THE HENRY J. KAISER FAMILY FOUNDATION

MARCH 2007

MEDICARE

ISSUE BRIEF

MEDICARE CONSUMER-DIRECTED HEALTH PLANS
MEDICARE MSAS AND HSA-LIKE PLANS IN 2007

March 2007

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INTRODUCTION

In July of 2006, the Centers for Medicare & Medicaid Services (CMS) announced that it was going to "improve access to consumer directed health plans in Medicare."[1] The agency indicated that it was soliciting bids from private health plans to offer beneficiaries high deductible health plans accompanied by tax-favored, personal health accounts through the Medicare Advantage (MA) program. Private health plans could bid to offer either a Medicare Medical Savings Account (MSA) plan as authorized under law or a Demonstration Medical Savings Account plan that would work more like the Health Savings Account (HSA) plans being sold in the non-Medicare market.

This announcement marked a new effort by the Bush Administration to promote the MSA approach within Medicare. Medicare MSAs were first authorized as a pilot test under the Balanced Budget Act of 1997 (BBA). Up to 390,000 Medicare beneficiaries were authorized to be enrolled in privately sponsored, high-deductible health plans that would be offered along with a cash deposit made by Medicare to the beneficiary's MSA.[2] After a few years experience with these plans, Congress would then determine whether to make the option permanent. The pilot test never got off the ground, however, because no private insurer ever contracted with Medicare to sponsor an MSA. Insurers reportedly did not believe that they could offer a viable product under the terms and conditions established by the BBA.

In 2003, Congress reestablished the authorization for Medicare MSAs as a provision of the Medicare Modernization Act (MMA) of 2003. Part of the makeover of the Medicare+Choice program into the Medicare Advantage Program, Congress lifted the time and enrollment limits on the Medicare MSAs, and conformed the provisions relating to payment methodology and organizational requirements to be consistent with the new MA rules.[3] However, the rules relating to the design of the benefits offered under Medicare MSAs were carried over from the BBA.

In the view of CMS, the statutory requirements relating to the Medicare MSAs do not give health plans the same flexibility as the HSA plans in the non-Medicare market. For this reason, CMS has chosen to make an additional Medicare MSA option available. Using its demonstration authority under the Social Security Act, it has established rules to facilitate the offering of HSA-like MSA plans for both individual Medicare beneficiaries and Medicare beneficiaries who are receiving their coverage through employer-provided plans.[4] CMS refers to this second type of MSA plan as *Medicare MSA Demonstration Plans.* For consistency, this report adopts the CMS labels *(see text box).*

Types of Medicare Consumer-Directed Health Plans 2007

Medicare Medical Savings Account Plan (MA MSA Plan): A type of Medicare Advantage (MA) plan that offers beneficiaries high deductible insurance plus a personal health account to help pay out-of-pocket expenses.

Medicare Medical Savings Account Demonstration Plan (MSA Demonstration Plan): A type of Medicare Advantage plan that is similar in design to high deductible health plans qualified for tax-favored Health Savings Accounts (HSAs).

In the context of the Medicare population, MSA plans raise a variety of important policy issues. Do they provide adequate insurance for a population that includes a relatively high proportion of individuals with chronic medical conditions and disabilities? Do they offer adequate incentives for beneficiaries to seek medical care on a timely basis and obtain preventive services? Although these questions can be asked of any new type of Medicare benefit design, they are especially relevant to a plan design that makes beneficiaries more responsible for the front-end costs of their medical care than does traditional fee-for-service (FFS) Medicare or other types of MA plans. Additional questions arise about the implications of these new plans for the Medicare program. What are the likely effects of these plan options on the overall Medicare risk pool and on overall program costs? What other implications do they have for Medicare beneficiaries and the Medicare program, both positive and negative?

Several years will pass probably before these questions can be fully answered with any certainty. The comparative data needed by researchers on the utilization of covered services and out-of-pocket costs of beneficiaries enrolled in the MSA plans versus other MA plans and traditional FFS Medicare are unlikely to be available for some time. Moreover, because of the scarce information available to beneficiaries on the MSA plans for 2007, enrollment is likely to lag, making it difficult to undertake meaningful assessments in the near-term. In February 2007, CMS reported only 2,238 enrollees in these types of plans. In addition, the effects of Medicare MSA plans will depend on the specifics of plan design and on which plans are actually selected by beneficiaries from those available.

That said, the new Medicare MSAs mark the first real test of high deductible plan designs within Medicare and merit examination. This report provides a first look at this new Medicare option. It describes the MSA and MSA Demonstration plan options, with respect to eligibility, plan requirements, premiums, benefits, cost sharing, how the MSAs work, and how these plans are paid by the Medicare program. The requirements for these plans are compared to those for MA coordinated care plans (such as health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs). Specific information on plans available in 2007 is provided including where they are being sold, what their benefits look like, and the amount of dollars deposited to enrollees' "cash accounts." Finally, the implications of these plan options for Medicare beneficiaries and the Medicare program are discussed.

MEDICARE MSA BASICS

Medicare MSA plans combine a high deductible Medicare Advantage plan with a Medical Savings Account for medical expenses that are not paid for by the plan. An MA-MSA Demonstration plan similarly combines a high deductible MA plan with an MSA for unpaid medical expenses but varies in a number of important ways. The requirements for both types of plans are complex; as a result, the implications for beneficiaries are sometimes difficult to assess. In particular, a beneficiary's potential out-of-pocket expenses depend on what medical expenses the plan counts toward the deductible and the amounts that out-of-network providers are permitted to charge.

What follows in this section is a description of the statutory and program requirements for the two types of MA MSA plans. Later on, the details of the plans actually being offered to beneficiaries in 2007 are described.

Eligibility

Any person entitled to Part A and enrolled in Part B of Medicare is eligible for either an MA MSA plan or an MSA Demonstration plan, with the following exceptions:

- beneficiaries with End-Stage Renal Disease (ESRD) (these beneficiaries are also not eligible for any MA plans other than demonstrations and special needs plans (SNPs) enrolling beneficiaries with ESRD),
- Medicaid-eligible individuals (i.e., dual eligibles),
- beneficiaries who have elected to receive Medicare hospice care,
- individuals covered under the Federal Employees Health Benefits Program, Veterans Administration (VA) or military health programs, and
- Medicare beneficiaries who remain active workers and are covered under their employer's health plan.

MSA enrollees also must provide assurances that they will reside in the United States for at least 183 days during the year.[5] The rationale for excluding beneficiaries with other sources of coverage from Medicare MSAs is that they already can draw on such sources to help pay expenses resulting from Medicare's deductibles and coinsurance requirements. Such beneficiaries would therefore not benefit as much from having a Medical Savings Account.[6]

Plan Requirements

Entities offering an MA MSA or MSA Demonstration plan must be organized and licensed under state law as risk-bearing and eligible to offer health insurance or health benefits coverage. The MA MSA plans are considered MA local plans and, therefore, must be marketed on a county-by-county basis. In contrast, the MSA Demonstration plans must have service areas that consist of at least an entire state (or U.S. territory).[7] Moreover, the benefit package or packages offered by the MSA Demonstration plans must be uniform throughout the state and available to all eligible beneficiaries living in the state.

Both types of MSA plans may use provider networks, but enrollees must be permitted to go to any health care provider certified to serve Medicare beneficiaries. Certified providers are those that have not opted out of Medicare and those that have not been excluded by the Office of Inspector General from the Medicare program.[8] As described below, the plans may use higher cost-sharing requirements to encourage enrollees to use providers who agree to participate in the plan's network.

TABLE 1: Major Differences in Requirements for Medicare Advantage Coordinated Care Plans and Medicare Savings Account Plans

Requirement	MA Coordinated Care Plans	MA MSA Plans	MA MSA Demonstration Plans
Basic benefit package	Plan covers all Medicare Part A and Part B services. Enrollee cost-sharing, in many plans, is limited to an annual cap on beneficiary liability. Regional plans are required to have annual out-of-pocket caps.	Plan covers all Medicare Part A and Part B services after enrollee meets an annual deductible, subject to possible "balance billing" amounts for those practitioners who are permitted to bill above the Medicare allowable fee in the traditional Medicare FFS program.	Plan may require enrollee coinsurance on Medicare Part A and Part B services after the enrollee meets an annual deductible and before enrollee reaches an annual out-of-pocket maximum. Plan then covers all Part A and Part B services, subject to differences for in and out-of-network and possible balance billing.
Beneficiary premium for Medicare Part A and Part B benefits	Permitted to charge a premium for basic benefits and optional supplemental benefits. The majority of plans currently are "zero premium" plans, and some plans "rebate" all or a portion of an enrollee's Part B premium.	A plan will charge a premium for Medicare Part A and B benefits only if its proposed premium (the equivalent of the bid of a non-MSA plan) exceeds the benchmark. However, in such case, no money would be available for deposit in the beneficiary's account. Plan is permitted to charge a premium for optional supplemental benefits.	Appears to be the same as for MA MSA plans.
Plan service area	May be county-based or may elect to operate as a regional PPO (covering an entire region).	County-based. Not classified as a regional plan, even if an entire region is covered.	At least an entire state.
Provider access requirements	Must provide access to appropriate providers, including credentialed specialists, for medically necessary treatment and services and provide for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization.	Same in statute. According to CMS Guidance, "MSAs do not have to demonstrate health care access since members are able to access any Medicare certified provider." [9]	Appears to be same as for MA MSA plans.

Table 1 (continued)

Requirement	MA Coordinated Care Plans	MA MSA Plans	MA MSA Demonstration Plans
CMS review of annual plan bid	Bid must be reviewed by CMS and is subject to negotiation.	Not subject to CMS review.	Not subject to CMS review.
Quality improvement requirements	Plans are required to have a Quality Improvement Plan that includes a program for improving chronic care, projects expected to have a favorable effect on the health outcomes and satisfaction of enrollees, and include ways to encourage plan providers to participate in various government quality initiatives	Not required.	Not required.
Treatment of difference between benchmark and plan bid	When a plan's bid is lower than the relevant benchmark, 25% of the difference goes to Medicare. The remainder must be returned (rebated) to beneficiaries as one or more of the following: extra benefits, reduction in cost-sharing, reduction in MA plan premium, reduction in Part B premium, or reduction in Part D premium.	For a "bid" (plan's proposed premium) below the benchmark, any difference in the amount between a plan's bid and the relevant benchmark is deposited into the enrollee's Medical Savings Account.	Same as for MA MSA plans.
Disclosure of information to beneficiaries	Plans must disclose to each enrollee the benefits offered under the plan and exclusions from coverage.	Plan must also provide a comparison of benefits under an MSA plan with benefits under other types of MA plans.	Same as for MA MSA plans.

Sources: Sections 1851-1859 of the Social Security Act, CMS Medicare Managed Care Manual, and CMS Guidance on Medicare Medical Savings Account Plans.

Covered Services

Benefits under MA MSA plans and MSA Demonstration plans must include all services covered under Medicare Parts A and B. Neither the MA MSA or MSA Demonstration plans are permitted to include prescription drug coverage (Part D) in their benefit packages. However, a beneficiary who enrolls in one of these plans is permitted to join a stand-alone Medicare Prescription Drug Plan (PDP). The same organization that is selling the MSA plan may sponsor a PDP.

Premiums

MA MSA plans and MSA Demonstration plans are permitted to charge a monthly premium for basic Medicare benefits. (The beneficiary continues to pay the annual Part B premium.) However, this is unlikely to occur in practice because the plan only can charge a premium if its proposed bid to the Medicare program exceeds a certain benchmark (see "How are Medicare MSA Plans Paid" below). In such an instance, there would be no money available to be deposited into the beneficiary's Medical Savings Account and thus the plan presumably would not be able to enroll anyone. MSA plans also may charge a premium for optional supplemental benefits, if any are offered.[10]

Cost Sharing

An MA MSA plan consists of a deductible and then reimbursement of covered health care costs above the deductible. The formula for calculating the annual maximum deductible amount is established by law. For 2007, the deductible can be no higher than $9,500 and can vary by plan. (Deductible amounts are announced annually by CMS in the *Announcement of MA Payment Rates*.) The law does not specify a minimum deductible amount.

Once the annual deductible is met, the MA MSA plan is required to pay, at a minimum, the lesser of two amounts: (1) 100% of the expenses for the service; or (2) 100% of the amounts that would have been paid for the service under traditional FFS Medicare (for Part A and Part B services), which includes the amounts that the beneficiary would pay under traditional FFS Medicare for deductibles and coinsurance. The coverage limits in FFS Medicare still apply. For example, coverage for inpatient mental health services under the MSA Plan is limited to the same 190-day lifetime maximum as it is under FFS Medicare.

The benefit design for the MSA Demonstration plan is different. It also must cover Medicare Part A and Part B services once the beneficiary has met the annual plan deductible. However, the plan is permitted, although not required, to cover preventive services before the deductible is met.[11] For 2007, CMS has established a minimum annual deductible of $2,000. After the deductible is met, the plan is permitted to require beneficiaries to share in the costs of the covered Part A and Part B services. Such enrollee cost-sharing is limited to an out-of-pocket maximum. This is the total amount that a beneficiary can be asked to pay out-of-pocket for Medicare services that the Demonstration plan is required to cover. In 2007, the out-of-pocket maximum cannot exceed $9,500. Once the out-of-pocket maximum is reached, the MSA

Demonstration plan must cover 100% of the cost of Medicare services. However, the beneficiary may still be responsible for "balance billing" amounts for those practitioners who are permitted to bill above the Medicare allowable fee in the traditional Medicare FFS program.

What expenses count toward the plan deductible? For both the MA MSA and MSA Demonstration Plans, only those medical expenses that would otherwise be covered under Medicare Parts A and B and then only those amounts that would be payable under Medicare FFS (including deductible and coinsurance amounts) count towards the plan deductible. Neither type of Medicare MSA plan is permitted to offer coverage of the deductible as a supplemental benefit.

Access to providers and balance billing. In contrast to coordinated care Medicare Advantage plans, MSA and MSA Demonstration plans do not have to demonstrate that enrollees have adequate access to providers.[12] This is because MSA plan enrollees, like beneficiaries in traditional FFS Medicare, can go to any Medicare-certified provider that is willing to serve them. A beneficiary has no guarantee of being accepted by a specific provider for treatment, however, unless the plan and the provider have a contract or the enrollee shows up in an emergency room. Of course, not all physicians are willing to serve traditional FFS Medicare beneficiaries, and some are only willing to serve their current patients, not new ones. Providers willing to serve traditional Medicare enrollees are not required to serve those who are enrolled in a Medicare MSA, however, which would necessitate handling patient bills differently.

Under the traditional Medicare program, providers who choose to treat a Medicare beneficiary must accept as payment in full the applicable Medicare payment amount. Exceptions apply, however. Non-participating providers or providers who do not accept assignment on a particular claim are permitted to "balance bill" the beneficiary, up to Medicare's applicable balance billing limits. These are generally limited to 15 percent of the applicable Medicare payment amount. Notably, nearly all physicians participating in Medicare are enrolled in the Medicare "participating physicians" program under which they sign an agreement that precludes them from balance billing their Medicare patients, while hospitals and other institutional provider types are precluded by law from balance billing Medicare beneficiaries.[13]

These same rules apply in the case of a beneficiary enrolled in a Medicare MSA plan. Thus, before a beneficiary has met their Medicare MSA plan deductible, the beneficiary will be liable for the entire Medicare payment amount (not just the applicable co-insurance or co-payment amount) plus the balance billing amounts (if any). After a beneficiary has met the deductible, the physician or other practitioner must bill the Medicare MSA plan for the Medicare payment amount. It is also the case that Medicare MSA plans may or may not apply balance billing amounts toward the plan deductible, and may or may not cover these additional amounts once the beneficiary has met the plan deductible.

Like other MA plans but unlike traditional FFS Medicare, an MA MSA plan may establish a preferred network of providers. The MSA plan may use a provider network so that it can offer enrollees discounted provider rates prior to meeting the annual deductible.[14] The provider agreement may also call for the plan to pay more than Medicare rates to the network providers. An MSA plan may also establish a provider network to offer enrollees protection against balance

billing. In such a case, the plan may require as a condition of participating in the network that the physician agree not to balance bill or to accept Medicare's balance billing limits.

An MA MSA Demonstration plan may also establish a preferred network of providers. In addition to the reasons described above, the Demonstration plans are permitted to establish different beneficiary coinsurance or co-payment amounts for services received from in- network and out-of-network providers. Also, they may recognize only the in-network level of cost-sharing for services received out-of-network in counting costs toward the deductible.[15] Moreover, the plan may have a separate, higher out-of-pocket cap for services received from out-of-network providers. Again, as is the case for the MA MSA plans, beneficiaries enrolled in the MSA Demonstration plans may or may not face balance billing by providers, depending on the specific plan, but only where balance billing is permitted in the traditional FFS Medicare program and only up to the permitted amounts.

Enrollment and Disenrollment

Beneficiaries may enroll in the MA MSA or MSA Demonstration plans only at the time of their initial Medicare coverage election (when they turn 65, for example, or qualify for Medicare under Social Security Disability Insurance (SSDI)) or during the annual election period, typically conducted in the late fall of each year. If the individual elects an MSA plan during an annual election period and has never before elected such a plan, then they may cancel that election but only if they do so by December 15th of the election year.[16] For example, if during the 2007 annual election period for their Medicare coverage beginning on January 1, 2008, a beneficiary elects an MSA plan for the first time, then he or she may cancel the MSA plan election but only if the cancellation is done by December 15, 2007.

Extra Benefits

MA MSA plans are permitted to offer optional supplemental coverage, for a premium, that pays for accidents, disability, dental care, vision care, and/or long-term care expenses. They can also offer an optional supplemental benefit that closes gaps in the Medicare benefit package for services obtained once the deductible is reached (e.g., inpatient mental health stays in excess of the Medicare 190-day lifetime maximum). As noted above, they cannot provide coverage for costs incurred for Medicare covered services prior to reaching the deductible.[17]

The Medical Savings Accounts

Each beneficiary who elects to enroll in an MA MSA or MSA Demonstration plan also receives from Medicare an annual cash deposit into an interest-bearing account. CMS provides these funds in a lump sum during the first month that the beneficiary's enrollment in the MSA plan becomes effective. Neither beneficiaries nor employers can deposit additional funds into the beneficiary's account.

These accounts are tax-favored because the deposits are not included as taxable income to the beneficiary. Moreover, any accumulated interest on the deposits is also tax free. The entity that holds these deposits, which is called a "trustee," is typically a bank or other financial institution. The trustee has been designated by the MSA plan (although a beneficiary technically can elect the MSA trustee) and may provide for fixed or variable interest depending on the types of investment instruments that it uses. In the non-Medicare market, for example, HSA trustees typically offer fixed interest rates, money markets, or higher-risk investment vehicles, such as stocks and mutual funds. The HSA trustees compete for customers on the basis of their interest rates, as well as on administrative fees and extra services, such as debit and credit cards, check writing services, and the like. Presumably this kind of competition could arise with Medicare MSA trustees as well. As discussed below, little information is available on the offerings by the Medicare MSA trustees.

The money deposited to the enrollee's Medicare MSA is intended to be used to cover their health care expenses that are not covered by their high deductible plan. These may include plan deductibles, copayments, and coinsurance. The account may also be used to pay other health care expenses that are not covered by the health plan. If these are "qualified medical expenses" under IRS rules,[18] then such payments are not taxed. Qualified medical expenses are more extensive than those generally covered under health insurance policies and include, in addition to medical, prescription drug, dental and vision services, such things as attending medical conferences on a family member's chronic illness, transportation for medical services, smoking cessation and weight loss programs.

Funds withdrawn by the beneficiary from MSAs established under both the statutory and demonstration programs cannot be used to pay for Part D (prescription drug) premiums. They may be used, however, to cover co-payments, coinsurance and deductibles for Part D drugs. Funds withdrawn from the MSA to pay for Part D drugs count towards' the beneficiaries true out-of-pocket costs (TrOOP).

Medicare requires an MSA trustee to: (1) register with CMS; (2) certify that it is a licensed bank, insurance company, or other entity qualified, under the Internal Revenue Code (IRC), to act as a trustee of individual retirement accounts; [19] (3) agree to comply with the MA MSA provisions of the IRC relating to reporting of MSA assets and to the transfer of funds from one MSA trustee to another; and (4) submit any other information that CMS may require.

If a Medicare beneficiary withdraws money from the MSA for a non-qualified expense, then those distributions are included in taxable income. An additional tax penalty applies when the total distributions for purposes other than qualified medical expenses in a tax year exceed a threshold. Simply stated, the penalty is designed to encourage beneficiaries to maintain a sufficient balance in the MSA to cover 60% of their annual deductible.[20]

Funds that remain in the MSA at the end of a year remain the property of the beneficiary that holds the account. These remaining funds are then "rolled over" for use in the next year. An MSA enrollee is "locked in" for the entire calendar year; unlike other MA enrollees, he or she may not disenroll from the MSA in January through March. Should a beneficiary's coverage end during the year (because the person has left the service area of the MSA plan, or due to death),

CMS recovers from the MSA plan the amount of the deposit made to the account corresponding to the remaining months of the year. Any funds left in a beneficiary's MSA at the time of death (other than the unused advance lump sum deposit) go to the beneficiary's surviving spouse. The spouse may continue the MSA but no new contributions can be made to it.[21] Distributions for qualified expenses would not be includible as taxable income. If there is not a surviving spouse, the money in the MSA in included in the taxable income of the beneficiary's estate.

How are Medicare MSA Plans Paid?

Like other MA plans, the Medicare MSA plan submits a "bid" (statement of premium, or required revenue) to CMS representing the amount that it projects it will need to pay benefits and cover its administrative costs (including any profit) for its Medicare enrolled population for the coming calendar year.

The plan's bid is then compared against a standardized benchmark for the county. The benchmark is based on the MA county capitation rates in the plan's service area, weighted for MA plan enrollment. The benchmark amount is then adjusted to reflect the relative risk of the MSA plans' enrollees based on demographics and health status.

Medicare pays the plan prospectively for each enrollee its risk adjusted bid amount. It also deposits to each enrollee's Medical Savings Account in one annual lump sum an amount that equals the difference between the benchmark and the plan's bid. This amount is the same for each plan member.

Payments to MSA Plans

Both types of MSA plans are paid by Medicare using a methodology similar to that for other Medicare Advantage plans, with one important exception. *(See text box for payment methodology)*. For other MA plans, Medicare keeps 25 percent of the difference between the benchmark amount and the plan bid when the benchmark is higher (which is almost always the case). The plan is required to use the remaining 75 percent to provide extra benefits, to reduce enrollee cost-sharing for Medicare covered benefits, or to reduce Part B or Part D premium amounts. For the MSA plans, however, 100 percent of the difference between the benchmark and the plan bid is sent to the MSA plans to be deposited into the enrollees' MSA accounts. Medicare does not keep any of these dollars.

MEDICARE MSA PLANS OFFERED IN 2007

Medicare Advantage choices for 2007 include three MSA plan offerings. Two of these plans meet the MA MSA requirements, while the third is offered as an MA MSA Demonstration plan. Plan enrollment data released by CMS in February 2007 indicated that 2,238 beneficiaries were enrolled in these plans.

CMS signaled modest enrollment expectations for 2007 for MSA plans, saying that it expected plan and beneficiary participation to increase between 2007 and 2008. Also, tight time constraints may have discouraged more MSA plan offerings for 2007. Insurers were given relatively short public notice by CMS to respond to its July 2006 solicitation for Medicare MSA and MSA Demonstration plans for the 2007 plan year. Plan applications to participate were due about two weeks after the request for solicitation was issued; plan bids, which require substantial detail about plan benefit design and other features, were due on August 10, 2006.

Some features vary among the three plans, but consistent with the requirements for these MA plans, none of them imposes a premium on enrollees beyond the regular Medicare Part B monthly premium.

Wellpoint Unicare "Save Well" and California Blue Cross "SmartSaver" Medicare MSA Plans

Two Medicare MSA plans are currently offered. The "Save Well" Medicare MSA plan, available through Unicare, a division of Wellpoint, is offered statewide in 35 states and the District of Columbia, and in parts of 3 other states.[22] Unicare is also offering these plans through employer retiree health benefits programs throughout the United States. Three versions of the plan are offered (Save Well I, II and III), reflecting different deductible and cash deposit amounts, but only one of these options is available in any given county. Counting all three options, 2,110 beneficiaries were enrolled in one of the Save Well plans as of the February 2007 CMS enrollment report.

A similar plan, "SmartSaver", is offered by California Blue Cross, also a division of Wellpoint, and is available only in California. (The Save Well plans are not offered there.) SmartSaver may also be offered through employer retiree health benefits programs in California. Three versions of the plan are offered (SmartSaver I, II and III), reflecting different deductible and cash deposit amounts. In February 2007, CMS reported a total of 128 beneficiaries were enrolled in a SmartSaver plan.

Deductibles and MSA Deposits. The amount of the plan deductible and cash contribution to the MSA vary among the Save Well and SmartSaver plan offerings. For Save Well, deductibles are $2,500, $3,500, or $4,500 while the accompanying MSA cash deposits are $1,250, $1,375 and $1,575 respectively. The differences between these figures, or the amount a beneficiary with medical expenses equal to the plan deductible would pay out-of- pocket under the three plans, are therefore $1,250, $2,125 and $2,925. This type of calculation obviously assumes that expenditures up to the full deductible amount are incurred during the first year of MSA coverage. If, however, the cash deposit made in the first year is allowed to roll over, in whole or in part, the beneficiary's out-of-pocket exposure in a later year would be correspondingly reduced.

Similarly, three versions of the SmartSaver plan are offered in California, with one offering per county. Deductibles are $2,500, $3,500, or $4,500 while the MSA cash deposits are $1,000, $1,375 and $1,725 respectively. The differences between these figures, or the amount a beneficiary with medical expenses equal to the plan deductible would pay out-of-pocket under the three plans, are therefore $1,500, $2,125 and $2,775.

Notably, however, actual out-of-pocket expenditures for a beneficiary enrolled in one of these plans could be higher or lower than the differences described above, depending on their total health care expenses and the extent to which their expenses can be applied toward the plan deductible. In particular, under these plans, the amount that is counted toward the plan deductible for a Medicare-covered service does not include any balance billing amounts. More

specifically, what counts toward the deductible is the total amount that would be paid for the service under traditional Medicare taking into account both the amount that the Medicare program would pay the provider plus any cost sharing that would be paid by or on behalf of the beneficiary. If a Medicare beneficiary enrolled in one of these MSA plans receives services from a physician or other provider who does not accept Medicare assignment, the beneficiary must pay in full the additional "balance billing" amounts, subject to the limitations that apply under traditional Medicare.

Beneficiaries will also pay more out-of-pocket than the differences shown in Table 2 if they choose not to use their Medicare MSA funds to cover the plan's deductible and any required coinsurance. In this case, they may elect to pay their medical bills with other funds and allow the MSA cash deposits to accumulate interest that is not subject to federal taxes. On the other hand, if the MSA cash amounts are allowed to build up over several years, the beneficiary's out-of-pocket exposure in a future year would be lower than the differences shown in Table 2.

Provider Network. The Save Well and SmartSaver MSA plans do not have a preferred provider network. Beneficiaries may use any Medicare provider that is willing to treat them. The Evidence of Coverage documents for each plan, however, state that they have contracts with some providers, and that "You can still seek care from other providers we do not contract with but because [SmartSaver/Save Well] has a special payment rate with our contracted providers, other providers may not be willing to furnish your care."

Additional Benefits. No additional benefits are provided under the Save Well or SmartSaver Medicare MSA plans. The plan brochures describe a "Passport Savings Program" which offers discounts on nutritional supplements, educational products, eyewear, hearing aids, smoking cessation program, gym memberships and weight management programs. However, these brochures indicate that the specific discounts are offered by independent vendors, are not endorsed by Save Well or SmartSaver, can be withdrawn or changed without notice, and are not subject to the Medicare appeals process.

Cost-sharing. Under the Save Well and SmartSaver plans, once the deductible has been met, beneficiaries are not responsible for any cost-sharing. However, beneficiaries must pay for any balance billing amounts if the provider does not accept Medicare assignment.

Medical Savings Account. The Save Well and SmartSaver plans establish a Medical Savings Account on behalf of an enrollee at ACS/Mellon Bank. The Evidence of Coverage documents indicate that funds may be withdrawn by beneficiaries using a debit card or checkbook, both of which will be provided by ACS/Mellon. Separate information on the MSA administrative fees charged by ACS/Mellon Bank is available on the plan website. Annual interest currently earned on the account is 3.75 percent, and bank fees include $15 to set up the account and a $3.25 monthly service charge. Interest and fees are subject to change, however. At the published rates, the $54 in fees paid by an enrollee for the first year of enrollment would, in many cases, be greater than the interest payments they would earn on their MSA deposit.

American Progressive "MPower Health" MSA Demonstration Plan

The "MPower Health" Medicare MSA demonstration plan is offered for individual enrollment by American Progressive in New York and Pennsylvania only. CMS reported in February 2007 that fewer than 10 beneficiaries were enrolled in this demonstration plan.
Additionally, American Progressive may offer this plan through employer retiree health programs anywhere in the country.

Deductibles and MSA Deposits. The amount of the plan deductible is $4,000, but the cash contributions to the MSA differ between New York and Pennsylvania, and are $1,558 and $1,285, respectively. The difference between these figures, or the amount a beneficiary with medical expenses equal to the plan deductible would pay out-of-pocket, is therefore $2,442 in New York and $3,715 in Pennsylvania. Actual out-of-pocket expenditures for a beneficiary enrolled in MPower Health could be higher or lower, however, depending on their total health care expenses and the extent to which expenses can be applied toward the plan deductible. The plan Summary of Benefits brochure does not discuss the plan's treatment of balance billing but CMS staff indicates that balance billing amounts do not apply toward the plan deductible and out-of-pocket cap.

Provider Network. The MPower Health Plan does not have a preferred provider network. Beneficiaries may use any Medicare provider that is willing to treat them.

Benefits. In addition to the required coverage of Medicare Part A and B benefits, MPower Health covers the following Medicare preventive services before the deductible is met, without application of any cost sharing: bone mass measurement, colorectal screening, immunizations, mammograms, Pap smears and pelvic exams, and prostate cancer screening.

Cost-Sharing. Once the deductible has been met, beneficiaries must pay 20 percent coinsurance on all services other than the preventive services listed above, up to a maximum out-of-pocket amount of $4,800. Once the out-of-pocket maximum is reached, the plan pays 100 percent of the Medicare-allowable cost. As noted above, CMS staff indicate that balance billing amounts do not apply toward the deductible and out-of-pocket maximum.

Medical Savings Account. MPower Health establishes a Medical Savings Account on behalf of each enrollee at Bank of America. Documents provided upon request through the American Progressive website do not discuss how the MSA funds would be withdrawn by beneficiaries, nor do they provide information on the MSA administrative fees charged by Bank of America. Such information is not available on the Bank of America website either, but the private HSAs they offer include a $5 monthly charge; no start-up fee is required.

TABLE 2: MSA PLAN OFFERINGS, 2007

Plan	Deductible	Cash Deposit from Medicare	Difference (Beneficiary Out-of-pocket liability)	Does Balance Billing Count Toward Deductible?	Co-insurance	Out-of-pocket maximum*	February 2007 Enrollment
Wellpoint – Medicare MSA Plans							
Save Well I	$2500	$1250	$1250	No	Not permitted	n/a	Save Well I, II, III combined enrollment = 2,100
Save Well II	$3500	$1375	$2125	No	Not permitted	n/a	
Save Well III	$4500	$1575	$2925	No	Not permitted	n/a	
SmartSaver I (CA only)	$2500	$1000	$1500	No	Not permitted	n/a	SmartSaver I, II, III combined enrollment = 128
SmartSaver II (CA only)	$3500	$1375	$2125	No	Not permitted	n/a	
SmartSaver III (CA only)	$4500	$1725	$2775	No	Not permitted	n/a	
American Progressive –Medicare MSA Demonstration Plans							
MPower Health Demo – NY	$4000	$1558	$2442	No	20% after deductible is met	$4,800	<10
MPower Health Demo – PA	$4000	$1284	$2715				
Total MSA Enrollment, February 2007							**2,238**

Note: None of these MSA plans charges a beneficiary premium for the basic Medicare benefit package beyond the regular Part B premium.

* Where no beneficiary coinsurance is required, the deductible is the out-of-pocket maximum. Not all medical expenses apply toward the deductible or out-of-pocket maximum, however.

SOURCE: Enrollment data from CMS, "Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Monthly Report by Contract", February 2007. Data reflect enrollment accepted through January 11, 2007.

GEOGRAPHIC AVAILABILITY OF MSA PLAN OPTIONS

About 34 million beneficiaries in 39 states have access to at least one Medicare MSA plan in 2007, accounting for more than three-quarters of all Medicare beneficiaries. In almost all cases, only one of the three available MSA plan options is available to a beneficiary. The exceptions are beneficiaries residing anywhere in Pennsylvania or in Allegheny County, New York, where both a Save Well plan and the MPower Health MSA demonstration plan are available.

Because only the Medicare MSA demonstration plan is permitted to cover preventive benefits before the deductible is met, only beneficiaries in New York and Pennsylvania have a Medicare MSA plan with this feature available to them. These beneficiaries account for only 15 percent of those that have any MSA plan option available to them.

IMPLICATIONS FOR MEDICARE BENEFICIARIES

A Medicare MSA may prove a good choice for some beneficiaries. For others, however, this type of MA plan could be very costly compared with other available options.

Beneficiaries with relatively low spending on Medicare-covered services, who are seeking the insurance protection of an out-of-pocket cap, could save significantly by enrolling in a Medicare MSA rather than purchasing private supplemental coverage. With an MSA plan, they would pay no additional premium and would have access to the Medicare cash deposit and possibly accumulated interest to cover non-Medicare covered health expenses as well as covered services that count toward meeting the plan deductible. Beneficiaries with other savings available to meet the plan deductible could benefit from using the MSA as a tax shelter even if they have significant health expenses.

Beneficiaries with relatively high health expenses and more limited resources, however, could quickly exhaust their MSA accounts and be faced with thousands of dollars in out–of- pocket expenses in order to meet the deductible as well as additional out-of-pocket costs to cover balance billing amounts (if any). As a result, a better choice for these beneficiaries might be traditional Medicare, supplemented by a Medigap policy (depending on the Medigap plan chosen) or a Medicare Advantage coordinated care plan. Because Medicare MSA plans do not cover the Medicare Part D drug benefit, beneficiaries seeking a potentially less costly alternative to traditional FFS Medicare might be better off with a coordinated care plan that includes Part D coverage.

Better information from the Medicare program and in MSA plan marketing materials on the features of this type of Medicare Advantage plan choice would put beneficiaries in an improved position to decide whether a Medicare MSA is a good choice for them. Information on Medicare MSA plans currently available to beneficiaries is limited.

The Medicare program's most comprehensive beneficiary guide to their options, *Medicare & You 2007,* describes the MSA plan options only generally, indicating that it is a new option in 2007 like a Health Savings Account, and consists of a high deductible plan and a Medical

Savings Account. While the Medicare.gov website displays the Medicare MSA plans among the various Medicare Advantage options available to a beneficiary in each local area, the standard comparison chart is not designed to account for differences between MSA plans and other Medicare Advantage options. In particular (as of late January 2007), no information on the plan deductible or MSA cash deposit – the major features of these plans – is shown on the standard comparison chart. In addition, the Medicare.gov website initially did not provide an estimated annual cost figure for these plans, so a cost comparison with other MA plans and traditional FFS Medicare could not be made during the annual open enrollment period beginning in November.

Additional information available from the marketing brochures available on the individual plan websites and those of insurance agents selling these products vary in their explanation of how Medicare MSA plans work. In particular, information on the MSA itself is limited. Plan documents include very little explanation about how a beneficiary can withdraw funds from their MSA or how the funds can and cannot be used, and no information on what penalties apply if the funds are used for expenses other than those that are permitted. For each of the two Medicare MSA plans, an overview plan brochure indicates that upon enrollment, a debit card and checkbook will be provided by the bank, and instructs beneficiaries to "Please consult with your tax professional to learn what healthcare services qualify for payment from Medicare MSA funds."

The more detailed "Evidence of Coverage" (EOC) document, which details plan benefits and exclusions, as well as enrollee rights and responsibilities, was not available for any of the Medicare MSA plans until the end of January 2007. This was the case even though beneficiaries were told in plan brochures that they could request the EOC prior to enrollment. The delay in availability of this key document might have been due to the short time frame within which the MSA plans applied and were approved as 2007 Medicare Advantage offerings. In addition, CMS did not provide a model EOC for MSA plans and, in some cases, language taken from other MA plan models is not appropriate for MSA plans. For example, the American Progressive MPower Health Demonstration plan EOC describes how an enrollee should inform MPower Health of other health insurance coverage they have for the purpose of benefit coordination, including employer coverage, Medicaid, and veteran's benefits, even though beneficiaries with these types of coverage are not eligible to enroll in a Medicare MSA.

In some cases, information in the plan brochure contradicts information on the Medicare.gov website. For example, regarding the SmartSaver and Save Well plans, Medicare.gov indicates that "Referral is required for network specialists (for certain benefits)". Yet, according to the plan brochures, these plans do not have a provider network, and enrollees are free to use any Medicare provider that is willing to treat them. Additionally, for all three of the available Medicare MSA plans, Medicare.gov indicates that "unless otherwise noted, out-of-network services not covered."

IMPLICATIONS FOR THE MEDICARE PROGRAM

The introduction of high-deductible plans combined with a tax-sheltered savings account for the non-Medicare population has raised issues that also apply to the extension of these plans to the Medicare program. Some of these issues relate to specific rules that might be readily changed by statute or regulation. Others are more basic to the high deductible-personal savings account approach represented by the new Medicare MSAs.

One concern is that a high deductible encourages enrollees to delay seeking needed medical care and in particular discourages the use of preventive services such as cancer screenings and immunizations. Preventive services have been shown to be cost effective and in the case of some immunizations and other services, cost saving. Indeed, the Medicare program has added a number of preventive services in recent years, including a "welcome to Medicare" physical for new beneficiaries. Under the law, MA MSAs are not permitted to cover preventive services without application of the plan deductible, although MSA Demonstration plans may do so, and the one current Demonstration plan has opted for this approach.

Concern has been expressed that private sector MSA plan options will attract healthier enrollees, raising the cost of coverage for those who remain in more traditional employer health plan arrangements. Within the Medicare program, this is a potential concern as well. Beneficiaries expecting to have low Medicare-covered medical expenses would benefit the most from these plans. Accordingly, steps have been taken to reduce risk segmentation in the Medicare market. Prohibitions are imposed on selective marketing practices, for example, that might result in discouraging enrollment in MSA as well as all MA plans of sicker, frailer beneficiaries. Most importantly, payments to all Medicare Advantage plans are prospectively adjusted to reflect the average health risk of each plan's enrollees. However, the current risk adjustment methodology is relatively new and is not yet applied in a manner that holds the traditional FFS program harmless from any adverse (or beneficial) selection that may result when beneficiaries enroll in Medicare Advantage.[23] There is also some debate about whether Medicare's risk adjustment system is refined enough to fully address selection bias.

A more general concern regarding MA plans, and Medicare MSA plans in particular, is their impact on Medicare program spending. These private alternatives are often presented by proponents as more efficient alternatives to the traditional FFS Medicare, yet MA plans were, on average, paid 12 percent more in 2006 for each Medicare enrollee than it would cost the traditional program to pay for their health care services.[24] While enrollees often gain additional benefits as a result of this "overpayment," the equity of paying for a higher level of coverage for some Medicare beneficiaries in this way has been questioned.[25]

The MA "overpayment" issue is exacerbated in the case of Medicare MSA plans because, unlike the payment formula applied to other MA plans, no provision is made to return efficiency-related savings from these plans to the Medicare program. When Medicare MSAs plans submit bids below the benchmark amount set out by the program, the plan receives its full bid amount and the difference between the per-enrollee benchmark and bid amounts is the cash deposit given to the beneficiary's MSA. In the case of other MA plans, the Medicare program retains 25 percent of the difference between the benchmark and the bid. Consequently, to the extent that Medicare

MSAs have the intended effect of encouraging more prudent use of health care services by Medicare beneficiaries, individual enrollees will have the benefit of additional MSA funds, but no financial gain will accrue to the Medicare program.

Deductibles are valued as a cost containment measure both within Medicare and health plans generally to the extent that they discourage unnecessary use of health services. Arguably, by depositing funds in the beneficiary's MSA, the Medicare program is effectively providing "first-dollar" coverage, which could be viewed as working at cross-purposes to the deductible. On the other hand, these funds could also be viewed as eliminating or at least reducing financial impediments to obtaining preventive benefits. Moreover, MSA amounts are carried over from year to year and become the property of the beneficiary. A beneficiary enrolled in an MSA plan may later choose to switch back to the traditional Medicare program or into another MA plan and would still have the MSA funds available to cover any cost sharing required by those plans. On the other hand, these deposit amounts are not identical to first-dollar coverage because MSA funds can be used more broadly than to fill in the plan deductible, such as paying for health services not covered by Medicare, or for growing tax-deferred savings.

Given the growing interest in consumer-driven health care, attention to Medicare MSA plans and their impact on beneficiaries and the Medicare program can be expected to continue. Additional Medicare MSA plans are likely to be made available in 2008 and beyond, and more information about the effects of these plans will be available as beneficiary and program experience with them is gained.

ENDNOTES

[1] Centers for Medicare & Medicaid Services, *Medicare News, CMS Announces Steps to Improve Access to Consumer-Directed Health Plans in Medicare*, July 10, 2006.
[2] Specifically, the BBA authorized a capped number of Medicare MSA enrollees on a time-limited basis (originally no new enrollments would be permitted after 2002 or after the number of enrollees reached 390,000).
[3] The same law included amendments to the Internal Revenue Code (IRC) to encourage the sale in the non-Medicare market of tax-favored Health Savings Accounts (HSAs) and associated high deductible health plans that meet specific design requirements. The HSAs were to be a successor to the Archer Medical Savings Accounts, which had first been authorized in 1996 under the Health Insurance Portability and Accountability Act (HIPAA) to be test piloted in the commercial market but had so far attracted only modest enrollment. Proponents of HSAs said that the 1996 law had placed too many restrictions on the MSAs; opponents said their lack of popularity indicated that consumers were not interested in high deductible policies.
[4] CMS is establishing the MA MSA Demonstration under section 402(a)(1)(A) of the Social Security Amendments of 1967. Centers for Medicare & Medicaid Services, *Guidance for Medicare Advantage Medical Savings Account (MSA) Demonstration Plans*, July 10, 2006, available at: www.cms.hhs.gov/MedicareAdvantageApps/Downloads/2007_MSA_Demo_Useful_Information.pdf. The demonstration design "waives certain MA MSA plan requirements under sections 1859(b)(3), 1853(e), and 1854(c) of the Social Security Act. This will allow entities to offer products that more closely resemble high deductible health plans that are offered with Health Savings Accounts to the non-Medicare population. This demonstration will be conducted under the Secretary's demonstration authority." CMS, Memorandum from Abby L. Block, Director, Center for Beneficiary Choices to Medicare Advantage Organizations and Other Interested Parties, Medical Savings Accounts Demonstration, July 10. 2006.
[5] Section 1851(b)(4) of the Social Security Act.
[6] Section 40.6 of the CMS Medicare Managed Care Manual.
[7] CMS requires that in case of the District of Columbia, the plan also include in its service area at least one contiguous state. Draft Q&A MSA Demo Guidance, July 10, 2006, p. 2.
[8] CMS Guidance, July 2006, p. 7. Special rules apply in the event of emergency situations.
[9] CMS treats the MSA plans much the same as the MA private fee-for-service plans, for which there are no provider access requirements.
[10] Section 30.3 of the CMS Medicare Managed Care Manual.
[11] The IRS has identified through guidance a range of preventive services that qualify for coverage before the deductible for HSA qualified high deductible health plans. It appears that CMS is adopting the IRS policy. However, because an MA MSA demonstration plan is only permitted to cover services that are Medicare-covered services, the MSA plan can in effect only cover preventive services that meet both the Medicare and IRS requirements. Other services that Medicare covers (e.g., a physician visit to monitor the side effects of statin drugs) are arguably preventive services but do not meet both criteria. In the context of plan offerings for 2007, this is not an issue because the one MSA Demonstration plan (MPower Health Plan) limits the preventive services covered under the deductible to only a subset of Medicare covered preventive services. See CMS, Medicare Advantage Medical Savings Account (MSA) Plan Demonstration Proposal, July 10, 2006. The IRS guidance is at: http://www.ustreas.gov/press/releases/reports/notice200423.pdf.
[12] CMS guidance seems to be inconsistent with statute and regulation on this point. However, CMS treats the MSA plans much the same as the MA private fee-for-service plans, for which there are no provider access requirements.
[13] Among physicians, participation rates reached 92 percent in 2005. (Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program*, June 2006, p. 111.) Certain services and supplies provided by physicians and suppliers who do not accept Medicare assignment are not subject to the 15 percent balance billing limit. These include durable medical equipment; ambulance services; vaccinations; some drugs, including cancer drugs, covered under Medicare Part B; prosthetics and orthotics; and surgical dressings. Some health care providers must always accept the Medicare amount as payment in full, and may not balance bill. These are: hospitals, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy or speech pathology services.
[14] CMS Guidance, July 2006, p. 7
[15] CMS *Fact Sheet on 2007 Medicare Medical Savings Account Plans*, September 2006. Available at http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/MSA_Hill_Fact_Sheet.9.29.06.pdf

[16] See §1851(f) (5) of the Social Security Act.
[17] CMS Guidance, July 2006, p. 2.
[18] See section 213(d) of the Internal Revenue Code.
[19] The rules for trustees of individual retirement accounts (IRAs) require, for example, that the entity demonstrate to the Commissioner of IRS the: capability to serve on an ongoing basis as a fiduciary, the ability to exhibit a "high degree of solvency," the experience and competence with respect to accounting for the interests of a large number of individuals, the experience and competence in handling of retirement funds, and adequate net worth. See sections 408(2) and 408(h) of the Internal Revenue Code.
[20] Non-qualified withdrawals for a tax year are subject to an additional 50 percent penalty to the extent they exceed the amount by which the account balance at the end of the prior year was greater than 60 percent of the MSA plan deductible for the year of withdrawal. The penalty is equal to 50 percent of this excess amount.
[21] The spouse may also have an account of his or her own.
[22] Save Well is offered statewide in AL, AZ, AR, DE, DC, FL, HI, ID, IL, IA, KS, LA, MD, MA, MI, MN, MS, MT, NE, NJ, NM, NC, ND, OK, PA, RI, SC, SD, TN, TX, UT, VT, WA, WV, WY, in one out of eight counties in CT, one out of 62 counties in NY, and 16 out of 29 counties in AK with Medicare eligibles.
[23] Under the Deficit Reduction Act of 2005 (P.L. 109-362), risk adjustment budget neutrality in determining Medicare's payment to MA organizations will be phased out by 2011. The budget neutrality provision was implemented by CMS to eliminate potential payment reductions to the MA plans in 2004 and thereafter that could have occurred as a result of the phase-in of the health status risk adjustment. In the absence of this provision, if the MA plans in the aggregate were enrolling beneficiaries projected to be of lower relative cost to the program than those in traditional FFS Medicare, then any savings resulting from risk adjustment would have been returned to the traditional program. In other words, instead of capturing any savings resulting from any favorable selection experienced by the MA plans, CMS gave the savings back to the plans in the form of additional payments. Individual plans would get more or less in MA payments depending on the average of their enrollees' risk scores.
[24] Medicare Payment Advisory Commission, *Report to the Congress, 2006, Increasing the Value of Medicare*, Washington, www.medpac.gov.
[25] Brian Biles, Geraldine Dallek, and Lauren Hersch Nicholas, "Medicare Advantage: Déjà Vu All Over Again?" *Health Affairs*, web exclusive, December 15, 2004: W4-586 to W4-597 and Medicare Payment Advisory Commission, Increasing the Value of Medicare, Report to Congress, 2006

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