Policy Research, LLC

Evaluation of MSA Plans Under the Medicare Program
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**Case Study Report – FINAL**

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# A. INTRODUCTION

## A.1. Medicare Medical Savings Account Offering Under Medicare Advantage

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) included Medicare Medical Savings Accounts (MSAs) as a permanent Medicare Advantage (MA) plan type for beneficiaries. MSA plans are now available as an additional option under MA along with health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans. In addition to the MA-MSA plans, Congress created demonstration MSA plans that are designed to have similar flexibility as health savings accounts (HSAs) offered in the non-Medicare market. The MSA Demonstration offers greater flexibility in plan design, including coverage of preventive services before the deductible is met. These newly created MSA options are intended to increase consumer choice and encourage prudent purchasing of health care services. Medicare Advantage plans began offering Medicare MSAs beginning January 1, 2007.

A Medicare MSA plan is a special type of Medicare Advantage plan that combines a high-deductible health plan (high-deductible plan) with a tax-favored savings account (MSA account) that is used for qualified medical expenses that are not paid for by the health plan. The high-deductible plan provides coverage for all Medicare Part A and Part B benefits, with no monthly plan premium. Members, however, continue to pay their Medicare Part B premium. Medicare MSA plans do not provide prescription drug coverage; however, enrollees can join stand-alone prescription drugs plans.

MA plans deposit funds annually into the member's medical savings account to help cover their health care expenses. Members are not allowed to deposit their own funds into their medical savings account. If members use the funds for qualified health care expenses, as defined by the Internal Revenue Service, the funds are not taxed. Members can use their funds for Medicare-covered Part A and Part B services, which count toward their annual deductible, as well as for other qualified expenses. Once members have reached their deductible, the health plan is responsible for all Medicare-covered services. Funds left in the medical savings accounts at the end of the year remains in the members account and can be used to cover health care costs for the following year. At the beginning of each year, an additional deposit will be made into the medical savings account, if the enrollee chooses to re-enroll into the MSA product.

## A.2. Description of CMS Evaluation of Medicare MSA Offering

The Centers for Medicare & Medicaid Services (CMS) is sponsoring an evaluation of the MSA plans offered under the Medicare Advantage program. In the context of the Medicare population, these plans raise a variety of important policy issues that will be explored in this evaluation. The evaluation focuses on examining early patterns of enrollment, market entry and risk selection among Medicare MSAs, and their potential effects on Medicare and beneficiary payments. The four key study aims include:

- Aim 1: Describe the early patterns of enrollment into MSA plans;
- Aim 2: Examine the early stages of the development of the MSA market;
- Aim 3: Document the potential for risk selection; and

- Aim 4: Explore the impact of MSA plans on Medicare program spending.

MSAs have been tested in the non-Medicare market with the Health Insurance Portability and Accountability Act (HIPAA) MSA offering, but this is the first time that high-deductible plan offerings are available in the Medicare Advantage market. Medicare MSAs were first introduced in the Balanced Budget Act of 1997, which created a demonstration pilot allowing up to 390,000 beneficiaries to enroll into MSAs. However, no private insurers contracted with CMS to offer such plans. Insurers felt that the design of the demonstration pilot limited their ability to offer a viable product.

A key area of interest is the take up of the MSA plans by Medicare beneficiaries. As of April 2008, about 3,500 beneficiaries were enrolled in such plans. As part of the evaluation, MSA enrollees will be profiled in terms of their demographic characteristics, health status, and health care utilization. Another research task will explore beneficiaries' initial reasons for enrolling into MSA plans and their early experience with MSA plans.

Another area of interest is the development of the MSA market. Without adequate health plan participation, Medicare beneficiaries' ability to choose an MSA plan will be limited. In addition, it will be important to identify any barriers to entry and understand why health plans decided to offer or not offer MSA plans. In 2007, three health plans offered MSAs. Four health plans offer MSA plans in 2008.

The evaluation will also explore the potential for risk selection. Some have contended that MSA plans tend to attract healthier enrollees, which raises the cost for those who remain in more traditional options. Finally, the study will examine the impact of MSA plans on Medicare program spending. An open issue is whether these types of benefit structures will result in savings to the Medicare program.

A combination of qualitative and quantitative research methods will be used throughout the evaluation, including:

- **Case studies** will be used to gain first-hand information from health plans regarding their participation in the MSA market, especially the reasons for offering (or not offering) MSA plans. In addition, the case studies will explore factors examined in establishing the target market for MSA plans; sales and marketing of MSA plans; design and pricing strategy of MSA plans; and early experiences in offering and managing the plans.

- **Focus groups and in-depth interviews** will be used to collection information on attitudes about, knowledge of, and experiences with the MSA plans. Using both of these methods, the research team will seek information about the MSA plans from a variety of different audiences, including: MSA plan enrollees, non-MSA MA plan enrollees and fee-for-service enrollees; State Health Insurance Assistance Program (SHIP) counselors and state SHIP directors; primary care physicians (PCPs); and, insurance agents and brokers.

- In-depth **analyses of Medicare administrative data** will be performed to address issues related to selection bias and impact of MSA plans on Medicare spending. In addition, the

evaluation team will use administrative data to profile the characteristics of MSA enrollees.

## A.3. Description of Case Study Component of Medicare MSA Evaluation

Case studies are an important tool for getting first-hand information from health plans that made a significant effort to develop and market MSA plans. The discussions focused on the health plan's core competencies and weaknesses, and how they may have influenced the plan's decision about whether to enter the MSA market. It also addressed perceived opportunities and threats that may have also influenced the health plan's decision to enter the market. This part of the evaluation also explored the development of the MSA plan, the characteristics of the MSA plan, and the sales and marketing of the MSA plan.

The key research questions addressed by the case studies include:

- What are health plans' reasons for offering or not offering MSA plans?
- Why did health plans choose to offer plans under the demonstration versus the regular MA option?
- With regard to the demonstration MSA plans, what impact did the transparency requirements have on health plans' decision to offer (or not offer)?
- Do those health plans who participate have organizational and experiential differences compared to those who do not participate?
- What are the characteristics of MSA plans?
- For those companies who participate, what are the means by which their plans are marketed and sold?
- Are health plans offering prescription drug plans that are being marketed to MSA enrollees?
- What are health plans' initial experiences with MSA plans?

### *A.3.1. Case Study Methodology*

Field visits were conducted between March 2008 and May 2008 with four health plans offering MSAs in 2008 (offerors) and three telephone interviews were conducted with health plans that do not offer MSAs (non-offerors). The research team used a semi-structured protocol to guide the discussion. Copies of the protocols are provided in Appendix A. Prior to the field visit, the research team provided each health plan a cover letter that described the purpose of the evaluation and the case study component and provided assurances that the team would work with the health plan to address any privacy or confidentiality issues. We also provided the health plan with a letter from CMS encouraging their participation in the study.

The research team conducted discussions with health plan staff most involved in the development of their MSA plan. Generally, health plan staff from sales and marketing, product development, government relations, and strategic planning participated in the discussions. Actuarial staff were not able to participate in the discussions because of the June 2nd deadline

for submitting Medicare Advantage bids for contract year 2009. The research team will follow-up with the health plan actuarial staff after June 2, 2008.

## B. DESCRIPTION OF MEDICARE MSA MARKET

### B.1. Characteristics of Offerors

In 2008, four health plans chose to offer Medicare Medical Savings Account (MSA) plans. Universal American Financial Corporation had participated in the MSA market in both 2007 and 2008, but left the market in the early part of 2008. For evaluation purposes, we consider Universal American Financial Corporation as an offeror. For their full book of business, these four offerors represent nearly 40 million lives. However, the number of enrollees ranges from 34 million to just over 200,000 across the four plans. All but one health plan sells products on a national scale. These three national health plans operate under several different names and brands. Only one of the plans offering the MSA product was limited in geographic scope; this plan focuses sales in central and northeastern Pennsylvania. Of the four MSA offerors, three are national companies that are publicly traded, and one is a smaller regional plan that is non-profit. A table summarizing these characteristics in presented in Exhibit 1.

**Exhibit 1. MSA Offeror Characteristics**

| | Geographic Scope | Publicly Traded | Total Members 2007 | MA Members 2007 |
|---|---|---|---|---|
| **WellPoint, Inc.** | National | Yes | Approximately 35 million | Approximately 1.2 million |
| **Coventry Health Care, Inc.** | National | Yes | Approximately 4.7 million | Approximately 286,000 |
| **Geisinger Health System** | Regional | No | Approximately 209,000 | Approximately 37,000 |
| **Universal American Financial Corporation** | National | Yes | Approximately 2 million | Approximately 240,000 |

Source: Case study interviews with health plan staff.

All offerors had a full array of Medicare services and products prior to joining the MSA market. Specifically, these plans offered stand-alone prescription drug programs (PDPs), health maintenance organization (HMOs), preferred provider organizations (PPOs), and private fee-for-service (PFFS) options. Prior to offering the MSA, each plan had success in another area of the MA market; for example, PFFS sales in 2007 boomed for one plan. HMO sales were a constant success for another plan. Success in other areas of the MA market may have positioned these offerors to sell the MSA product.

## B.2. Description of MSA Plans and Account

### *B.2.1. MSA Plans*

Health plans offered their MSA plans only to the individual market, stating there was very little interest in MSAs in the employer market. Each health plan underwent an iterative process with actuarial firms to determine the amount of the deductible and deposit for the MSA account by reviewing demographics and reimbursement rates. At the time of the interviews, the actuaries involved in the development of these products were not available because they were busy preparing Medicare Advantage bids for the upcoming plan year. The research team plans to follow up with these individuals after the due date for these bids (June 2, 2008). Other staff for the health plans offered anecdotal information regarding the pricing of these products.

All mentioned that utilization played a role in the assumptions for the MSA account. Two plans noted that the pricing of the high deductible products was driven by an expectation of lower use of services; as beneficiaries become aware of the high deductible, they would tend to decrease utilization. These plans mentioned this assumption was used in the pricing of the MSA product, and did, in fact, make the product more attractive. However, when probed by evaluators, health plans did recognize that because there are no real barriers to service in the MSA, enrollees might spend the money in their account freely and, consequently, the MSA product may not discourage utilization to the same extent as a high deductible health plan with no associated health savings account. Subsequent tasks in this evaluation will address this issue.

The key for the offerors was determining pricing and trying to "find the balance between the deposit and the deductible." In terms of pricing of the account, one health plan indicated that the MSA was very difficult to price because much of the profit went to the administration of the banking account and into the members' account. Another noted that the MSA plan must be priced conservatively as "one dollar may make a huge difference" in the senior market. Along the same vein, a third offeror indicated that being able to put enough money in the account represented a "tip point." If the amount is too low, no one will sign up. The MSA options offered by each health plan are presented in Exhibit 2.

Given the complexity of determining the appropriate deductible and deposit, most offerors only focused on a single option in their first year of selling this product. If a plan offered more than one option, it was done in a limited geographic area. Only two of the plans offered more than one MSA plan option, however, each plan offered only one option in any given location As noted above, the plans with the most enrollees are structured quite similarly; the difference between the deductible and the deposit ranges from $1,250 to $1,500. The Universal American plan is the only offeror without an option in this range. In all cases, once the deductible was met, enrollees would not be responsible for any further costs for Medicare services.

**Exhibit 2. MSA Options Offered by Plan, 2008**

| Parent Company | Organization Name | Plan Name | Deductible | Deposit |
|---|---|---|---|---|
| Coventry | First Health Life & Health Insurance Company | Advantra Savings - Plan I | $2,500 | $1,250 |
| Coventry | First Health Life & Health Insurance Company | Advantra Savings - Plan II | $4,000 | $1,570 |
| Geisinger | Geisinger | Geisinger Gold Reserve | $3,000 | $1,500 |
| Universal American Corporation | Universal American Financial Corporation | MPower Health | $4,000 | $1,558 |
| WellPoint | Anthem Health Plans, Inc. | Smart Saver | $3,500 | $1,175 |
| | Anthem Health Plans of New Hampshire | Smart Saver | $3,000 | $1,225 |
| | Anthem Insurance Companies, Inc. | Smart Saver | $3,000 | $1,300 |
| | Blue Cross of California | Smart Saver - Plan I | $2,750 | $1,000 |
| | Blue Cross of California | Smart Saver - Plan II | $3,800 | $1,375 |
| | Blue Cross of California | Smart Saver - Plan III | $5,100 | $1,725 |
| | Empire HealthChoice Assurance, Inc. | Smart Saver | $3,000 | $1,300 |
| | Rocky Mountain Hospital and Medical Services, Inc. | Smart Saver | $4,000 | $1,175 |
| | Unicare Life and Health Insurance Inc. | Save Well - Plan I | $2,750 | $1,250 |
| | Unicare Life and Health Insurance Inc. | Save Well - Plan II | $4,000 | $1,375 |
| | Unicare Life and Health Insurance Inc. | Save Well - Plan III | $5,000 | $1,575 |

Source: CMS. Medicare Medical Savings Account (MSA) Plans by State Data – Calendar Year 2008.

### *B.2.2. Medical Savings Account*

All the offerors have partnered with a financial institution to act as a custodian for the medical savings account. With the exception of Universal American Financial Corporation, the remaining offerors had an existing health savings account relationship with their financial institution. Mellon Bank administers health savings accounts for both WellPoint and Geisinger and HealthEquity administers the accounts for Coventry. Exhibit 3 displays the features and costs associated with MSAs. Two health plans, Coventry and Geisinger, pay the banking fees of the MSA plan for their members. In total, these fees can amount to $50 to $60 dollars per year. However, if members disenroll from the health plan but choose to continue their MSA, members are then responsible for the monthly maintenance and other fees associated with the MSA. The interest rates offered by MSAs are similar to regular savings accounts ranging from 1.03% to 1.375%.

Finally, other common services provided by MSAs include: debit card and checkbook services; telephonic and online access to account balances and claims payment status; and record keeping and tax reporting services.

**Exhibit 3. Characteristics of MSAs**

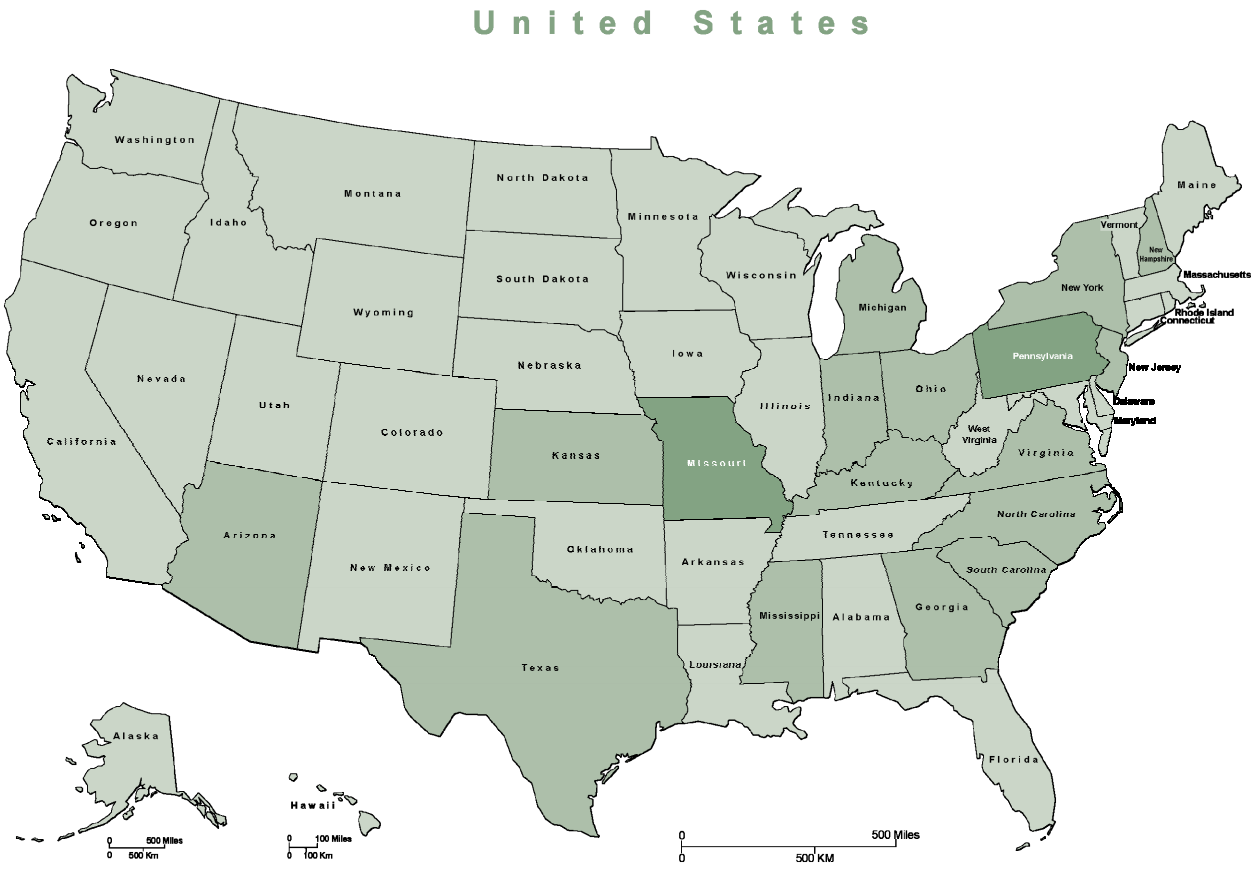
| | Custodian | Set-up and Monthly Fee | Other |
|---|---|---|---|
| **Wellpoint, Inc.** | Mellon Bank | $15 set-up<br>$3.25 monthly | Debit card and checkbook |
| **Geisinger Health System** | Mellon Bank | None: GHS pays these fees for members | Debit card and checkbook |
| **Coventry Health Care, Inc.** | HealthEquity | None: Coventry pays these fees for member | Debit card only |
| **Universal American Financial Corporation** | Bank of America | Not available | Not available |

Source: Health plan custodian materials.

## B.3. Where MSA Plans are Being Offered

Just as the geographic reach of MA plans varied prior to the MSA offering, the four health plans varied geographically, as well, in where they offered the MSA product. As depicted in Exhibit 4 below, MSA plans were generally offered in a variety of geographic areas by the national plans. WellPoint, through its subsidiaries, offered the MSA product in all 50 states; Coventry targeted 11 urban areas and New Hampshire. The sole non-national health plan, Geisinger Health Plan, offered the MSA in a selection of counties in Central Pennsylvania. In terms of the MSA demonstration plan, this option was only offered in one state: Pennsylvania, though the offeror originally considered selling this plan in New York State. Those plans that did not offer the MSA product to their entire service area noted that they just wanted to gain experience and "get their feet wet" with the MSA product. Two plans also mentioned that the reimbursement rates in certain counties made the MSA product less viable and therefore, the plans did not opt to sell in those counties. Moreover, the two plans remaining in the MSA market that did not offer the MSA product in all states indicated that they would like to expand the number of areas in which this product is offered in 2009.

**Exhibit 4. Geographic Offerings of the MSA Products, 2008**




Source: CMS. Medicare Medical Savings Account (MSA) Plans by State Data – Calendar Year 2008.

Legend:

- State with standard MSA plan offered by 3 health plans and MSA Demonstration plan offered
- State with standard MSA plan offered by 2 health plans
- State with standard MSA plan offered by 1 health plan

## B.4. Number of Plans Sold (2007, 2008)

Exhibit 6 on page 11 illustrates the number of plans sold by each offeror. About 2,200 Medicare MSA plans had been sold by the end of 2007, the first year of the MSA offering. The following year showed a small increase in MSA enrollment. April 2008 enrollment figures from CMS indicated that 3,524 MSA plans had been sold, about a 50 percent increase in enrollment over the previous year. These figures are well below offeror's initial enrollment expectations. One health plan did not provide their initial enrollment expectations, but did express disappointment that their enrollment figures were lower than expected. Another health plan projected 2,000 enrollees while a third health plan expected 1,000 enrollees in their first year of offering the MSA plan. The fourth MSA offeror reported that they expected anywhere between 500 and 20,000 enrollees.

By health plan, WellPoint had the greatest number of MSA enrollees. Offering in all 50 states, WellPoint had about 86 percent of the MSA enrollees, or 3,062 members. WellPoint's enrollment was highest in Louisiana and the southwestern states. All enrollees for Geisinger Health Plan were in central Pennsylvania, with the highest number of enrollees in Lancaster and York counties (just west of the Philadelphia area). Coventry, which had limited offerings across the country, had the greatest pocket of enrollment in the Cincinnati, Ohio area.

While plans are offered in all 50 states, MSA enrollment is "concentrated" in a relatively limited number of counties. Of the 3,141 counties or county equivalents in the United States, there are only 78 counties with at least 10 MSA enrollees. The table below shows the 10 counties with the highest MSA enrollment. These 10 counties account for approximately 17 percent of all MSA enrollees.

**Exhibit 5. Ten Counties with the Highest MSA Enrollment**

| County | State | MSA Enrollment (as of 4/08) |
|---|---|---|
| Maricopa | AZ | 144 |
| Lancaster | PA | 83* |
| Ouachita | LA | 59 |
| Sonoma | CA | 58 |
| Los Angeles | CA | 48 |
| St. Landry | LA | 46 |
| Atlantic | NJ | 45 |
| Sedgwick | KS | 44* |
| Person | NC | 36 |
| Garfield | CO | 33 |

* Lancaster, PA and Sedgwick, KS have two MSA plans available. The enrollment number included above is for only one of the two plans available in the county. Enrollment information for the second plan is unavailable because there are nine or fewer individuals enrolled in the plan. Therefore, there may be as many as 9 more beneficiaries enrolled in MSA plans in these two counties than displayed above.

Source: CMS. Monthly Medicare Advantage/Part D Contract and Enrollment Data.

It is interesting to note that among the 10 counties with the highest enrollment, two counties encompass major metropolitan areas – Maricopa County, AZ (Phoenix) and Los Angeles County, CA. The other eight counties appear to be located in less urban areas. Subsequent research tasks under this contract will attempt to further explore this and other factors that impact MSA enrollment.

## Exhibit 6. MSA Monthly Enrollment by Health Plan, January 2007 to April 2008

| Monthly MSA Enrollment by Health Plan | Jan 2007 | Feb 2007 | Mar 2007 | Apr 2007 | May 2007 | Jun 2007 | Jul 2007 | Aug 2007 | Sep 2007 | Oct 2007 | Nov 2007 | Dec 2007 | Jan 2008 | Feb 2008 | Mar 2008 | Apr 2008 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Anthem Insurance Companies, Inc./Anthem BCBS (Wellpoint) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 29 | 339 | 347 | 435 |
| Empire Health Choice/ Empire BCBS Assurance, Inc. (Wellpoint) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | * | * | * | * |
| Anthem Health Plans, Inc./ Anthem Blue Cross Blue Shield (Wellpoint) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | * | * | * | * |
| Blue Cross of California/ Anthem Blue Cross (Wellpoint) | * | 128 | 135 | 181 | 184 | 187 | 191 | 202 | 212 | 215 | 217 | 216 | 220 | 256 | 256 | 277 |
| First Health Life and Health Insurance Co./Advantra Savings (Coventry Health Care, Inc.) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 17 | 190 | 205 | 206 |
| Unicare Life and Health Insurance, Inc./Unicare (Wellpoint) | * | 2,110 | 2,047 | 2,148 | 2,077 | 2,062 | 2,061 | 2,070 | 2,055 | 2,045 | 2,055 | 2,055 | 1,949 | 2,315 | 2,258 | 2,335 |
| Rocky Mountain Hospital and Medical Services, Inc./Anthem BCBS (Wellpoint) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | * | * | * | * |
| Geisinger Indemnity Insurance Co./Geisinger Gold (Geisinger Health System) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 107 | 244 | 246 | 256 |
| Anthem Health Plans of New Hampshire, Inc./Anthem BCBS (Wellpoint) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | * | * | * | 15 |
| American Progressive/ MPower Health (Universal American Financial Corp.) | * | * | * | * | * | * | * | * | * | * | * | * | N/A | N/A | N/A | N/A |
| **TOTAL** | **< 30** | **2,238+** | **2,182+** | **2,329+** | **2,261+** | **2.249+** | **2,252+** | **2,272+** | **2,267+** | **2,260+** | **2,272+** | **2,271+** | **2,322+** | **3,344+** | **3,312+** | **3,524+** |

Source: CMS. Monthly Medicare Advantage/Part D Contract and Enrollment Data: January 2007 to April 2008.

## C. KEY FINDINGS

### C.1. Decision to Enter the MSA Market

As noted above, the four health plans positioned themselves in the MA market prior to joining the MSA market. The growth of the internal business may have also played a role in this positioning. All health plans felt that the addition of the MSA product would make their companies a full service organization and a "one-stop shop" for MA products. All four plans mentioned wanting to diversify their offerings and expressed an interest in being able to offer Medicare beneficiaries many choices. One health plan became interested in the MSA product after segmenting the marketplace. This offeror determined that the MSA would help them grow in this service area.

*"We want products to meet the diverse needs"*

*"Why should it be different when people are 65? They should have their choices, too!"*

Previous health savings accounts (HSAs) offerings did not play a huge role in companies' decisions to enter market. While three health plans did offer the HSA plans in the commercial market, all noted that the HSA offering did not play a role in the decision to offer the MSA plan. In fact, one plan noted, "The HSA has not been a huge hit, but why not see if the MSA is viable?" Aside from using similar claims processing vendors and custodians, none of the plans mentioned collaboration with the commercial side of their organization. Few lessons seem to have been drawn from the under 65 market for the 65 MA market. Though previous experience did not play a role in entering the MSA market, three plans mentioned the desire for people with HSAs now to enroll into the MSAs in the future. Three plans noted additional experience offering high deductible plans. One plan offered these plans in both the group and individual market – the other solely in the individual market.

Additional factors influencing the decision to enter the MSA market included (1) personal reactions, (2) the political climate, and (3) the consumer directed health plan market (CDHP). For two of the four health plans, there was a personal interest in offering the MSA product. These individuals personally liked the product and noted they would be interested in the MSA product if they were in the senior market. One plan representative told of a senior officer receiving a good reaction after discussing the MSA plan at his country club. For another plan, the representative felt that the political climate made it a good time to enter into the MSA market. Finally, one health plan specifically mentioned a commitment to consumer directed health plans as a chief reason for entering the MSA market. This plan is trying to get "learnings" in the CDHP market.

When considering whether or not to enter the MSA market, all of the health plans wanted this product to reach a new segment of the market or "piece of the pie." None expected nor wanted the MSA product to take current members away from other products, but rather they wanted the MSA to encourage new members to join. Two of the health plans indicated, though, they would like the Medicare Supplement enrollees to change to this Medicare Advantage product.

*"We were hoping for a new market niche. We did not want to cannibalize off of our own."*

*"We don't want this as a Medicare Advantage replacement… unless the person wants to be in control."*

Not all of the health plans had data on the MSA enrollees. However, for one health plan, only ten (approximately 4 percent) of the MSA enrollees were existing members. The rest of the MSA membership represented new enrollees to the health plan.

Finally, health plans offering MSAs saw their organization as willing to take risks to be innovators in the market:

*"We like change and innovation. That is why we offered this product".*

### C.1.1. Demonstration vs. Standard Plan

All health plans considered both the MSA Demonstration Plan and the standard MSA plan. Only one plan opted to participate in the demonstration. The health plans noted the following issues with the demonstration plan:

- *Statewide rate*. Three offerors (and one non-offeror) indicated that the requirement to provide one rate statewide was an issue, as most pricing is done on a county level. Offerors did not want to offer the same deductible statewide. Even the health plan that offered the MSA demonstration plan noted that it was difficult to make assumptions on the statewide level.

  *"We do a lot of our segmentation by county and we are not ready to go statewide."*

- *Preventive Care*. One offeror noted that the preventive care option of the MSA demonstration is attractive; however, should preventive services be added, the deductible would need to increase, or the deposit would decrease.

  *"Buying up for preventive services flew in the face of the zero premium concept."*

- *Transparency Requirements*. Two of the four health plans indicated that the transparency requirements did not play a role in their decision to offer the standard MSA plan over the MSA demonstration plan. In fact, one health plan acquired a company to help them report cost and quality information to members to help them make better decisions; this offeror plans to provide ratings for physicians who participate in MSA plans and the costs of treatments. However, one plan did mention the transparency requirement as an issue, as they were not sure whether or not they would be able to provide such information for non-network providers.

- *Timing*. One plan noted that the selling season of the demonstration plan was particularly short. Once the demonstration plan was approved, agents could only sell throughout the annual election period. Another offeror noted that they were too far down the development path when the demonstration plan came out. At this point, this offeror does not want to change from the standard plan. Timing was a consistent issue for offerors and caused them to opt for the standard MSA plan.

*"The selling thing was the killer."*

The health plan that did offer the demonstration plan opted to do so because of "business reasons." But, specifically that the demonstration allowed a co-payment after the deductible was met, an attractive feature, especially if the MSA were to be integrated into an employer market. One health plan reported that there was interest by some large employer groups in the MSA product, particularly the demonstration plan because of its similarity the employer's HSA option.

### *C.1.2. Questions about the MSA Product*

Prior to entering the MSA market, the health plans noted a series of questions about the product. Most questions from the offerors involved the flow of funds and the eligibility requirements. It was initially unclear to offerors when the money would be available in the account and when CMS specifically would deposit the funds into the account. As CMS processes enrollments early in the month and then waits until the first of the next month to deposit the funds, many members were questioning at what point their debit cards would work. Two plans opted to fund the account as soon as the enrollee was eligible, despite the fact that the funds from CMS may arrive weeks later. Additionally, eligibility requirements were an issue for one plan who was unsure if Veterans were able to enroll in the MSA plan or not.

Similarly, two of the health plans had questions about prorating the deductible and deposit from members who enrolled after January.

*"You may have some enrollments in January and March, and they get a prorated share of the amount deposited, but still have the full deducible… which isn't fair."*

All health plans noted that the custodian had similar questions regarding the CMS regulations on the bank account. Most banks are not familiar with the CMS requirements and had difficulty understanding what was required of them, even though two of the three financial institutions have experience with health savings accounts. Of similar concern, two plans noted that the banks are not used to the CMS reporting requirements.

Despite all of these concerns prior to entering the MSA market, all plans indicated that CMS was responsive to questions or concerns after they began offering the MSA. However, these plans noted that the guidance from CMS was sometimes contradictory or unclear, as both parties were still trying to work out all of the kinks in the MSA process. They indicated that things improved considerably over time. Because of the uncertainty about rules and operating procedures, a number of plans indicated that they were satisfied with the relatively modest initial enrollments. While all of the health plans had hoped for higher enrollment numbers, and increased enrollment between 2007 and 2008, these plans indicated they are hopeful and looking towards the future.

## C.2. Decision Not to Enter the MSA Market

This section summarizes interviews with 10 health plans[1] that provided their rationale for not offering the MSA product. Several health plans commented that MSAs are potentially attractive products for beneficiaries who are aging into Medicare and have experience with health savings accounts. One health plan indicated that they would not enter the MSA market for another three to five years, unless enrollment increases significantly. However, in the interim, this health plan is developing a transition product that features a high-deductible plan with a health savings account for uninsured retirees aged 50 to 60.

Several health plans noted that their market was either not primed for consumer directed health plans or unable to support multiple health plan options. Health plans noted that they saw little demand for health savings accounts or medical savings accounts in their marketplace.

One health plan felt that they "just can't offer everything" especially a complex product with high start-up costs such as an MSA. Another health plan echoed these reasons and added that it would be a challenge to educate beneficiaries on MSAs given their short marketing and selling season, which they reported was between October and December. Establishing a relationship with a financial institution was another factor in one health plan's decision not to enter the MSA market.

Despite re-evaluating the MSA option on annual basis, one health plan is concerned about the financial risk associated with offering MSAs. This health plan was uncomfortable funding the savings account without knowing how much they would be paid by CMS, which would be determined when a consumer enrolled in the product.

## C.3. Sales and Marketing of MSA Plans

This section examines how MSA plans are being marketed to Medicare beneficiaries. Offerors used various distribution channels to market their MSA plan. Health plans used brokers and agents, captive agents (those agents employed directly by the health plan), and direct marketing activities concurrently to market their MSA plan. In addition, one health plan sponsored four to five small group presentations during the open enrollment season to educate individuals on the MSA plan. Most health plans sold their MSA products through brokers and agents, but only a small number of brokers within each health plan sold the product.

In terms of broker commissions, health plans use the same commission scale for the MSA plan as other Medicare Advantage products. Thus, there are no financial disincentives for selling a high-deductible plan compared to a more comprehensive product if, for example, commissions are based on a percent of the plan premium amount. However, two offerors reported that because of the complexity associated with a tax-preferred account, it may take more time to explain the MSA plan compared to other insurance products. Another health plan disagreed, stating that MSA plans were not more time consuming to sell.

[1] Note that the evaluation team conducted three health plan interviews. The other seven interviews were provided to the evaluation team by our Government Task Leader who had collected information from another contract on reasons why health plans did not offer MSAs.

After their experience with selling the MSA plan, offerors wanted to re-tool their distribution strategy. Two health plans suggested that financial advisors may be better able to educate individuals on the tax preferences associated with the MSA.

Traditional training methods for new health insurance products were used by health plan to educate brokers and agents on the MSAs. These training sessions were either conducted in-person or online. Offerors approached the breadth of MSA training differently. One health plan had trainings that were specific to MSAs and provided to all brokers and agents while one health plan made the training only available to those who requested it. Another health plan incorporated the MSA product along with the other Medicare Advantage products in their yearly update trainings.

### *C.3.1. Main Selling Features of MSAs*

Health plans were asked about which features of MSAs were highlighted by their distribution staff. Two offerors indicated that brokers and agents highlighted the deposit into the savings account, which can be saved and used for future health care expenses.

One health plan encountered an issue with a broker selling their MSA plan door-to-door and remedied this situation. As a result of this, the health plan surveyed all their MSA enrollees to ensure that their members understood health coverage under the MSA plan.

### *C.3.2. MSA Target Market*

Two health plans shared their target market for MSAs. One health plan described the model MSA buyer as higher income individuals (e.g. with over $40,000 in income). Another health plan felt that their brokers segmented the market into two groups. The first group includes individuals who want comprehensive coverage and are willing to pay for it. The second group includes individuals who are interested in a zero premium health plan. They felt that only individuals in the second group would be interested in MSAs.

### *C.3.3. MSAs and Prescription Drug Plans*

Health plan staff felt that it was important to provide beneficiaries with both the health and prescription drug coverage. Moreover, health plans indicated that brokers and agents routinely sold MSAs from one health plan and a stand-alone prescription drug plan from another health plan.

### *C.3.4. Characteristics of Current Enrollees*

Offerors were able to provide anecdotal information on the demographic characteristics of their MSA enrollee. One offeror indicated that the demographics did not have any consistent patterns. Another health plan indicated that their enrollees were in the middle-income range and tended to be younger. Finally, one offeror shared a detailed age breakdown of their enrollees. One-third of their MSA enrollees are between 65 to 69 years old and another one-third are 75+ years old. In addition, based on the counties in which most MSA plans were being sold, the health plan indicated that these counties tended to have higher income levels.

## C.4. Early Health Plan Experience with MSAs

Overall, the plans initial experiences in offering and managing the MSA plans have mostly been positive. Although plans reported several challenges, they were generally able to work around issues. From the member perspective, the most common issue centered around when the member would receive the deposit and be able to use their debit card. As mentioned above, two of the plans chose to address this issue by funding the member account before receiving the deposit from CMS. From the plan's perspective, the most significant issues, which are described in more detail below, included issues related to developing MSA-specific marketing materials, setting up the medical savings account, recovering funds from disenrollees, and prorating the plan deductible.

### *C.4.1. MSA-Specific Marketing Materials*

All of the plans reported difficulties with the process of developing marketing materials for the MSA plans. All of the plans specifically mentioned the lack of MSA-specific model marketing materials as a significant challenge in developing and marketing the plans. The plans indicated that the model Evidence of Coverage and Summary of Benefits, two documents required by CMS, did not include language appropriate for the MSA plans. Three of the plans also stated that the lack of other supplementary materials was a barrier to the marketing efforts and/or a challenge for implementation. One plan stated they needed a brief educational piece to explain MSA plans generally and suggested that CMS develop a one-page handout for beneficiaries about how to make decisions about their health care coverage. Another plan indicated that they sought guidance from CMS for developing marketing materials, such as an MSA plan brochure, but did not receive information in time to develop any materials to market their plan the first year it was offered. Finally, the third plan stated that there is a need for a series of MSA member letters, such as a letter explaining the medical savings account, in order to facilitate management and oversight of the plans.

Two of the plans also reported issues related to the marketing review process at CMS. These plans reported that there was significant confusion about who within CMS was responsible for reviewing the materials and that the point of contact changed several times as CMS tried to decide whether the materials should be reviewed by the same reviewer as for the plan's other MA offerings or by a separate MSA-specific reviewer. Because of changing points of contact, the plans were often given conflicting or inconsistent guidance about their materials. Both plans indicated that this issue appears to have been resolved, as CMS has now assigned a single reviewer who has been very responsive and provided helpful and consistent guidance on their materials.

In addition, one of the plans identified two other issues with the marketing review process—the inability to "file and use" marketing materials and the requirement that all MSA materials are reviewed under the 45-day standard review timeframe.

### *C.4.2. Establishing the Medical Savings Accounts*

The Patriot Act includes several requirements for individuals establishing new bank accounts, which presented some challenges for setting up the medical savings accounts. One plan stated

that banks are required to gather additional information from account holders and when members were not responsive, the custodian could terminate the account. Another plan explained that failure to meet all of the Patriot Act requirements, such as a requirement for a street address rather than a Post Office box, led to several accounts being frozen. Nearly all of the plan's funding difficulties were related to the Patriot Act requirements.

*"Once they got their documents, some members tried to use the materials, but the Patriot Act screening has some disconnects, as well. If their preferred mailing is a P.O. Box, funds will be frozen. We need to know about Patriot Act screening sooner."*

### *C.4.3. Recovering Funds from Disenrollees*

Two plans reported significant challenges with CMS's requirements for recovering funds from members who have disenrolled or died during the year. The plans explained that, although CMS deposits the full annual deposit at the beginning of the year and members may use the full annual deposit immediately, the member actually only earns 1/12$^{th}$ of the funds each month they are enrolled. Thus, if a member disenrolls at the end of June, they have only earned one half of their deposit. As a result, the plan must recover the other half of the deposit from the member, which is challenging for a number of reasons:

- *Account privacy issues*. One plan reported that they have had difficulty accessing the funds in the account because of privacy issues. Another plan addressed this issue by inserting a statement on the enrollment form to allow them to recover funds if the member disenrolls. However, the plan pointed out that they also need a mechanism to determine the account balance in order to avoid overdrafting the account.
- *Difficulties collecting against an estate*. If a member has died and there are no funds available in the account, the plan must attempt to collect the funds from the spouse or the estate. One plan representative indicated that it can be difficult to contact family members after the death of a loved-one, explain the fund recovery process, and burden them with the task of recovering the funds.
- *Lack of consumer-friendly information explaining the recovery requirements and process*. One plan added that it was unclear how beneficiaries would react to the information.
- *Fluctuations in eligibility*. One plan reported that they have begun the fund recovery process only to discover that the disenrollee has re-enrolled in the plan. The fluctuations in eligibility and enrollments add to the challenges of recovering the funds.

One of the plans reported several hundred disenrollments during the past year and projected that, with CMS expanding disenrollment opportunities for beneficiaries, the recovery process would remain a significant issue. Because of the staff time required to recover the funds, one of the plans was exploring setting a minimum level for the recovery process – in situations in which the recovery amount did not meet this threshold, the plan would simply repay CMS and take a loss rather than attempting to recover the funds from the disenrollee.

### *C.4.4. Prorating the Deductible*

Two of the plans indicated that it did not seem fair that, for beneficiaries who enroll after January, the plan must prorate the deposit but cannot prorate the deductible. That is, a beneficiary who enrolls on July 1st would receive half of the annual deposit but would need to pay the entire deductible amount.

Both plans felt that this was a significant barrier to enrollments outside of the annual election period. One representative pointed out that the plan expects MSA plans to appeal most to individuals who have HSAs through their employers and are aging into Medicare. Because these individuals become eligible and enroll in Medicare throughout the year, the proration policy penalizes the segment they would most like to target for these plans.

## C.5. Future of Medicare MSAs

Overall both offerors and non-offerors felt that the growth of MSA would not occur for another three to five years. Health plans expect the product to grow in enrollment over time and indicated that the baby boomers will be interested in this product, given their experience with health saving accounts.

*"It will definitely grow over time as people age in from health savings accounts."*

*"It will take time to catch on."*