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Evaluation of MSA Plans Under the Medicare Program
HHSM-500-2006-00009I/T.O. #6

Cross-Cutting Findings – FINAL

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EXECUTIVE SUMMARY

The passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 made Medicare Medical Savings Accounts (MSAs) a permanent type of Medicare Advantage (MA) plan for beneficiaries. These plans combine a high-deductible health plan with a tax-favored savings account that is used for qualified medical expenses not paid for by the health plan. In response, the Centers for Medicare & Medicaid Services (CMS) in 2006 created demonstration MSA plans that had the goal of increasing consumer choice and encouraging prudent purchasing of health care services by offering greater flexibility in plan design and cost-sharing after the deductible up to a higher out-of-pocket limit. Beneficiaries began enrolling in these Medicare MSAs starting Jan. 1, 2007, and, since that time, four companies have offered these plans.

MSA plans provide beneficiaries with a rebate that is put into a savings account that the enrollee can use to pay expenses toward the deductible. A deposit is made into this account each year and can be carried over from year to year. For those who do not spend all of the funds in this account in a given year, they can develop savings accounts that eventually have enough funds to cover the entire deductible. As a result, MSA plans may be particularly attractive to healthier beneficiaries who are more likely to be able to defer spending and build up a reserve for the future. Our findings showed that beneficiaries who enrolled in MSAs were healthier compared to FFS and MA populations after controlling for age, race and dual eligible status.

Through the use of case studies, focus group and an in-depth analysis of Medicare administrative data, the research team sought to:

- Understand why health plans decided to offer or not offer MSA plans and identify any barriers to plan entry;
- Profile MSA enrollees in terms of their demographic characteristics, health status and health care utilization;
- Explore beneficiaries' initial reasons for enrolling into MSA plans and their early experience with MSA plans;
- Explore the potential for risk selection; and
- Examine the impact of MSA plans on Medicare program spending.

The research team identified 2,708 Medicare beneficiaries enrolled in an MSA plan in 2007, the majority of whom came from Medicare fee-for-service (FFS) and, more specifically, MA plans. Six states accounted for about 75 percent of MSA enrollment in 2007 and enrollees were more likely to be male, ages 65 to 74 and white or black than non-MSA enrollees. Furthermore, MSA enrollees tended to be healthier, have fewer medical conditions and have less Medicare spending. The research team used multinomial logistic regression models (MLMs) to determine whether health status exerted an independent effect on a beneficiary's decision to enroll in an MSA plan and found strong evidence that beneficiaries who enrolled into an MSA plan in 2007 were healthier than the general MA and FFS populations after controlling for age, race and dual eligibility.

In general, the research team concluded that, due to the small number of plans available and the lack of take-up by beneficiaries, many Medicare beneficiaries were not exposed to this new type of plan. As beneficiaries have a number of options for MA and Part D drug plans, the MSA option is just one choice and is, thus, not likely to capture much attention. Enrollment levels were only high in areas where brokers specifically marketed these plans to beneficiaries; in all other regions, those enrolling were most likely individuals who had prior knowledge or experience with such options. The research team determined further barriers to MSA enrollment, including: prorating the deductible, short selling season, lack of coverage for preventive care, client disbelief in receiving deposit and lack of prescription drug coverage. Still, focus group participants enrolled in MSA plans generally rated their plan positively.

INTRODUCTION

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. The MSA plans combine a high-deductible health plan with a tax-favored savings account that is used for qualified medical expenses that are not paid for by the health plan. In addition to the MSA plans allowed under current law, in 2006, CMS created demonstration MSA plans that are designed to have similar flexibility as health savings accounts offered in the non-Medicare market. This MSA demonstration offers greater flexibility in plan design, including coverage of preventive services before the deductible is met, and cost-sharing after the deductible up to a higher out-of-pocket limit. These newly created MSA plans are intended to increase consumer choice and encourage prudent purchasing of health care services. Medicare Advantage organizations began offering Medicare MSAs on January 1, 2007.

MSA plans provide beneficiaries with a rebate that is put into a savings account that the enrollee can use to pay expenses toward the deductible. A deposit is made into this account each year and can be carried over from year to year. For those who do not spend all of the funds in this account in a given year, they can develop savings accounts that eventually have enough funds to cover the entire deductible. As a result, MSA plans may be particularly attractive to healthier beneficiaries who are more likely to be able to defer spending and build up a reserve for the future. Our findings showed that beneficiaries who enrolled in MSAs were healthier compared to FFS and MA populations after controlling for age, race and dual eligible status.

In practice, these plans provide beneficiaries with a rebate that is put into an account that the enrollee can use to pay expenses toward the deductible. The amount of this account each year is often about half as much as the deductible, and can be carried over on a year to year basis. For those who do not spend all of the funds in this account in a given year, the savings accounts can eventually grow to a size such that there are enough funds to cover the deductible. This attribute makes the MSA plans particularly attractive to healthier beneficiaries who are more likely to be able to defer spending for several years, building up a reserve for the future. The other advantage of such a plan is that once the deductible is met, there are no other out-of-pocket costs for Medicare-covered services, making the plan more valuable for those who do exceed the deductible as compared to traditional Medicare coverage. For these reasons, it was believed that there might be considerable interest in these plans.

MSAs have been tested in the non-Medicare market with the Health Insurance Portability and Accountability Act (HIPAA) MSA offering, but January 2007 was the first time that high-deductible plan offerings were available in the MA market.[1] These plans raise a variety of important policy issues, prompting CMS to contract with L&M Policy Research, LLC (L&M) to

[1] 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 in 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 product. In 2003, The Medicare Modernization Act made MSAs a permanent type of Medicare plan and lifted several restrictions that had been in effect during the MSA pilot demonstration: Elimination of the time limit on enrollment and the limit on the number of beneficiaries who could enroll; and extension of the protection from balance billing by non-contracting providers to include MSA enrollees (in addition to enrollees in coordinated care plans). Insurers still felt that the law limited their ability to offer a MSA product. In summer 2006, using waiver authority, CMS announced a waiver of restrictions in Medicare MSA demonstration that allowed more flexibility in benefit designs.

conduct an evaluation of Medicare MSA plans. Several of the key research topics are summarized below.

- Describing the number and types of plans available;
- Understanding why health plans decided to offer or not offer MSA plans and identifying any barriers to plan entry;
- Profiling MSA enrollees in terms of their demographic characteristics, health status, and health care utilization;
- Exploring beneficiaries' initial reasons for enrolling into MSA plans and their early experience with MSA plans;
- Exploring the potential for risk selection; and,
- Examining the impact of MSA plans on Medicare program spending.

The evaluation combined qualitative and quantitative research methods and included the tasks described below.

- *Case studies* were completed with each of the four MSA plan offerors in 2007, 2008, as well as several plans that considered offering an MSA plan but did not. The case study interviews provided 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 explored factors examined in establishing the target market for MSA plans; sales and marketing of MSA plans; design and pricing strategy for MSA plans; and early experiences in offering and managing the plans.

- *Focus groups and in-depth interviews (IDIs)* were used to collect information on attitudes about, knowledge of, and experiences with the MSA plans. The team conducted the groups in August and September 2008 in four research sites (Cincinnati, OH; Lancaster, PA; Phoenix, AZ; and Sonoma County, CA) and via telephone. The research team sought information about the MSA plans from various audiences, including: MSA plan enrollees (36 participants), non-MSA MA plan enrollees (19 participants), and fee-for-service beneficiaries (19 participants); SHIP counselors and state SHIP directors (12 participants); primary care physicians (PCPs) (16 participants); and insurance agents and brokers (6 participants).

- *An in-depth analysis of Medicare administrative data* explored issues related to selection bias and impact of MSA plans on Medicare spending. In addition, the evaluation team used administrative data to profile the characteristics of MSA enrollees. For purposes of this study, we focused on beneficiaries enrolled in MSA plans in 2007, the first year of implementation. Three health plans offered MSA plans during this time period, including Unicare and Blue Cross of California (which are divisions of WellPoint, Inc.) and American Progressive. Enrollees in MSA plans were compared to comparison groups of MA and fee-for-service (FFS) enrollees not enrolled in an MSA plan.

Detailed descriptions of the methodology and results from each of these tasks are provided within the task reports previously submitted to CMS.[2,3,4]

This report highlights some of the key results from across the research tasks, and allows a consideration of some of the important policy considerations that have been identified in the literature on private high-deductible health plans. These considerations include possible risk selection, desired and undesired utilization impacts affecting beneficiary health and overall system financial performance, increased information demands and difficulty ensuring an adequate supply of entities willing to enter the high-deductible plan market. Accomplishing these tasks allows for a closer look at whether these issues also apply to the Medicare sector, as well as whether there are unique issues involved in providing these plans to this market segment.

There is some evidence in the private insurance market that high-deductible health plans attract healthier enrollees which may lead to adverse selection, reducing pooling in other types of plans and leading to a destabilization of the insurance market (Buchmueller, 2009). These may also be important considerations for the Medicare market, and this research allows for a comparison of risk selection for MSA plans.

Another important concern is the extent to which high-deductible plans change utilization in ways detrimental to member health. While lower utilization is most likely one of the results of enrollment in a high-deductible plan, and a desired goal is a reduction in unneeded services and an improvement in the overall efficiency in the health system, the lower utilization may imply a decrease in unnecessary care, or a decrease in care that would improve a member's well-being. There is some evidence to suggest that individuals in high-deductible plans are more likely to forgo necessary care (Dixon, Greene, & Hibbard, 2008). However, other studies have come to the opposite conclusion, noting that individuals with health savings accounts may actually spend more as they face no costs until the money deposited for them is used up (Buchmueller, 2009). By exploring beneficiaries' early experiences with their plans, it is possible to assess self-reported changes in behaviors. Clearly, reductions in utilization may lower costs of providing health care to individuals in high-deductible plans. However, given the current payment structure to the plans, overall health expenditure savings could not be calculated. Instead, savings, or expense to the Medicare program was calculated.

Recent research suggests that high-deductible health plans increase the need for beneficiary information and education. First, beneficiaries must understand how these plans work and the financial implications of the plans. There is some evidence in the commercial market, for instance, that members of plans may not have adequate information regarding their deductible and may change their behavior even if a service is exempt from the deductible (Reed, et al., 2009). Second, if beneficiaries are to choose the highest quality of care for themselves at the best

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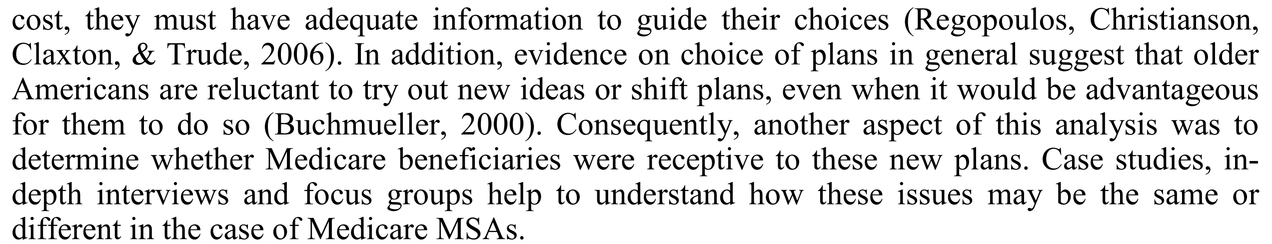
[2] Tanamor, M, Moriarty, K et al. Evaluation of MSA plans under the Medicare program: Case study report. Contract No. HHSM-500-2006-00009I/Task Order #6. This report focuses on the case study findings and may be found at: http://www.cms.gov/Reports/downloads/Tanamor.pdf

[3] Moriarty, K, Tanamor, M et al. Evaluation of MSA plans under the Medicare program: Focus group report. Contract No. HHSM-500-2006-00009I/Task Order #6. This report focuses on the focus group findings and may be found at: http://www.cms.gov/Reports/Downloads/MSA_Focus_Group_Findings_Report_2009.pdf

[4] Koenig, L, Goldberg Dey, J et al. Evaluation of MSA plans under the Medicare program: Secondary data analysis report. Contract No. HHSM-500-2006-00009I/Task Order #6. This report has not yet been posted on the CMS website



cost, they must have adequate information to guide their choices (Regopoulos, Christianson, Claxton, & Trude, 2006). In addition, evidence on choice of plans in general suggest that older Americans are reluctant to try out new ideas or shift plans, even when it would be advantageous for them to do so (Buchmueller, 2000). Consequently, another aspect of this analysis was to determine whether Medicare beneficiaries were receptive to these new plans. Case studies, in-depth interviews and focus groups help to understand how these issues may be the same or different in the case of Medicare MSAs.

Finally, MSAs and other high-deductible health plans are only a feasible choice to consumers if offered. The literature provides example motivations and disincentives for health organizations to offer these plans. For example, these organizations may believe that these are good products, or they may implement plans defensively (Regopoulos, Christianson, Claxton, & Trude, 2006). In the private market, however, employers are important players. In their place, most Medicare beneficiaries must either make their own choices or turn to insurance brokers for more help in assessing the many choices they face. The case studies offer a unique perspective on these organization's motivations and disincentives in the Medicare market.

DESCRIPTION OF MEDICARE MSA MARKET

MSA Offerors

Since their introduction in 2007, a total of four companies have offered Medicare MSA plans. In 2007, two companies offered MSA plans – WellPoint, Inc., and Universal American Financial Corporation. Universal American was the only plan to offer a demonstration plan. In 2008, Coventry Health Care, Inc. and Geisinger Health System began to offer MSAs. Universal American left the MSA market after 2007, WellPoint left after 2008, and Coventry has decided to leave for 2010. Therefore, only Geisinger will continue to offer an MSA plan in 2010. Table 1 summarizes the geographic scope, total covered lives, total MA members, and the year(s) the organization offered the MSA plan.

Table 1. MSA Offeror Characteristics

Organization	Geographic Scope	Publicly Traded	Total Members (2007)	Medicare Advantage Members (2007)	Offered Medicare MSA Product (Years)
Coventry Health Care, Inc.	National	Yes	4,700,000	286,000	2008, 2009
Geisinger Health System	Regional	No	209,000	37,000	2008, 2009, 2010
Universal American Financial Corporation	National	Yes	2,000,000	240,000	2007
WellPoint, Inc.	National	Yes	35,000,000	1,200,000	2007, 2008

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.

MSA Plans

In designing their plan offerings, each organization 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. The key for the MSA offerors was trying to “find the balance between the deposit and the deductible.” One offeror indicated that being able to put enough money in the account represented a “tip point.” If the deposit amount is too low, no one will sign up. That is, individuals are likely to consider whether enough is available to meet immediate needs before the deductible is met. The gap between the deposit amount and the deductible is essentially what the individual has at risk. If it seems very large, beneficiaries may be reluctant to take the chance on this new type of plan.

Only two of the plans offered more than one MSA plan option, however, each plan offered only one option in any given location. The plans with the most enrollees are structured quite similarly, with the difference between the deductible and the deposit typically ranging from $1,250 to $1,500.

The MSA options offered by each health plan in the 2007, 2008, 2009, and 2010 plan years are presented in Table 2.

Table 2. MSA Options Offered by Plan, 2007-2010

Offeror	Plan Name	Deductible and Deposit			
		2007	2008	2009	2010
Coventry Health Care, Inc.	Advantra Savings – Plan I		$2,500 $1,250	$2,700 $1,250	
	Advantra Savings – Plan II		$4,000 $1,570	$4,000 $1,570	
	Advantra Savings – Plan III			$3,000 $1,300	
Geisinger Health System	Geisinger Gold Reserve		$3,000 $1,500	$3,000 $1,500	$3,000 $1,500
Universal American Financial Corp.	MPower Health (NY)	$4,000 $1,558			
	MPower Health (PA)	$4,000 $1,284			
WellPoint, Inc.: Anthem Health Plans, Inc.	Smart Saver		$4,000 $1,175		
WellPoint, Inc.: Anthem Health Plans of New Hampshire, Inc.	Smart Saver		$3,000 $1,225		
WellPoint, Inc.: Anthem Insurance Companies, Inc.	Smart Saver		$3,000 $1,300		
WellPoint, Inc.: Blue Cross of California	Smart Saver – Plan I	$2,500 $1,000	$2,750 $1,000		
	Smart Saver – Plan II	$3,500 $1,375	$3,800 $1,375		
	Smart Saver – Plan III	$4,500 $1,725	$5,100 $1,725		
WellPoint, Inc.: Empire Health Choice	Smart Saver		$3,000 $1,300		
WellPoint, Inc.: Rocky Mountain Hospital and Medical Services, Inc.	Smart Saver		$4,000 $1,175		
WellPoint, Inc.: Unicare Life and Health Insurance, Inc.	Save Well – Plan I	$2,500 $1,250	$2,750 $1,250		
	Save Well – Plan II	$3,500 $1,375	$4,000 $1,375		
	Save Well – Plan III	$4,500 $1,575	$5,000 $1,575		

Source: CMS. Medicare Medical Savings Account (MSA) Plans by State Data – Calendar Year 2008, 2009; Case study interviews with health plan staff; Medicare Options Compare Web site, 2009.

Medical Savings Account

All the offerors partnered with a financial institution to act as a custodian for the MSA. Table 3 displays the features and costs associated with the accounts.

Table 3. Characteristics of Medical Savings Account (2008)

	Custodian	Set-up and Monthly Fee	Interest Rate	Other
Coventry Health Care, Inc.	HealthEquity	Coventry pays these fees for member	1.5%* (1.0% - 4.0%)	Debit card only
Geisinger Health System	Mellon Bank	GHS pays these fees for members	1.375%	Debit card and checkbook
Universal American Financial Corporation	Bank of America	Not available	Not available	Not available
WellPoint, Inc.	Mellon Bank	$15 set-up $3.25 monthly	3.75%	Debit card and checkbook

*The interest rate varies by balance in the account. 1.50% corresponds to a balance of $1,250 (the plan's deposit).

Source: Health plan custodian materials.

Number of Plans Sold

Table 4 illustrates the number of plans sold by each offeror in each quarter from the first quarter of 2007 through the third quarter of 2009. About 3,500 beneficiaries were enrolled in MSA plans in 2009.

Table 4. MSA enrollees by plan, 1st quarter 2007 through 3rd quarter 2009

Offeror	1Q 2007	2Q 2007	3Q 2007	4Q 2007	1Q 2008	2Q 2008	3Q 2008	4Q 2008	1Q 2009	2Q 2009	3Q 2009
Coventry Health Care, Inc.					205	210	218	220	2,885	2,988	3,083
Geisinger Health System					246	256	256	254	410	405	403
Universal American Financial Corp.	*	*	*	*							
WellPoint, Inc.: Anthem Health Plans, Inc.					*	*	*	*			
WellPoint, Inc.: Anthem Health Plans of New Hampshire, Inc.					*	23	25	28			
WellPoint, Inc.: Anthem Insurance Companies, Inc.					347	472	525	562			
WellPoint, Inc.: Blue Cross of California	135	187	212	216	256	275	276	277			
WellPoint, Inc.: Empire Health Choice					*	*	*	*			
WellPoint, Inc.: Rocky Mountain Hospital and Medical Services, Inc.					*	*	12	15			
WellPoint, Inc.: Unicare Life and Health Insurance, Inc.	2,047	2,062	2,055	2,055	2,058	2,282	2,264	2,248			
APPROXIMATE TOTAL*	**2,182**	**2,249**	**2,267**	**2,271**	**3,312**	**3,518**	**3,551**	**3,604**	**3,295**	**3,393**	**3,486**

* Cells with an asterisk denote plans that had between 1 and 9 enrollees. For privacy reasons, CMS does not release the actual number of enrollees when a plan has fewer than 10 members. For this reason, the totals provided in the last row are estimates and do not include enrollees in the plans with fewer than 10 members.

Source: CMS. Monthly Medicare Advantage/Part D Contract and Enrollment Data: January 2007 to September 2009.

MSA Enrollee Demographics

The data analysis compared demographic characteristics of 2007 MSA plan enrollees with non-MSA MA enrollees and FFS beneficiaries in the same counties. The research team identified 2,708 Medicare beneficiaries who were enrolled in an MSA plan in 2007.[5] The majority of these beneficiaries, or 64 percent came from Medicare FFS, with 21 percent enrolling from an MA plan. The remainder were newly eligible for Medicare. A larger share of MSA enrollees were from MA plans compared to the general Medicare population. Since they had already made the choice in the past to try something other than the traditional option, this group may have been more willing to experiment. Although MA plan enrollees were more likely to enroll in an MSA plan in 2007 than FFS enrollees, the vast majority of MSA enrollees were from Medicare FFS.

Beneficiary enrollment into MSA plans is highly concentrated geographically. More than half of all states had fewer than 25 MSA enrollees. Six states had 100 or more MSA enrollees (Arizona, California, Louisiana, New Jersey, North Carolina, and Texas) and accounted for about 75 percent of all MSA enrollment in 2007.

In 2007, MSA enrollees were more likely to be male, age 65 to 74, and white or black than non-MSA enrollees. MSA enrollees were less likely to be eligible for Medicare because of disability and dually eligible. We found that MSA enrollees are healthier (as measured by the Hierarchical Condition Category (HCC) model), have fewer medical conditions, and have less Medicare spending. In addition, we observe that MSA enrollees were located in areas with lower household income than non-enrollees as seen in Table 5.

Table 5. Comparison of Medicare MSA Enrollees to Non-MSA Enrollees, 2007

	Non-MSA Enrollees	MSA Enrollees	Difference
Total Beneficiaries	2,741,757	2,708	2,739,049
Gender			
% Female	56%	51%	5%*
Aged			
% Age 65-74	44%	64%	-20%*
% Age 75-84	30%	22%	8%*
% Age 85+	11%	5%	6%*
Disabled			
% Under 45	4%	1%	3%*
% Age 45-54	5%	2%	3%*
% Age 55-64	7%	6%	1%*
Dual Eligibility			
% Duals	14%	1%	13%*
Race/Ethnicity			
% White	81%	83%	-2%*
% Black	11%	12%	-1%*
% Other	9%	4%	5%*
Median Household Income (2000 Census Data for Census Block) [1]	$51,262	$41,333	$9,929*

*Significant at 5% level.

[1] The household income data are based on 1,788 and 2,170,177 MSA and non-MSA enrollees with available data.

[5] While the total enrollment for each quarter of 2007 was less than 2,708 MSA enrollees, for the purposes of this analysis, we included any person who enrolled in an MSA plan at any point in the year – regardless if a beneficiary disenrolled from an MSA.

The HCC risk score for beneficiaries who enrolled in an MSA from an MA plan is 0.23 (or 21 percent) lower than for the comparison group of non-MSA MA plan enrollees. MSA enrollees enrolling from FFS have an average HCC risk score 0.20 (or 18 percent) lower than non-MSA enrollees. These differences are statistically significant.

Among MSA enrollees that were Medicare FFS beneficiaries, we find that monthly Medicare spending was $235 (or 37 percent) less for MSA enrollees than for non-enrollees in the year prior to MSA enrollment. These differences remain after standardizing to the MSA population in terms of demographic factors. See Table 6.

Table 6. Health Status and Utilization: Medicare MSA Enrollees vs. Non-MSA Enrollees by Enrollment Type (Non-standardized Estimates)[1]

	MA Plan Enrollees	MSA Enrollees from MA Plan	Difference	Medicare FFS Enrollees	MSA Enrollees from FFS	Difference
Total Beneficiaries	597,607	574	597,033	2,083,095	1,688	2,081,407
Health Status*						
HCC Risk Score	1.09	0.86	0.23*	1.12	0.92	0.20*
# of HCC[2]	1.43	1.06	0.37*	1.41	1.15	0.26*
% Diabetes	23%	21%	2%	20%	22%	-2%**
% COPD	12%	10%	2%	11%	10%	1%
% Heart Failure	11%	8%	2%*	11%	10%	2%*
% Cancer	7%	6%	1%	7%	6%	1%
% CAD	10%	6%	4%*	8%	8%	0%
Medicare Utilization (Monthly)[3]						
Total Medicare Spending				$640	$405	$235*
Spending for Inpatient Hospital				$253	$178	$75*
Spending for Physician Services				$202	$138	$64*
Spending for Primary Care				$33	$23	$10*
Spending for E&M Services				$64	$41	$23*
Spending for ED visits				$9	$6	$3*

[1] New Medicare enrollees who were not enrolled in FFS or an MA plan in October of 2006 were excluded from this analysis.

[2] HCC = Total number of conditions captured in the HCC model.

[3] Health care utilization data are unavailable for those beneficiaries that are enrolled in an MSA or MA plan.

*Significant at 5% level

**Significance at 10% level

KEY FINDINGS

A summary of key findings from the three research tasks (case study interviews, consumer and intermediary focus groups, and secondary data analysis) is provided below. Detailed descriptions of the methodology and results from each of these tasks are provided within the reports previously submitted to CMS

Health Plan Decisions to Enter (or Not Enter) the MSA Market

As was the case in the commercial market for high-deductible plans (Regopoulos, Christianson, Claxton, & Trude, 2006), the case study interviews revealed a number of reasons for the offerors' decisions to develop MSA plans, including:

- An interest in diversifying plan offerings and in being able to offer Medicare beneficiaries a full range of choices.
- An interest in reaching a new segment of the market, a segment that would probably not be interested in the offerors' more traditional health plans.
- An interest in having a product available for those individuals who are currently enrolled in commercial HSA plans.
- Personal interest in offering the MSA product on the part of health plan staff/executives. That is, staff personally liked the product and noted that they would be interested in the MSA product if they were in the Medicare market.
- The belief that the political climate was conducive to entering into the MSA market.
- A commitment to consumer directed health plans.
- A willingness to take risks in order to be innovators in the market.

In addition to the case studies with the four MSA plan offerors, the research team conducted or reviewed interviews with 10 health plans[6] that chose not to offer an MSA. These non-offerors cited a variety of reasons for their decisions, including:

- Limited consumer interest in Medicare MSAs. Several plans indicated that they expected the MSA market to develop over the next few years but that there was limited interest in these types of plans at this time.
- Interest in offering a streamlined set of Medicare products.
- Complexity and costs associated with creating an MSA product.
- Challenges in educating beneficiaries on MSAs given their short marketing and selling season.
- Effort required to establish a relationship with a financial institution.
- Financial risk associated with offering MSAs.

[6] Note that three health plan interviews were conducted by the evaluation team. 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.

While many of these reasons were similar to the commercial market, issues surrounding a short marketing period were unique to Medicare MSAs.

Decision to Offer a Demonstration or Standard MSA Plan

All four companies offering MSA plans considered both the MSA demonstration plan and the standard MSA plan. Only one plan opted to participate in the demonstration and this plan dropped out in early 2008. The health plans noted the following issues with the demonstration plan:

- *Statewide service area and uniform benefit requirement. Statewide service area and uniform benefit requirement.* Three offerors and one non-offeror indicated that the demonstration requirement to provide one deductible and deposit statewide was an issue. The demonstration required that the service area of the demonstration product must consist of at least an entire State or territory and the benefit package or packages offered by an organization must be uniform throughout the State and available in the entire State. However, payment to the demonstration plans is done on a county level and MA plans are generally not required to be statewide, including non-demonstration MSA plans, with the statutory exception of regional PPOs at section 1859(b)(4) of the Act.

- *Preventive care*. One plan noted that the preventive care option of the MSA demonstration is attractive; however, the plan felt it was difficult to provide coverage for preventive services while limiting the difference between the deposit and deductible.

- *Transparency requirements*. One plan mentioned the transparency requirement as an issue, indicating that they were not sure whether they would be able to provide cost and quality information for non-network providers.

- *Timing*. Two plans mentioned the limited time to develop and market the demonstration plan. One offeror explained that they were too far down the development path for the standard MSA when the demonstration plan became available.

The one health plan that did offer the demonstration plan opted to do so for "business reasons." Specifically, the demonstration offeror felt that the option to charge a co-payment after the deductible was met was an attractive feature of the demonstration plan, especially if the MSA plans was going to be integrated into an employer market.

Sales and Marketing of MSA Plans

Similar to their counterparts in the commercial market, selling MSA plans required educating consumers, particularly to the financial aspects of the products (Regopoulos, Christianson, Claxton, & Trude, 2006). In addition, target markets for the MSA plans appear to be similar to commercial plans, including healthier, younger and wealthier individuals. These products tend to be tax advantageous to wealthier individuals because the tax subsidy is greatest as they face a higher marginal tax rate. They are also more cost-effective for healthier individuals (Buchmueller, 2009). However, the Medicare market was different from the commercial market in several respects. First, Medicare regulations were different surrounding pro-rating the deductible and the selling period. Second, Medicare beneficiaries face different alternative choices than individuals in the commercial market. For example, they may expect to purchase products with prescription drug coverage included, and the MSA option has the disadvantage of

requiring beneficiaries to buy a separate drug plan—something quite different than what they face with other Medicare Advantage plans.

Role of insurance agents and brokers

The case study participants indicated that they mostly sold their MSA products through brokers and agents, but that only a small number of brokers within each health plan sold the product. For example, one health plan has about 10,000 brokers and agents across the country selling their products, but reported that only 20 to 30 brokers and agents sold MSAs.

All of the plans offered MSA-related training to their agents, although they varied in whether this training was provided to all agents or only to those who requested it. While the commissions paid for MSA enrollments were similar to those paid for enrollment in other MA products, two of the health plans speculated that the additional time required to explain and sell an MSA product may have discouraged brokers from selling the plans. Interestingly, the interviews with insurance brokers did lend some support to this concern, although the agents who reported ambivalence about continuing to sell the plans indicated that it was because of the time required to assist beneficiaries after their enrollment in an MSA, rather than the time required to actually sell the plan. This is similar to findings among the younger population; when people need to try something new and unusual, it takes more effort on the part of brokers to convince them to take a chance.

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.

The consumer research results also indicated that insurance agents were essential to the sale of MSA plans. In the MSA beneficiary focus groups, nearly all of the participants stated that they first heard about the MSA plans from an insurance agent and many indicated that they only began to understand how the plans worked through discussions with the agents. In addition, many MSA enrollee and agent participants stated that the agent was equally important in helping the participants to stay enrolled in the plans. As discussed below, issues related to setting up the accounts and processing initial claims were widespread. Many of the MSA participants and agents reported that MSA plan members turned to their agents, who contacted Medicare, the plans, and/or the banks on their client's behalf to help resolve these issues. With the initial issues addressed, nearly all of the MSA participants indicated that they would like to continue with the plans.

Main selling features

The case study interviews, the focus groups with MSA enrollees, and the interviews with insurance agents, all indicated that the MSA plan's main selling features were related to cost. It is interesting to note, however, that the following segments tended to highlight different cost aspects of the plans, as described below.

- *Health plans:* 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.

- *MSA enrollees:* MSA participants were asked in a written exercise to identify the most significant factors driving their enrollment. Sixteen of 35 MSA participants indicated that "cost" or "price" was a factor (without elaboration on what aspect of the cost played a role) and another seven indicated that the absence of monthly premiums was a factor.

- *Insurance agents and brokers:* The agent participants indicated that much of their sales pitch focused on the potential cost savings associated with the plan. Most emphasized that the MSA limited an enrollee's out-of-pocket exposure to the difference between the deposit and the deductible and several compared these costs with the premiums for Medigap policies or MA plans. Some agents also emphasized the potential for the account to grow if funds were not spent during the year. One highlighted the plan's flexibility in being able to use the MSA funds for a range of health care services, such as dental care or prescription drug co-payments.

Target market

The research team attempted to glean information about the target market for the MSA plans through the case study interviews, agent/broker interviews, and secondary data analysis. The results from each are summarized below.

The case study participants were hesitant to provide much detail about their target market for the MSA plans, however, two offerors provided limited information about the types of beneficiaries they viewed as best suited for the plans. 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 the plans were of interest only to those individuals who are interested in a zero premium health plan, rather than those who want, and are willing to pay for, comprehensive coverage.

When asked about the types of beneficiaries who are most appropriate for the plans, several agent participants described individuals aging into Medicare who have experience with high deductible plans and/or health savings accounts. The participants used the following descriptions for individuals likely to enroll (those most frequently mentioned are "healthy," "savvy," and "young"):

- About to enroll in Medicare
- Disposable income
- Experience with HSAs
- **Healthy**
- **Savvy**
- **Young**

The MSA enrollee profiling completed for the data analysis provided information about the types of beneficiaries who actually chose to enroll and showed some consistency with the target markets identified above. In particular, the data analysis revealed that 2007 MSA enrollees were more likely to be younger and healthier (based on HHC risk scores) than their non-MSA counterparts. In addition, MSA enrollees were more likely to be male, and white or black than non-MSA enrollees. MSA enrollees were less likely to be eligible for Medicare because of disability and dually eligible.

Barriers to enrollment

The research team identified barriers to MSA enrollment through the interviews with health plan representatives and insurance agents and brokers. Barriers included:

- *Prorating the deductible:* Two offerors and several agent participants indicated that the need to prorate the deposit, but not the deductible, for beneficiaries who enroll after January deterred enrollments outside of the annual election period. One participant pointed out that the plan expects MSA plans to appeal most to individuals who have HSAs through their employers and are aging into Medicare, so the proration policy penalizes the segment they would most like to target for these plans. And since the findings of enrollment indicated that younger beneficiaries were more likely to be interested in these products, this is particularly an area where this is a disadvantage.

- *Short selling season.* Several of the agents agreed that the short selling season was a barrier to selling the plans. They explained that beneficiaries can only enroll in MSA plans during the Annual Coordinated Election Period, or AEP, which runs for six weeks from November 15th to December 31st every year. Other MA plan types, however, have the Open Enrollment Period, or OEP, which runs from January 1st to March 31st as well as the AEP to enroll in, disenroll from, or change plans. The shortened selling season gives agents less time to inform clients about the plans and help them complete the enrollment process.

- *Lack of coverage for preventive care.* The Independent (or Field) Marketing Organization (IMO) representative mentioned that insurance agents were concerned that their clients were not able to access preventive care services.[7] This representative encourages independent agents to recommend clients talking to their physicians to ensure that preventive services are being utilized.

- *Client disbelief in receiving deposit.* Several agents indicated that their clients were "leery" that the Government would deposit funds into an account. They mentioned that after explaining MSA plans some clients commented that receiving these funds is "too good to be true."

- *Lack of prescription drug coverage*. It appears that the lack of prescription drug coverage was a barrier to enrollment in certain markets. Agents from California and Arizona indicated that the lack of drug coverage was a barrier to selling the plans and named its addition as one of the top three features they would change. However, agent participants in Pennsylvania, Ohio, and Texas indicated that it was actually an advantage of the MSA plans because it allowed clients to better customize their drug coverage. The offerors did not mention the lack of drug coverage as a sales barrier, but indicated that most of the MSA enrollees had Medicare prescription drug coverage through a stand-alone PDP offered by their or another organization.

[7] Health plans generally contract with IMOs to promote and distribute their products to independent insurance agents and brokers.

Plan Experiences in Developing and Offering MSA Plans

The case study interviews indicated that plans' initial experiences in offering and managing the MSA plans have mostly been positive, although the participants reported several initial challenges. The most significant issues are described below.

- *Marketing material development*: All of the plans reported difficulties with the process of developing marketing materials for the MSA plans. All specifically mentioned the lack of MSA-specific model marketing materials as a significant challenge. Plans requested MSA-specific language for the Evidence of Coverage and Summary of Benefits, as well as supplementary materials, such as a brief educational piece to explain and market MSA plans generally and a series of MSA member letters to facilitate management and oversight of the plans. In addition, two plans reported issues related to the marketing review process at CMS. These plans stated that there was significant confusion about who within CMS was responsible for reviewing the materials and that the point of contact changed several times, resulting in conflicting or inconsistent guidance. Both of the plans indicated that this issue was mostly resolved after CMS assigned a single reviewer for MSA materials.

- *Establishing the medical savings accounts:* The Patriot Act includes several requirements for individuals establishing new bank accounts, which presented some challenges for plans in setting up members' MSA. 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. Since this is a new and unusual aspect of insurance for most Medicare beneficiaries, it is particularly important that such accounts be easy to establish and maintain. Lack of making this a seamless and simple process would seem to be an important drawback.

- *Recovering deposit funds from disenrollees:* Two plans reported significant challenges with CMS's requirements for recovering a prorated portion of the deposit funds from members who have disenrolled or died during the year. This process was challenging for a number of reasons, including difficulties related to accessing the funds in the account because of privacy issues, determining the account balance in order to avoid overdrawing the account, and attempting to recover funds from the spouse or the estate when the account funds were inadequate. In addition, one plan indicated that fluctuations in eligibility and enrollments added to the challenges of recovering the funds, since there were situations in which they have begun the fund recovery process only to discover that the disenrollee has re-enrolled in the plan.

Member Experiences with MSA Plans

Like enrollees in commercial plans, the MSA focus group participants generally rated their MSA plans highly (Davis, 2004). However, they expressed significant dissatisfaction with certain aspect of the plans, including the bank component and the plan's impact on their relationship with their physician. While in commercial markets there has been concern about underutilization of preventive services (Dixon, Greene, & Hibbard, 2008), issues regarding individuals' relationship with their physician may be unique to the Medicare population.

Regarding the accounts, participants reported delays in receiving the deposits, checks, and debit cards, and a great deal of dissatisfaction about the monthly fees charged for the accounts. The fees, in particular, seemed to be a significant aggravation to the participants, both because it was perceived as an attempt to squeeze more money for the enrollees and because the fees made it difficult to determine the account balance leading a few to overdraw their accounts. Several complained that the fees were not disclosed when they were considering the plans. Many participants also indicated that they either had moved their funds and closed their accounts or were considering it.

The MSA participants also reported some strain on the patient/provider relationship. First, participants noted that many providers were unsure of whether or not they could see MSA enrollees, resulting in anxiety for some participants while they waited to learn whether they could continue seeing their physician. Several physician participants also indicated that the physicians of MSA plan enrollees should be informed about the MSA plan structure and coverage. In addition, many were concerned that their providers were not being paid on time due to delays in billing or confusion about who should pay and how much. Finally, most participants expressed frustration that they needed to explain the MSA plan and the claims process to their providers. A few of the participants reported that their relationship with their provider was bordering on adversarial due to the issues with the MSA plans.

In addition to the issues identified by the MSA enrollees who participated in the groups, the research team asked agents who sold the plans to describe any initial issues their clients' encountered. Agents described the following challenges with the MSA plans:

- Delays in receiving the deposit or debit card.
- Lack of training for health plan customer service representatives (CSRs).
- Delays in receiving Explanation of Benefit (EOB) statements or inaccuracies in the EOBs.
- Difficulty determining the account balance because of monthly fees or delays in processing checks.

Selection Bias Analysis

Similar to the commercial market, there does to appear to be selection bias in the enrollment into MSA plans. As noted above, MSA enrollees tended to be younger and healthier than average Medicare beneficiaries. For the data analysis task, the research team used multinomial logistic regression models (MLMs) to determine whether health status exerted an independent effect on a beneficiary's decision to enroll in an MSA plan. The team found strong evidence that beneficiaries who enrolled into an MSA plan in 2007 were healthier than the general MA and FFS populations after controlling for age, race, and dual eligibility.

To examine the effects of geography on the relationship between HCC risk score and MSA enrollment, the team ran separate logistic regression models for each of the six states with more than 100 MSA enrollees in 2007. The team found that a higher HCC risk score was associated with a lower probability of enrolling in an MSA plan for four of the six states, although the relationship was statistically significant in only California and Texas, which together account for 36 percent of MSA enrollment in 2007.

Further, although the risk scores are likely to be important indicators of potential selection bias, another issue is the attitude of the beneficiary toward use of health care services in general. For a given risk score, there is still a great deal of variation in health care spending, in part reflecting individuals' decisions to access the health care system at any point in time. Those who are less likely to use health care services would be naturally attracted to an insurance plan that allowed them to "benefit" from lower use of services by accumulating savings over time. This impact could not be fully studied for this analysis, but the findings of substantially lower spending by those who enrolled in the year before signing up (as described below) suggests that this is also a factor that needs to be considered. It is one difference that risk adjustment cannot control for and would lead to selection bias. This aspect deserves further analysis and study.

Impact of MSAs on Medicare Spending

To analyze the impact of MSAs on Medicare spending, we estimated what Medicare's monthly costs would have been for an MSA enrollee if they had enrolled in Medicare FFS and if they had enrolled in another non-MSA MA plan. Taking into account the probability that an MSA enrollee would have selected FFS versus another MA plan, the team then calculated an average cost to Medicare for MSA enrollees had they not enrolled in the MSA plan. Researchers then compared this average to Medicare's estimated costs for each MSA enrollee. This approach does not take into account any potential shifts in utilization that the MSA plans might induce. While some people claim that these plans should result in lower spending, the incentives are actually somewhat more complicated. Individuals face an incentive to use fewer services below the deductible because they must pay either out of pocket or with resources in their savings account which can be reserved for other uses in the future. Once they have met the deductible, however, there is no cost sharing, lowering the incentive to spend more judiciously. And over time, if the accounts accumulate a sufficient amount, enrollees could come to treat these accounts in somewhat the same way as flexible spending accounts that need to be spent on some type of medical care and encourage more, not less spending. Shifts in utilization in the commercial market, have not been definitive as other supply-side managed care options may also shift utilization (Buchmueller, 2009). However, it does provide an initial look at overall system costs to Medicare.

The research team estimated that Medicare would have spent $554 per beneficiary per month for MSA enrollees had they been in FFS. Using the MSA individuals' risk scores, county benchmark rates, and national rebate amount, the team calculated that Medicare would have spent $669 per beneficiary per month for MSA enrollees had they enrolled in a non-MSA MA plan. Using the probabilities of selecting FFS versus MA, the team estimated that the overall cost to Medicare would have been $566 if MSA enrollees had not enrolled in an MSA plan. Researchers estimated that the Medicare program spent an average of $695 per month in 2007 for each MSA enrollee, or an additional $129 per member.

Table 7. Mean Estimated Medicare Spending for MSA Enrollees by HCC Quartile Compared to Estimated Spending in the Absence of an MSA Plan

Quartile of HCC Score	Mean Medicare Spending per Month in the Absence of MSA (From Table 16)	Mean Medicare Spending for MSA
Quartile 1	$285.33	$295.12
Quartile 2	$426.51	$491.53*
Quartile 3	$640.31	$812.91*
Quartile 4	$1,387.39	$1860.44*
Total (all HCC scores)	**$565.90**	**$695.25***

Analysis includes only MSA enrollees with enrollment in FFS or MA in 2006.

Q1=HCC Risk Score<0.52; 0.52<=Q2<0.814; 0.814<=Q3<1.393; 1.393<=Q4.

Estimates are based on the enrollee's county of residence and HCC score as well as utilization of matched FFS group.

* Differences between Medicare spending in an MSA and in the absence of an MSA are significantly different overall, but are not significantly different for the first quartile.

These cost differences are driven primarily by two factors. First, Medicare expenditures for FFS are lower than for MA plans, whether MSA or other types of MA plans. In the absence of an MSA alternative, some individuals may have elected to stay in FFS, and this drives much of the cost difference between expenditures for individuals in an MSA plan and expenditures for these same individuals had the MSA alternative been unavailable. Second, Medicare expenditures for MSA plans are higher than they would be for MA plans. This factor is driven by the differences in Medicare payment to MA plans in general as compared to MSA plans. Where a MA plan bid is lower than the county benchmark, Medicare pays the plan the county benchmark plus 75 percent of the difference between the bid and the benchmark (adjusted by health risk score). For an MSA plan, where such a difference exists, 100 percent of the difference is paid by Medicare to the plan. However, there are important differences in how this rebate must be used by the plan in the case of MA plans and MSA plans.

For an MA plan, this 75 percent rebate amount must be used for the beneficiaries' benefit, either by reducing cost-sharing for Part A, B or D services, offering services not covered under original Medicare, or offering a reduction in Part B premiums. Each plan may decide how to allocate the rebate. As the plan, not the individual, decides on the allocation, the actual value to the enrollee may not equal the rebate amount. In this sense, waste may occur. However, in the case of MSA plans, the rebate is deposited into the enrollees account, ensuring that the full value of the rebate is received by the enrollee.

Three important limitations of the study are worth noting. First, we used national estimates of MA plan rebates in conducting the cost analysis. The estimated impact of MSA plans on Medicare spending would change if we had available plan-specific rebate information. It is important to recognize, however, that plan rebates would not affect our findings with respect to Medicare beneficiaries that would have been in FFS, if an MSA plan were not available. We estimated that most MSA enrollees would have been in Medicare FFS if an MSA plan were not available. Second, the results reported in this study could change over time as Medicare MSA plans evolve. Third, we were unable to explore how enrollment in an MSA plan affects beneficiary out-of-pocket expenses, because these data are unavailable for enrollees in MSA and

MA plans. Instead, the analysis focused on Medicare spending and only takes the perspective of the Medicare program.

Conclusion

This analysis faced a number of challenges that make it difficult to offer a complete view on MSA options in Medicare. The small number of plans offering MSA plans (four plans between 2007-2010) and the lack of take up by beneficiaries suggest that many Medicare beneficiaries were not exposed to this new type of plan. Where brokers took it upon themselves to market these plans, there was considerably greater participation. But in areas of the country where plans were available but only a handful of people enrolled, those enrolling were most likely individuals who had prior knowledge or experience with such options. The goal of proponents of MSAs to make this option a viable choice for beneficiaries has not yet been realized. The departure from the market of insurers and the lack of interest in pursuing this option suggests that further expansion of the MSA option in the near future may be limited or unlikely. The many choices facing beneficiaries in Medicare Advantage and Part D drug plans means that at best the MSA option is just one of many.

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