex and disability status (as is done in the existing AAPCC payment methodology for Medicare HMOs), Medicare payments to MSA plans would be nearly twice what the predominantly healthy MSA enrollee population would have cost under the current Medicare program.

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[2] White, Joseph. "Medical Savings Accounts: Fact Versus Fiction," Brookings occasional paper, Government Studies Program. The Brookings Institution, Washington DC, 1995.

Due to these selection effects, the MSA model will actually result in a net increase in Medicare program costs. In this respect the MSA model as currently conceived is actuarially unsound. While in theory, these increases in program cost could be corrected with a careful risk adjustment process, the resulting reduction in health plan payments is likely to result in substantially smaller MSA contribution amounts, thus discouraging participation by both health plans and beneficiaries.

In this analysis, we estimated enrollment and the net change in Medicare program cost under the MSA model. We also estimated the impact of varying program design elements such as: permitting tax deductions for additional beneficiary contributions to MSAs; varying catastrophic plan deductibles; and permitting MSA disbursements for non-medical uses. Our analysis is presented in the following sections:

- Selection Effects
- Alternative Catastrophic Deductible Amounts
- Allowing Additional Tax Deductible MSA Contributions
- Alternative MSA Withdrawal Policies
- Enrollment under Budget-Neutral Scenario.

A detailed discussion of the data and methods used in this analysis is presented in ***Appendix A***.

B. SELECTION EFFECTS

The beneficiaries who would enroll in the MSA program would be individuals who believe that they can benefit under the program financially. Under the MSA model, private insurers would market a package of coverage including a high deductible insurance plan and a cash contribution to the individual's MSA. In general, persons who find that the MSA contribution amount would be greater than what they expect to spend on health care during the year are persons who could potentially benefit from the program. Conversely, persons who, because of their health status, expect to spend more on health services than the MSA contribution amount would not expect to benefit under the program. Thus, the MSA model would attract healthy individuals who expect to spend little on health care while discouraging enrollment by individuals in poorer health who have high health care costs.

This "selection bias" in the health status of individuals who enter the MSA could lead to a substantial increase in overall Medicare program spending if it is ignored. For example, Medicare currently uses the Average Adjusted Per Capita Cost (AAPCC) to pay HMOs that accept Medicare recipients on an at-risk basis. These AAPCC amounts represent the average Medicare program cost for beneficiaries in each geographic area by

age, sex, and disability status. While these AAPCC amounts adjust plan payments for demographic and geographic cost variation, they do not vary the payment amount by the actual health status of the individual. This is an important deficiency because there is substantial variation in health status across beneficiaries within each of these demographic groups. Thus, if payments to health plans under the MSA model are based upon the AAPCC amount, payments to plans under the program would exceed what enrollees would have cost under the traditional Medicare program resulting in a net increase in Medicare program costs.

1. Analytic Methods

To illustrate the potential increase in Medicare costs resulting from these selection effects, we simulated the impact of an MSA program that is similar to what is now being considered by Congress.[3] This plan would allow beneficiaries to accept a voucher amount that can be redeemed for MSA coverage offered by private insurers. For example, the MSA package would include a catastrophic health plan covering all Medicare covered services in excess of a $3,000 deductible. The plan would then make a contribution to the MSA equal to the difference between the Medicare voucher amount and the cost of the catastrophic plan. Medicare payments to plans would be equal to the AAPCC amounts which varies with the age, sex, disability status and geographic location of beneficiaries. We assumed that at the end of the year, beneficiaries are permitted to withdraw unspent MSA balances in excess of 60 percent of their plan deductible amount.

We estimated the number of persons enrolling in the MSA option using the Lewin-VHI Health Benefits Simulation Model (HBSM). HBSM was used to estimate the cost of catastrophic plan premiums by geographic area and expected health spending for individuals in various health status groups. We assumed that individuals would enter the MSA program only if their expected level of health spending is less than the MSA contribution amount that they could receive.[4] A portion of these individuals were selected to enroll based upon studies showing the rate at which individuals change from traditional fee-for-service plans to other types of coverage as lower cost alternatives become available.[5] In addition, to reflect the risk-adverse nature of this population, we assumed that no one would enroll in the MSA if the amount for which they are at-risk (i.e., the difference between the plan deductible amount and the MSA contribution amount) is

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[3] See: "Saving the Medicare System with Medical Savings Accounts," National Center for Policy Analysis, September 12, 1995. This study analyzed an MSA program where plans would be free to market plans with a deductible of up to $10,000.

[4] The MSA contribution amount for each individual is equal to the difference between the AAPCC amount and the cost of the catastrophic policy.

[5] See: Buchmueller, T. and Feldstein, P., "The Effect of Price on Switching Among Health Plans," May 1995.

greater than five percent of family income. The methods used to develop these estimates are presented in detail in ***Appendix A***.

2. Enrollment and Selection Effects

Using this methodology, we estimate that about 1.1 million Medicare beneficiaries would enroll in the MSA program in 1996 (***Figure 1***). This would result in a net increase in Medicare program costs of $3.1 billion in 1996 due to selection effects. We estimate that the total amount of AAPCC voucher payments to plans would be $6.8 billion in 1996. However, Medicare program costs for those individuals who would elect the MSA would have been only $3.7 billion in that year had they remained in the traditional Medicare program. This reflects the fact that the MSA would attract a disproportionately healthy population with low health care costs. Thus, plan payments under the program would be nearly twice what the MSA enrollees would have cost under the traditional Medicare program even though the AAPCC payment to plans adjusts for the age, sex and disability status of the MSA enrollee population.

The net increase in Medicare program costs over the 1996 through 2002 period would be $15.3 billion. This estimate represents an increase in Medicare program costs over the spending levels called for in the budget resolution. This estimate assumes no fail-safe mechanism to limit total Medicare outlays through reductions in provider payment rates as has been proposed. Application of the fail-safe would result in reduced provider payments under the traditional Medicare program.[6]

[6] Thus, these estimates reflect the decline in enrollment over time resulting from the fact that the voucher amounts would be indexed to the per-capita program growth rate of 4.9 percent per year while private insurance costs are expected to grow at 7.4 percent per year over that period. (See discussion below.)

FIGURE 1

SUMMARY OF CHANGES IN MEDICARE HEALTH SPENDING UNDER AN ILLUSTRATIVE MSA SCENARIO [a/]

Beneficiaries by Enrollment Status	Number of Beneficiaries in 1996 (in thousands) [b/]	Total Spending (in Billions)			
		Cost under Traditional Medicare in 1996 [c/]	AAPCC Payments to Plans in 1996 [d/]	Net Increase (Decrease) in Medicare Spending [e/]	
				1996	1996 - 2002 [f/]
Enroll in Medical Savings Account	1,070	$3.7	$6.8	$3.1	$15.3
Remain in Traditional Medicare	35,742	$205.2	--	--	--
All Beneficiaries	36,812	$208.9	$6.8	$3.1	$15.3

a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Figures include only those persons enrolled in both Part-A and Part-B of Medicare. MSA enrollment is assumed to be limited to only Medicare beneficiaries who are not in nursing homes.

c/ Medicare program costs in 1996 including benefits and administration under current trends.

d/ Includes the AAPCC amount for each individual electing the MSA option. Estimate represents the weighted average of the AAPCC amount corresponding to the age, sex, and disability status of each beneficiary entering the MSA program.

e/ Equals plan payment amounts less actual costs for MSA enrollees under traditional Medicare.

f/ These estimates represent an increase in Medicare program costs over the spending levels called for in the recent budget resolution. The increase in Medicare spending declines each year because enrollment in MSAs declines as a result of capping the per-capita growth in payments to health plans to 4.9 percent per year as implied by the budget resolution.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The average AAPCC plan payment would be $6,342 per MSA enrollee which is actually about 12 percent higher than average Medicare spending per enrollee under the current Medicare program in 1996 ($5,655).[7] This reflects the fact that MSA enrollment is likely to be greatest in those geographic areas where the AAPCC payment amount is highest.[8] By comparison, the beneficiaries who enroll in the MSA would have cost only

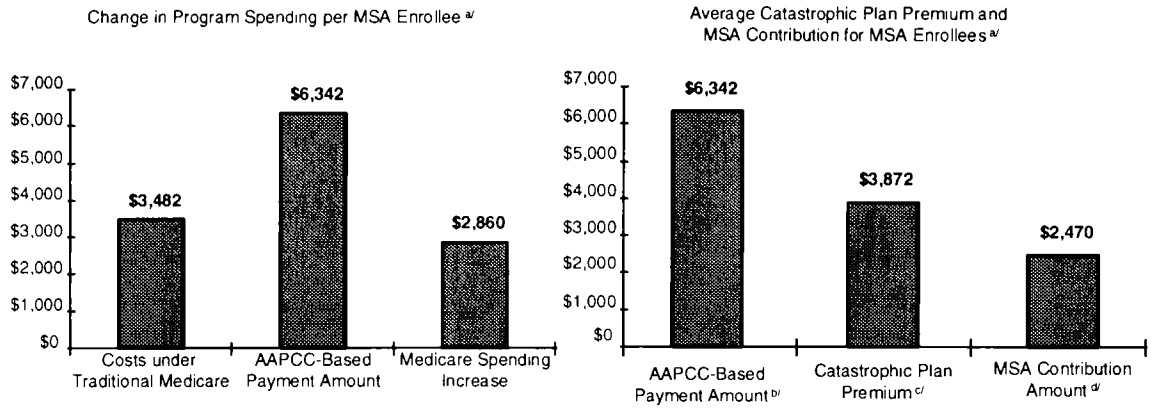
[7] Medicare expenditures in calendar year 1996 are projected to be $208.1 billion and Medicare Part-B enrollment is projected to be 36.8 million which gives an average Medicare expenditure of $5,655 in calendar year 1996 before spending reductions under the budget resolution.

[8] AAPCC amounts vary substantially across geographic areas due to geographic differences in utilization patterns and provider payment levels.

about $3,482 under the traditional Medicare program in that year (***Figure 2***). Thus, Medicare spending would increase an average of $2,860 per MSA enrollee. The average cost of the catastrophic plan would be $3,872 for MSA enrollees (reflecting private sector costs) resulting in an average MSA contribution of $2,470.[9]

FIGURE 2

CHANGES IN PROGRAM SPENDING AND PER-CAPITA MSA CONTRIBUTION AMOUNTS [a/]



a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Includes the AAPCC amount for each individual electing the MSA option. Estimate represents the weighted average of the AAPCC amount corresponding to the age, sex, and disability status of each beneficiary entering the MSA program.

c/ Assumes a catastrophic policy with a $3,000 deductible. Reflects utilization savings and provider payment amounts consistent with private Preferred Provider Organizations (PPOs).

d/ Equals the difference between the AAPCC-based payment amount less the catastrophic premium amount for persons who enroll.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

3. Changes in Enrollment Over Time

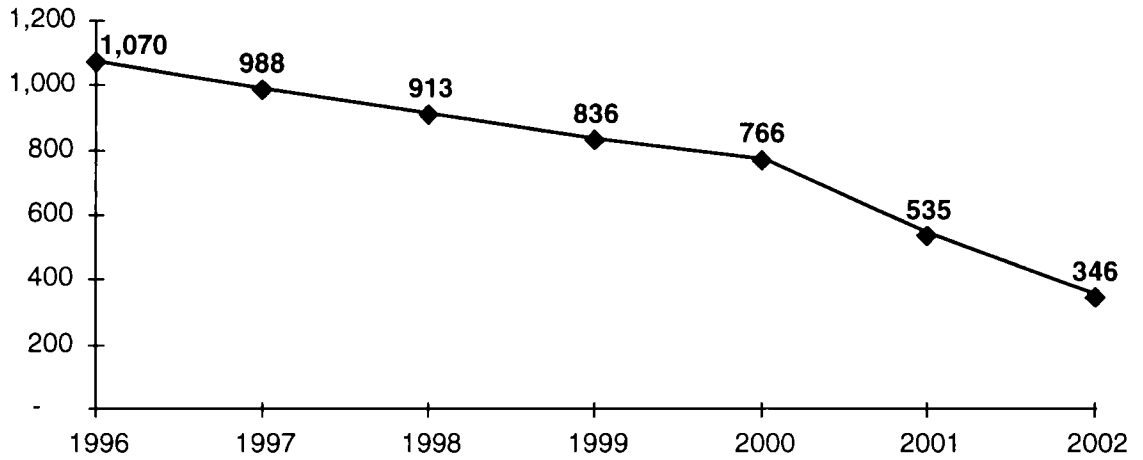
Our estimates indicate that MSA enrollment would actually decline in future years due to the way the AAPCC voucher amount would be indexed over time. To be consistent with the $270 billion reduction in Medicare spending called for under the recent

[9] The catastrophic premium was estimated for each geographic area by adjusting the AAPCC amount to reflect differences between the Medicare program and private insurance including: managed care savings; increases in provider payments to private payer levels; and administrative costs.

Congressional budget resolution, we assumed that the AAPCC payment amount would be indexed to the annual rate of growth in per-capita costs implied by the resolution (4.9 percent). By comparison, per-capita private insurance costs are projected to grow by about 7.4 percent per year through 2002.[10] Consequently, the buying power of the AAPCC-based voucher amount will decline over time resulting in smaller potential MSA contribution amounts with an associated reduction in enrollment. We estimate that MSA enrollment would decline from about 1.1 million persons 1996 to about 350,000 persons by 2002 (***Figure 3***).

FIGURE 3

NUMBER OF MSA ENROLLEES: 1996 - 2002 [a/]



a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Assumes that the Medicare payment to plans is indexed at 4.9 percent per year (i.e., the per-beneficiary growth rate implied by the budget resolution) while per-capita private insurance costs are ass med to increase by 7.4 percent per year. Declining enrollment in future years reflects the declining buying power of the voucher over time.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

C. ALTERNATIVE CATASTROPHIC DEDUCTIBLE AMOUNTS

The MSA model could be implemented with a variety of catastrophic deductible amounts. In fact, an MSA model could be implemented where the insurer sets the

[10] Based upon HCFA projections of private insurance costs and CBO projections of enrollment in private health plans.

deductible amount based upon market conditions and consumer demand for coverage vs. MSA contributions. To illustrate the impact of these alternatives, we used HBSM to estimated enrollment and costs under alternative catastrophic plan deductible amounts.

Our analysis indicates that the number of persons enrolling in the MSA model would increase as the deductible amount is increased. For example, MSA enrollment would increase from 1.1 million under the $3,000 deductible plan to 1.3 million under a $5,000 deductible plan and 1.6 million with a deductible of $10,000 (***Figure 4***). This reflects the fact that the MSA contribution amount increases as the deductible amount is increased, thus increasing the potential financial benefit of participating in the MSA. This is particularly the case among healthier individuals with low expected health care costs. This increase in enrollment occurs primarily among higher income groups where individuals are most willing to go at risk for a higher deductible amount. This increase in enrollment is partially offset by decreased enrollment among lower income persons who are far less likely to go at risk for a substantial deductible amount.

FIGURE 4

MEDICARE BENEFICIARIES ELECTING MEDICAL SAVINGS ACCOUNT OPTION UNDER ALTERNATIVE PLAN DEDUCTIBLE AMOUNTS [a/]

	$3,000 Deductible Plan		$5,000 Deductible Plan		$10,000 Deductible Plan	
Family Income of Beneficiary	Number of Enrollees (in thousands)	Percent in Group Taking MSA	Number of Enrollees (in thousands)	Percent in Group Taking MSA	Number of Enrollees (in thousands)	Percent in Group Taking MSA
under $15,000	162.7	1.4%	36.5	0.3%	- -	- -
$15,000 - $20,000	177.6	3.5%	24.9	0.5%	- -	- -
$20,000 - $30,000	117.4	1.7%	142.9	2.1%	- -	- -
$30,000 - $40,000	150.9	4.2%	267.3	7.4%	122.3	3.4%
$40,000 - $50,000	162.3	7.4%	248.0	11.3%	410.6	18.7%
$50,000 - $75,000	164.3	6.1%	318.9	11.9%	580.6	21.6%
$75,000 - $100,000	68.0	4.5%	144.8	9.5%	307.3	20.2%
$100,000 or more	67.0	6.1%	92.9	8.5%	208.9	19.1%
Self-Reported Health Status						
Good / Excellent	664.9	3.8%	888.8	5.1%	1,425.3	8.2%
Poor / Fair	405.2	2.4%	386.7	2.3%	204.4	1.2%
TOTAL	1,070.1	3.1%	1,275.5	3.7%	1,629.7	4.7%

a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a high deductible (i.e., $3,000, $5,000 or $10,000) and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

For example, under the $3,000 deductible model, about 28 percent of MSA enrollees (299,000 persons) would have annual family incomes of $50,000 or more. Under the $10,000 deductible plan, the number of MSA enrollees with incomes in excess of $50,000 would increase to 1.1 million while the number of persons in lower income groups would decline dramatically. The analysis also shows that as the deductible is increased, the number of persons reporting themselves to be in good health who enroll would increase while enrollment would decline for those reporting themselves to be in poorer health. Thus, our estimates suggest that higher deductible amounts will tend to increase enrollment among healthier individuals in higher income groups while reducing enrollment among lower income individuals in poorer health.

Under all three deductible amounts, the MSA program would experience strong selection bias resulting in a net increase in Medicare program costs. However, due to the demographic shifts in enrollment, the average net increase in Medicare costs per enrollee declines as the deductible increases. Consequently, there is little change in the total net increase in Medicare program costs due to selection bias across the three scenarios. Thus, the dollar amount of the increase in Medicare spending is roughly $15.0 billion under all three deductible levels (***Figure 5***).

FIGURE 5
SUMMARY OF CHANGES IN MEDICARE HEALTH SPENDING UNDER THE MSA PROGRAM UNDER ALTERNATIVE CATASTROPHIC PLAN DEDUCTIBLE AMOUNTS [a/]

	Number of Beneficiaries (in thousands)	Total Spending (in billions)			
		Cost under Traditional Medicare [b/]	AAPCC Payments to Plans [c/]	Net Increase (Decrease) in Medicare Spending [d/]	
				1996	1996 - 2002 [e/]
Assuming $3,000 Deductible Plan					
Beneficiaries Enrolled in MSA	1,070	$3.7	$6.8	$3.1	$15.3
Assuming $5,000 Deductible Plan					
Beneficiaries Enrolled in MSA	1,275	$4.6	$7.6	$3.0	$14.8
Assuming $10,000 Deductible Plan					
Beneficiaries Enrolled in MSA	1,629	$6.1	$9.2	$3.1	$15.4

a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Medicare program costs in 1996 including benefits and administration under current trends.

c/ Includes the AAPCC amount for each individual electing the MSA option. Estimate represents the weighted average of the AAPCC amount corresponding to the age, sex, and disability status of each beneficiary entering the MSA program.

d/ Equals plan payment amounts less actual costs for MSA enrollees under traditional Medicare.

e/ These estimates represent an increase in Medicare program costs over the spending levels called for in the recent budget resolution. The increase in Medicare spending declines each year because enrollment in MSAs declines as a result of capping the growth in payments to health plans to 4.9 percent per year as implied by the budget resolution.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

D. ALLOWING ADDITIONAL TAX DEDUCTIBLE CONTRIBUTIONS TO THE MSA

Under some variants of the MSA model, beneficiaries who enroll in the MSA program are permitted to make additional contributions to the MSA that are tax deductible. For example, enrollees could deposit in their account an amount equal to their expected health expenses in excess of the MSA contribution amount. This would effectively permit individuals to pay for virtually all health care expenses (including Medicare covered and non-covered services) with pre-tax dollars resulting in a reduction in federal tax liability. For higher income individuals in particular, this would increase the financial benefit of participating in the MSA, thus leading to an increase in MSA enrollment.

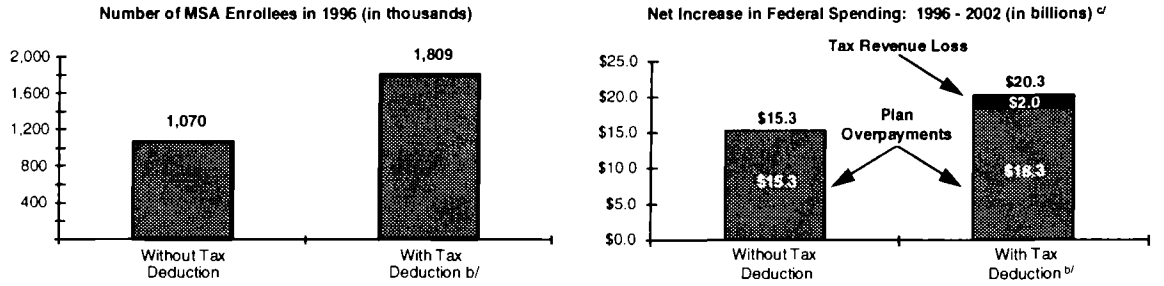
Using HBSM, we estimated the number of persons enrolling in the MSA program assuming that these tax deductible contributions are permitted. In this analysis, we assumed that individuals who enroll in the MSA would deposit in their account an amount equal to what they expect to purchase in non-Medicare-covered services.[11] We then calculated the tax reduction associated with these contributions based upon the marginal tax rates that apply to individuals at various income levels. These tax savings were counted as an additional financial benefit of enrolling in the MSA which results in an increase in our enrollment estimates.

Permitting tax deductible contributions to the MSA would increase MSA enrollment from 1.1 million persons without the tax deduction to 1.8 million with the tax deduction (***Figure 6***). This increase in enrollment would be associated with an increase in the net federal cost of the program over the 1996 through 2002 period from $15.3 billion without the tax deduction to $20.3 billion with the tax deduction. This reflects both the loss of tax revenues due to the deduction ($2.0 billion) and additional plan overpayments under the AAPCC model for those who are added to the MSA program.

[11] This amount was estimated from the HBSM out-of-pocket spending data. For persons who have MediGap coverage under current policy, we assumed that individuals deposit an amount equal to the MediGap premium amount they would have paid under current policy.

FIGURE 6

THE IMPACT OF PERMITTING TAX DEDUCTIONS FOR ADDITIONAL BENEFICIARY CONTRIBUTIONS TO THE MSA [a/]



a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Assumes that MSA enrollees are permitted a tax deduction for additional contributions to the MSA.

c/ Includes the difference between Medicare AAPCC-based plan payments and what Medicare program costs would have been under traditional Medicare in these years. Also includes amount of federal tax loss.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

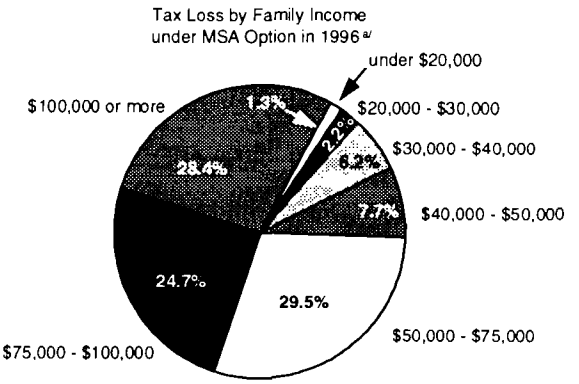
The increase in MSA enrollment due to the tax deduction would be concentrated among higher income groups. In fact, we estimate that with the tax deduction, about 21 percent of all beneficiaries with incomes in excess of $100,000 would enroll in the MSA program (***Figure 7***). The average value of the tax deduction would be $238 per MSA enrollee. The average tax deduction per enrollee would vary from $4.0 for those with incomes of less than $15,000 to $540 for enrollees with incomes in excess of $100,000. Over half of the tax revenue loss due to the deduction would be among MSA enrollees with annual incomes of $75,000 or more.

FIGURE 7

MSA ENROLLMENT AND TAX BENEFITS UNDER THE TAX DEDUCTION SCENARIO [a/]

MSA Enrollment and Average Tax Benefit

Family Income of Beneficiary	Percent in Group Taking MSA	Average Tax Benefit per Enrollee
under $15,000	1.4%	$4
$15,000 - $20,000	3.5%	$27
$20,000 - $30,000	2.4%	$61
$30,000 - $40,000	5.4%	$137
$40,000 - $50,000	10.4%	$145
$50,000 - $75,000	14.8%	$319
$75,000 - $100,000	17.2%	$406
$100,000 or more	20.7%	$540
TOTAL	5.2%	$238



Total Tax Loss: $430.9 million

a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year. Also, assumes that MSA enrollees are permitted a tax deduction for additional contributions to the MSA.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

E. ALTERNATIVE MSA WITHDRAWAL POLICIES

Under all of the MSA scenarios discussed above, we assume that individuals are permitted to withdraw the amount of unspent MSA account balances at the end of the year in excess of 60 percent of the plan deductible amount. Our estimates indicate that under this provision, most individuals would not be able to withdraw significant amounts from the MSA for non-medical uses until after they have participated in the program for a few years. This has the effect of reducing the value to the individual of whatever financial benefit he/she expects to derive by participating in the MSA program. In fact, in the estimates presented above, we adjusted our MSA enrollment model to reflect the impact of this delay in access to these amounts in estimating the net financial benefit of enrolling in the MSA.[12]

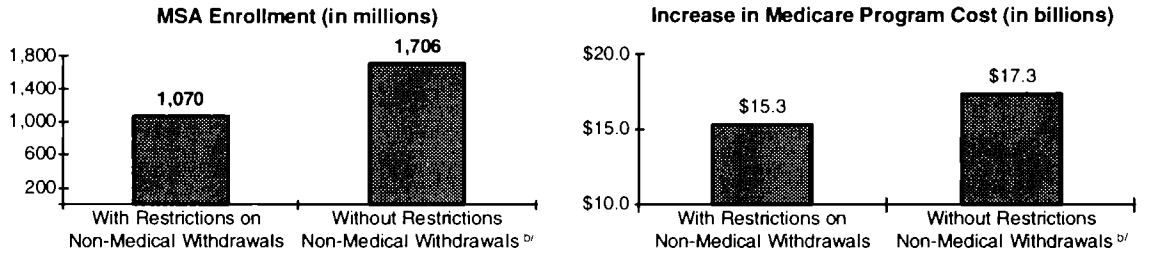
To test the importance of this provision, we estimated MSA enrollment and costs assuming that individuals are permitted to withdraw the entire amount of unused MSA balances at the end of the year. This has the effect of increasing the value to the individual

[12] In developing the estimates presented above, we discounted the expected financial benefit derived from enrolling in the plan to reflect the time value of money. This was done by calculating the net present value of all net benefits from enrolling in the MSA. We used this discounted amount in simulating the enrollment decision. See ***Appendix A*** for details.

of any expected financial benefit from participating in the MSA program by requiring the individual to wait only until the end of the year to access unspent account balances. Under this scenario, the number of MSA enrollees would increase from about 1.1 million with withdrawal restrictions to 1.7 million assuming no restrictions on end-of-year withdrawals (***Figure 8***). The net increase in federal costs under this scenario over the 1996 through 2002 period would increase from $15.3 billion under the program with restrictions to $17.3 billion without the withdrawal restrictions. Again, this reflects the fact that the AAPCC-based plan payment amount is substantially greater than the costs that would be incurred by these disproportionately healthy MSA enrollees under the traditional Medicare program.

FIGURE 8

MSA ENROLLMENT AND NET INCREASE IN MEDICARE SPENDING WITH AND WITHOUT RESTRICTIONS ON NON-MEDICAL WITHDRAWALS [a/]



a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Assumes that all MSA end-of-year balances can be withdrawn at the end of the year.

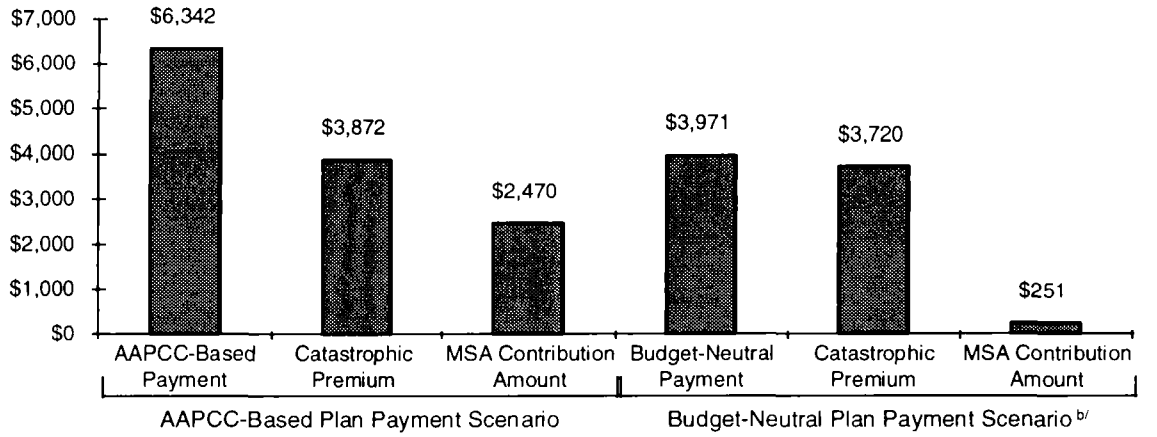
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

F. BUDGET-NEUTRAL OPTION

In theory, the increase in Medicare program costs under the MSA model could be eliminated simply by reducing the plan payment amount to better reflect the actual costs of the disproportionately healthy individuals who will be most inclined to enroll in the program. However, our analysis suggests that to eliminate the net increase in costs under the MSA model, payments would have to be reduced to 55 percent of the AAPCC amount, even though the AAPCC already adjusts payments for age and other factors (***Figure 9***). This is because the promise of cash rewards for MSA enrollees with low health care costs results in such extreme selection bias that the AAPCC amount fails to approximate the true actuarial cost for MSA enrollees.

FIGURE 9

AVERAGE PROGRAM PAYMENTS, CATASTROPHIC PREMIUMS AND MSA CONTRIBUTION AMOUNTS UNDER ALTERNATIVE MSA PLAN PAYMENT METHODOLOGIES [a/]



a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Assumes Medicare payments are adjusted to reflect actual cost of MSA enrollees

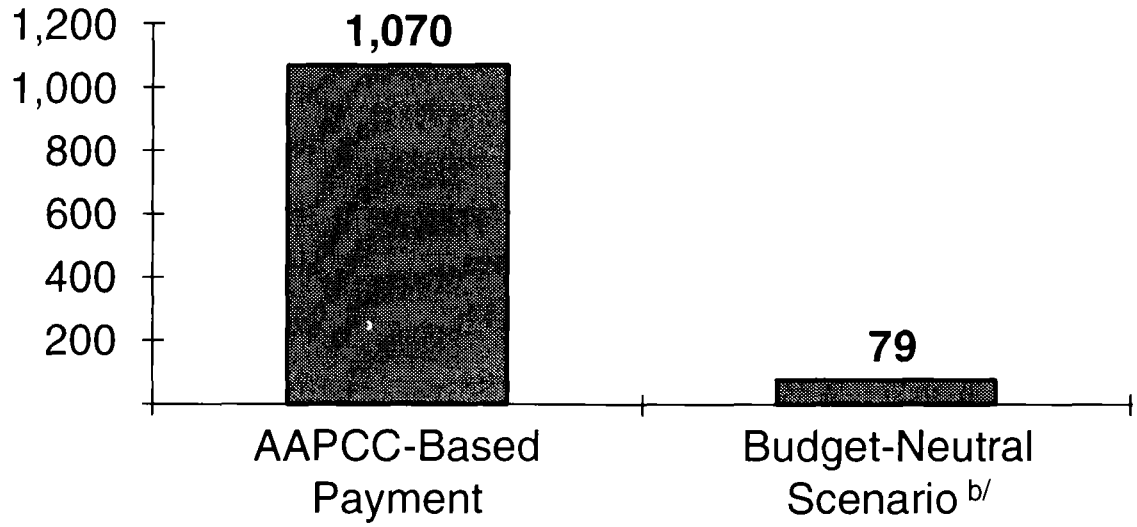
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Reducing payment levels to budget neutral levels would reduce the average plan payment amount from $6,342 under the scenarios discussed above to about $3,971. With this payment amount, plans would be able to make MSA contributions of about $250 per enrollee. This is likely to make the program unattractive to both health plans and beneficiaries resulting in reduced MSA enrollment. In fact, under this scenario, we estimate that fewer than 100,000 persons would enroll (***Figure 10***).

Research is currently under way to develop better risk adjustment methodologies for the Medicare population. Once these methods are developed they would provide a basis for making risk-adjusted payments to plans that reflect differences in risk associated with particular health conditions as well as the basic demographic and geographic adjustments now used. Competitive bidding for MSA contracts could also help offset selection effects. However, these methods are still under development and are largely untested. Moreover, none of the risk adjustment models now being developed is designed to correct for the extreme selection invited by an MSA program that rewards low health services utilization with cash balances.

FIGURE 10

NUMBER OF PERSONS ENROLLED IN MSA OPTION UNDER ALTERNATIVE MSA PLAN PAYMENT METHODOLOGIES [a/]



a/ Assumes an MSA program where private plans receive a total payment equal to the AAPCC amount (i.e., age, sex and disability status adjusted amount by geographic area) for all MSA enrollees. Assumes private insurers provide a catastrophic plan with a $3,000 deductible and contribute to the MSA the difference between the catastrophic plan cost and the AAPCC-based plan payment amount. Assumes no tax deduction for additional contributions to the MSA. Assumes that beneficiaries are permitted to withdraw unused MSA account balances in excess of 60 percent of the deductible amount at the end of the year.

b/ Assumes Medicare payments are adjusted to reflect actual cost of MSA enrollees

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

G. CONCLUSION

Our MSA analysis shows that an optional health coverage program that promises potential cash benefits to persons who are able to keep their health spending low will experience extreme selection bias. Even adjusting MSA plan payments by age, sex, disability status and geography as under the AAPCC method fails to correct for the selection effects that such a program would experience. Moreover it is unclear whether any other risk adjustment methodology could ever fully correct for these selection problems. Thus, the MSA model will almost certainly result in a net increase in Medicare program costs regardless of the risk adjustment model used.

Despite the potential for profitable selection activity however, we find that only about three to five percent of Medicare beneficiaries would enroll in the MSA model. This reflects the fact that Medicare beneficiaries tend to be risk adverse and are often unable to go at risk for high deductible amounts. It also reflects the fact that the value of the AAPCC-based payment amount relative to the cost of insurance in an area varies

substantially across geographic areas. Moreover, only individuals in very good health would have low enough expected health care costs to be able to realize the potential financial benefits of participating in the program.

The impact of the MSA model on beneficiaries and program spending would vary depending upon the actual provisions of the plan. The impacts discussed above would change depending upon how attractive the program is made to health insurers and beneficiaries through: the methods used to pay plans; tax preferences for MSA enrollees; and MSA balance withdrawal policies. Moreover, this study examined a Medicare reform policy that has never before been attempted on a broad scale in the U.S. Our estimates are very sensitive to assumptions concerning behavioral responses by both health plans and beneficiaries. Thus, our estimates should be considered illustrative of potential impacts rather than point estimates of actual policy outcomes.

APPENDIX A:
DATA AND METHODS USED IN THE MSA ANALYSIS

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This analysis required developing a model of health expenditures and Medicare beneficiary behavior when presented with coverage alternatives. We developed a micro-simulation model of individual Medicare beneficiaries based upon the Lewin-VHI Health Benefits Simulation Model (HBSM). This approach permits us to estimate the impact of alternative Medicare voucher programs including MSAs based upon actual health expenditure data for a representative sample of Medicare beneficiaries. It also permits us to develop enrollment and selection effect estimates based upon behavioral models where consumer decisions vary with individual circumstances.

The methods used in this study are presented in the following sections:

- The Health Benefits Simulation Model (HBSM)
- Estimation of Catastrophic Premiums
- Enrollment Behavior

A THE HEALTH BENEFITS SIMULATION MODEL (HBSM)

The Health Benefits Simulation Model (HBSM) is a microsimulation model of the U.S. health care system.[13] HBSM is based upon the National Medical Expenditures Survey (NMES) which is a representative sample of the U.S. population that provides information on household health insurance coverage; health services utilization; and health expenditures by source of payment. The survey also provides basic demographic information as well as income and employment data. These data provide detailed information for Medicare recipients including: health expenses; supplemental coverage data; and beneficiary out-of-pocket expenses and premium payments. These data also include: Medicaid coverage and expenditures; retiree coverage and expenditures data, and MediGap covered services information.

The NMES data are "aged" in HBSM to be representative of the population and health expenditures in the year(s) of analysis (i.e., 1996 through 2002). Population data are first adjusted to reflect the most recent Bureau of the Census data (i.e., the March 1994 Current Population Survey) on the distribution of persons by age, sex, income, family status, sources of coverage, employment by industry firm size and other factors. These data are then aged to future years based upon population projections by age, sex, and state of residence developed by the Bureau of the Census. Income data is also aged to reflect projected income levels by source of income in future years. These income

[13] For documentation of HBSM see: "The Financial Impact of the *Health Security Act*," Appendix D, December 9, 1993.

adjustments are developed with a methodology that reflects historical trends on the changing distribution of income across population groups. These adjustments are based upon data showing income growth for individuals at each decile level of family income for aged and non-aged persons. Tax payments are also estimated for each family using the Lewin-VHI Household Income and Tax Simulation Model (HITSM).[14] Finally, the health expenditure data in the model is adjusted to reflect projections of health spending by type of service and source of payment in future years developed by the Health Care Financing Administration (HCFA).

The resulting database provides a sample of individuals and families that is representative of health expenditures, income and the demographic composition of both Medicare beneficiaries and the population as a whole in future years. These data were used in this analysis to estimate premiums for private health plans with alternative deductible and copayment requirements. These data were also used to identify individuals who would potentially benefit under voucher programs such as the MSA model and to estimate the share of this population that would enroll in the program.

B. ESTIMATING PRIVATE PREMIUMS

A key issue in measuring the impact of the MSA and other voucher-based Medicare reforms is estimating the premium that private insurers will charge for covering Medicare beneficiaries. We developed separate private premium estimates for each state based upon the Average Adjusted Per-Capita Cost (AAPCC) data used to pay HMOs under the current Medicare at-risk program. These data reflect differences in the cost of care provided to Medicare beneficiaries across geographic areas by age, sex, and disability status. We adjusted these AAPCC amounts to reflect various differences between Medicare coverage and private insurance coverage by state. These premium estimates were developed in the following steps:

- **Calculate Weighted Average AAPCC Levels by State:** Using Medicare program data, we estimated the average AAPCC amount for urban and rural areas for each state. These AAPCC amounts represent the average cost of Medicare services provided in each county for various age and sex groups by disability status and Medicaid coverage status. These data are the basis used to calculate Medicare payments to HMOs under the at-risk contracting program. We used a weighted average of the AAPCC amounts in each state because our simulation model does not permit disaggregation of data below the state level. These figures were updated to future years and were used as the AAPCC levels that would apply to persons in each state.

[14] Lewin-VHI, "Documentation to the Household Income and Tax Simulation Model," December, 1991.

- **Adjust the AAPCC Amounts to Reflect Catastrophic Plan:** The value of services covered under a high deductible plan generally will be less than the amounts reported in the AAPCC data. We used the Medicare benefits simulation module of HBSM to estimate the amount of physician and hospital benefits covered under a catastrophic policy. These data were used to adjust the state average AAPCC amounts for physician and hospital spending to reflect the higher deductible.

- **Adjust for Changes in Utilization under a High Deductible Plan:** We adjusted the AAPCC amounts to reflect the fact that individuals are expected to use fewer health services under a high deductible plan. We based this adjustment on data provided by the American Academy of Actuaries indicating that utilization of health services is about 30 percent lower than after the deductible is met.[15] These data were used to adjust the state-level AAPCC payment levels to reflect HBSM estimates of changes in the amount of hospital and physician services reimbursed under a high deductible catastrophic plan. This step was executed in HBSM as part of the prior step to capture the interaction between reductions in service use and covered expenses in excess of the deductible amount.

- **Adjust for Managed Care in the Private Sector:** In this analysis, we assumed that all private catastrophic health plans under the MSA option will be provided through Preferred Provider Organizations (PPOs). We did this by adjusting private plan expenditures to reflect state-level differences in hospital utilization rates in managed care plans as compared to fee-for-service utilization. These adjustments were constrained so that managed care savings in the aggregate do not exceed 12 percent overall.[16] We capped managed care savings at 12 percent to reflect recent research showing that PPOs reduce costs by about 12 percent as compared to fee-for-service plans.[17]

- **Adjust to Private Sector Provider Payment Levels:** Hospital inpatient payment levels under Medicare are on average equal to about 90 percent of costs while private sector hospital inpatient payment levels average about 130 percent of costs.[18] Payments for physician services under the program are also equal to about 65 percent of private payment rates for comparable services.[19] In this analysis, we adjusted the catastrophic premiums to reflect an increase to private payment rates based upon data on actual payment differentials by state. We assumed that hospital costs under the plan are increased by an average of

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[15] American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995.

[16] Based upon state level data obtained from the Health Care Investment Analysts (HCIA) for 1993.

[17] Lewin-VHI, Inc., "New Evidence on Savings from Network Models of Managed Care," Washington, DC, May 1994.

[18] ProPAC, "Medicare and the American Health Care System," June 1995 (based on AHA data).

[19] Holahan, John, "Medicaid Physician Fees, 1990: The Results of a New Survey," The Urban Institute, October 1991.

16 percent to 105 percent of costs and that physicians payments are increased to match private sector payment levels. Separate adjustments were performed for each state due to wide variation in Medicare payments relative to private sector payment levels across states.

- **Adjust Premiums to Private Sector Levels:** We assumed that administrative costs would equal 12 percent of benefits costs. This assumption is based upon recent data on administrative costs in managed care plans.[20] In estimating administrative costs as a percentage of benefits, we computed the administrative cost as a percentage of the full AAPCC payment amount to the plan rather than the catastrophic premium alone to reflect the fact that the insurer must process claims both for the catastrophic plan and the MSA account.

These steps produced estimated AAPCC amounts and private catastrophic premiums by age, sex and disability status for urban and rural areas within each state. These data were then used to estimate which individuals will enroll in the MSA option.

C. ENROLLMENT BEHAVIOR

We estimated the number of persons enrolling in the MSA model based upon the expected savings to the individual under the plan. In this analysis, we estimated the voucher amount for each individual Medicare beneficiary in HBSM based upon the AAPCC amount estimated in the prior step which corresponds to each individual's demographic characteristics and state of residence. The catastrophic premium for each individual is then taken from the matrix of catastrophic plan premiums corresponding to that individual's state of residence and his/her age, sex, and disability status. The difference between the voucher amount and the catastrophic premium is assumed to be the amount of the MSA contribution amount. Thus, under this model, the MSA contribution amount varies across beneficiaries by both the demographic characteristics of the individual and the geographic variations in the price of private insurance relative to the voucher payment amount.

The decision to enroll in the MSA plan is estimated based upon the potential savings to the individual. In this context, the potential savings to a beneficiary is defined to be the difference between the MSA contribution amount and the individual's expected level of out-of-pocket health spending. For example, consider an individual who could potentially enter an MSA with a catastrophic deductible of $3,000 and MSA contribution amount of $2,100 who expects to spend only $700 on health care in the next year. In this case, the individual could be expected to benefit under the plan by $1,400 (i.e., $2,100 -

[20] Data provide by American International Healthcare.

$700). This individual would be more likely to enroll than another individual who expects to spend $1,800 on health care (i.e., potential benefit of $2,100 - $1,800 = $300).

Thus a crucial step in this analysis is estimating the expected level of health spending up to the amount of the deductible for each Medicare beneficiary. We did this by estimating the average amount of spending up to the catastrophic plan deductible for Medicare beneficiaries using HBSM. These figures include the amount of spending for Medicare covered services adjusted to reflect the reduction in utilization resulting from the increased deductible. Average expenditure amounts were calculated for beneficiaries by age, sex, disability status, and self-reported health status. Under a plan with a $3,000 deductible, these average amounts ranged from and average of $730 for younger Medicare beneficiaries reporting themselves in excellent health to over $2,100 for older Medicare beneficiaries in poor health.

Each Medicare beneficiary in the HBSM was then assigned the average expenditure amount for individuals in corresponding age, sex, and health status groups. The imputed amounts were assumed to be the amount that each beneficiary expects to spend on health services up to the amount of the deductible. The difference between the contribution and the beneficiary's expected level of spending is assumed to be the net benefit amount to the individual.

The next step was to estimate the value of the expected benefit to the individual adjusted for the time value of money. For example, under an MSA model where the individual can not withdraw unused MSA balances for non-health-related uses, the value of the benefit to the individual would be less than if they could withdraw some portion of the benefit at the end of the year for other uses. To approximate this effect, we converted the expected net benefit to the individual to its net present value. Thus, benefits that could not be withdrawn until health expenses are incurred in future years were discounted to reflect the time value of money.[21] Consequently, our model shows greater enrollment under a plan that permits end-of-year withdrawals of fund balances than under a plan where these balances must be retained in the account until they incur health expenses in future years.

The MSA enrollment decision is simulated on the basis of this estimate of the discounted present value of the expected benefit to the individual. In this analysis, any individual that has an expected benefit amount under the MSA (i.e., MSA contribution amount minus expected expenses) is assumed to consider the MSA as a lower-cost coverage option to the beneficiary. We then select individuals to take the MSA option

[21] The portion of balances that can be withdrawn at the end of the year are discounted for one year assuming an interest rate of eight percent reflecting the fact that cash can not be withdrawn until a year has passed. Balances that must be retained until future years are assumed to be discounted at an interest rate of eight percent per year assuming funds will remain in the account for ten years.

based upon a study of changes in health plan enrollment associated with differences in individual premium costs in employer groups with multiple health plan offerings.[22] Using data provided in this study, we assumed that each one dollar difference in monthly plan costs attributable to the MSA is associated with 0.34 percent of affected beneficiaries shifting to the MSA option.

The model also estimates the increase in MSA enrollment that is likely to occur if individuals are permitted to make tax-deductible contributions to the MSA. Such a policy would effectively permit individuals to make payments for services not covered under the catastrophic plan in pre-tax dollars. Thus, the tax deduction increases the expected benefit of the plan to the individual by the amount of the tax savings to the individual resulting in higher enrollment. In this analysis, we estimated the potential contribution amount to the MSA to include: 1.) whatever individuals now pay in MediGap premiums; and 2.) the average expected amount of spending for services not covered under Medicare. The tax benefit to the individual is then computed by multiplying the individual's contribution amount by the marginal federal tax rate faced by each individual. This tax benefit amount is added to the expected benefit from the MSA itself. This increases the expected benefit to the individual resulting in higher enrollment.

We impose certain other constraints on the simulation including:

- Individuals enroll in an MSA only if the catastrophic premium is less than the voucher amount.
- Individuals do not enroll in an MSA unless the MSA contribution amount exceeds the expected health spending up to the amount of the deductible.
- We assume that no one will join an MSA if they are at risk for a non-covered expense (i.e., deductible minus MSA contribution amount) in excess of five percent of family income.
- Medicaid recipients are assumed not to enroll.

[22] Buchmueller, T., and Feldstein, P., "The Effect of Price on Switching Among Health Plans," May 1995.