

# Contradictory Incentives in the Medicare+Choice Medical Savings Account Program

By

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**Abstract.** The Medicare+Choice Medical Savings Account program (MSA) was created by the Balanced Budget Act of 1997 as a component of the larger Medicare+Choice (M+C) program. A goal of the M+C program was to increase managed care options for eligible Medicare beneficiaries. The MSA program was one such option. To date, no Medicare+Choice Organizations (M+COs) have offered a MSA plan. This paper addresses the cause of this lack of participation among Medicare managed care providers. It is found that if M+COs prefer the more profitable plan, and beneficiaries prefer the least costly plan, there are no instances in which it is in both the M+CO's and the beneficiary's best interest to adopt a MSA plan. Given that beneficiaries will always choose to decrease their personal health care expenses, M+COs have no incentive to offer a MSA plan.

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## I. Introduction

With the creation of the Medicare+Choice program (M+C), the Balanced Budget Act of 1997 (BBA) instituted what is arguably the most important change to Medicare managed care since Medicare's inception. The Medicare+Choice program encompassed a variety of measures designed to increase Medicare beneficiaries' managed healthcare choices and to expand Medicare managed care offerings to more of the Medicare eligible population. One of the newly created offerings was the Medicare+Choice Medical Savings Account program (MSA). MSA plans combine a high deductible M+C plan with a contribution from the Health Care Financing Administration (HCFA) to a medical savings account for the enrolled beneficiary.<sup>1</sup>

The primary purpose of this paper is to examine the structure of the MSA program and to identify the incentives of both M+COs who might choose to offer a MSA plan, and beneficiaries who might choose to enroll in such a plan. This analysis will illustrate that the incentives of M+COs and beneficiaries to participate in the MSA program are incompatible, and that given rational beneficiaries, a M+CO will always earn greater profit offering a M+C plan than by offering a MSA plan. The empirical evidence that no MSA plans have been implemented or even proposed since the program's inception on January 1, 1999 supports this theory. Reasons for the lack of participation are identified in the following analysis.

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<sup>1</sup> When the MSA program was instituted, the Health Care Financing Administration (HCFA) was responsible for its implementation. As of June 2001, the Centers for Medicare and Medicaid Services (CMS) administer Medicare services.

The paper proceeds as follows. Section II details the MSA program. Section III illustrates the inherent conflicts in the program. Section IV suggests a program reform, and Section V concludes.

## **II. The Medical Savings Account Program**

In the BBA, Congress authorized a limited number of beneficiaries to participate in a MSA program demonstration. The M+C MSA plans are designed to be a combination of a high deductible M+C plan (health insurance policy) and a Medicare savings account. Medicare pays the premium for the M+C plan and makes a monetary deposit into a Medicare savings account for the beneficiary. The beneficiary uses the money in the account along with his own personal money as necessary to pay for healthcare services until the deductible is met. After the deductible is met, the M+C plan pays for 100 percent of all Medicare covered healthcare services.

As defined by the Department of Health and Human Services Federal Register, the MSA is "a tax exempt trust created solely for the purpose of paying the qualified medical expenses of the account holder."<sup>2</sup> The MSA program was created as a demonstration project. Under the project, qualified M+COs were authorized to accept enrollees in a MSA plan from January 1, 1999 until January 1, 2003, at which point the project would be evaluated and the MSA program either continued or terminated. The program was limited to 390,000 enrollees, or approximately one percent of the Medicare population. Two restrictions on enrollment differ from enrollment in a M+C plan. First, an enrollee must reside in the United States for at least 183 days of the year in which he is enrolled.

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<sup>2</sup> Department of Health and Human Services Federal Register (1998), page 35032.

Second, beneficiaries with "first dollar" government health plans are specifically excluded (i.e. those with Medicaid or Veterans Administration benefits). These exclusions ensure enrolled individuals use their account funds rather than other insurance to pay for healthcare services until the deductible is met.

The MSA program imposes requirements on beneficiaries, M+COs, and HCFA that differ from the requirements each assumes under a M+C plan. Under the MSA program, beneficiaries have greater responsibilities than they have under standard M+C plans. Because MSA plans combine a MSA account with a M+C plan policy, eligible beneficiaries must choose a policy offered by a M+CO, and then choose a bank or other institution to serve as trustee for the account. Beneficiaries then may enroll for one year beginning January 1.<sup>3</sup> At the beginning of the year, HCFA makes a lump sum deposit into the beneficiary's account for the entire year. The beneficiary then uses that money to pay for his health care. The money can be used for medical or non-medical expenses. If the money is used for anything other than a qualified medical expense, the money is taxed as income and may carry an additional tax penalty.<sup>4</sup> After exhausting the money in the account, the beneficiary must use his own money to pay for health care services until he reaches his deductible. If the account money is not used, it remains in the beneficiary's account the following year and is increased by another annual lump sum on January 1. If the beneficiary disenrolls, any money in his account remains and can

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<sup>3</sup> Contrary to other M+C plans, beneficiaries must remain enrolled in the MSA for the entire year; they are not permitted to terminate the plan during the year but may non-renew the following January.

<sup>4</sup> Qualified medical expenses are defined by IRS rules relating to itemized deductions for medical expenses. This definition encompasses a broader range of items than are covered by Medicare (for example prescription drugs and dental care). Items considered qualified medical expenses by the IRS do not necessarily count towards a plan's deductible. Expenses countable toward the deductible are specified by each policy. Money used other than for qualified medical expenses are taxed, and a penalty may apply, as outlined by IRS rules.

continue to be used to help pay for healthcare.<sup>5</sup> Beneficiaries may or may not be restricted to particular doctors and hospitals, depending on the policy.<sup>6</sup> Once the deductible is met, the policy coverage becomes effective and the policy pays for covered Medicare expenses. The only payment beneficiaries must make is the Medicare Part B (medical insurance for doctors' services and other outpatient healthcare) monthly premium. The beneficiary pays no monthly premium to the M+CO. In theory, the beneficiary pays a lower monthly premium for what is essentially a catastrophic insurance policy with a high deductible. He uses the account money to cover expenses prior to reaching the deductible.

M+COs' responsibilities also are different under a MSA plan than under a standard M+C plan. M+COs must make available to an enrollee or provide reimbursement for all Medicare covered services after the enrollee's countable expenses reach the plan's annual deductible.<sup>7</sup> The M+CO must count towards the deductible either the actual costs paid by the beneficiary for services, or the amount that would have been paid by a beneficiary under a Medicare fee-for-service arrangement, whichever is less (this encourages the beneficiary to obtain reasonably priced health care services, as only reasonable expenses will be counted toward the deductible). M+COs are free to include additional expenses in the countable expenses if they so desire. After the deductible is met, the M+CO pays the lesser of 100 percent of the actual cost of service, or 100 percent of the amount that

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<sup>5</sup> Account money of a beneficiary who dies during the policy year is returned to Medicare on a pro-rated basis for the portion of the year the beneficiary was not enrolled.

<sup>6</sup> Unlike Original Medicare and other M+C plans, the Medicare program does not limit what providers can charge a beneficiary. It is each beneficiary's responsibility to ensure charges are commensurate with acceptable Medicare charges and to choose services wisely.

<sup>7</sup> The maximum allowable deductible is \$6,000 per year.

would have been charged under original Medicare for that beneficiary, including the deductible and coinsurance that the beneficiary would have paid. In other words, M+COs are required to pay the full Medicare payment rate once the deductible is met.

Administratively, the MSA program costs HCFA exactly the same amount as paying the monthly individually adjusted payment rate that is paid to M+COs for M+C plans. Under a MSA plan, HCFA pays into a beneficiary's account the difference between the countywide payment rate (as determined by HCFA for each county in the US) and the premium the M+CO would charge a beneficiary under its M+C plan. On January 1, HCFA deposits this difference into the beneficiary's account as a lump sum. By this methodology, each beneficiary in the MSA within the same county receives the same lump sum deposit into his account. In addition to this payment, each month HCFA pays the premium for the beneficiary to the M+CO, and also pays the M+CO additional money for beneficiaries whose demographically adjusted payment rate is greater than the average county rate that was used to determine the lump sum. The main difference between the payments HCFA makes under the M+C plan and under the MSA plan is under the M+C plan, HCFA pays the entire per-enrollee demographically adjusted rate directly to the M+CO. Under the MSA plan, HCFA pays part of the per-enrollee demographically adjusted rate to the M+CO, and part to the beneficiary. Figure 1 illustrates the flow of funds under a M+C plan. The beneficiary's coinsurance payments to the M+CO apply after the deductible has been met.

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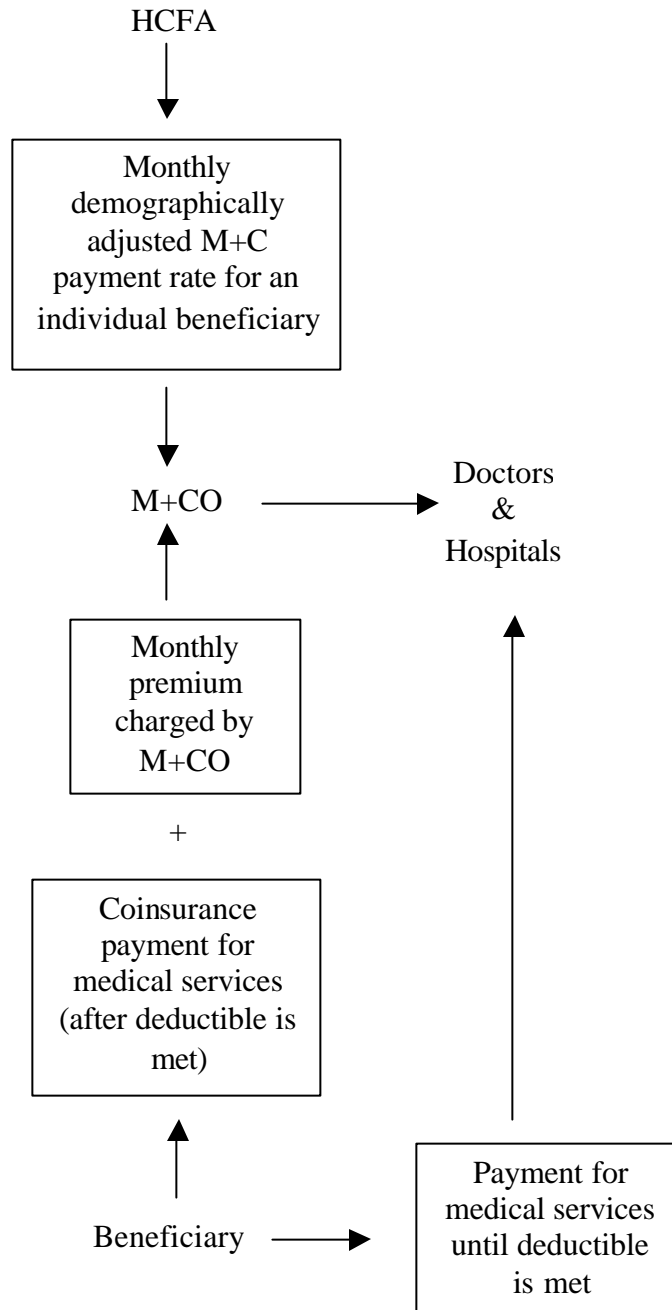


Figure 1  
Flow of Funds Under a M+C Plan

Figure 2 illustrates the flow of funds under a MSA plan. A beneficiary's payments are made only until the deductible has been met. M+CO's payments are made only after the deductible has been met.

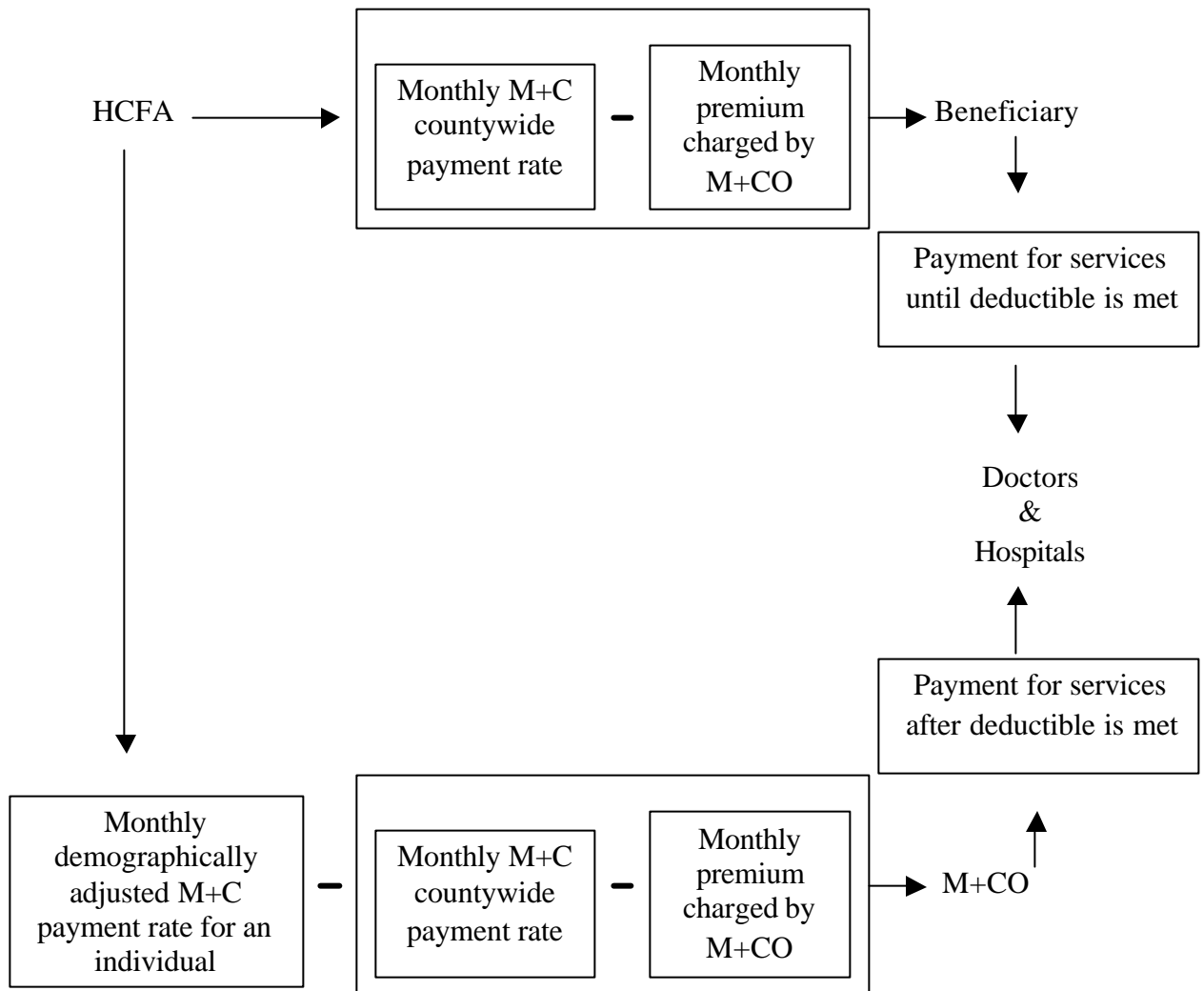


Figure 2  
Flow of Funds Under a MSA Plan

The MSA program seems to be a worthy program for a number of reasons. First, it adds greater flexibility in coverage options for beneficiaries. In addition to obtaining

health care services from the plan's network of doctors and hospitals, beneficiaries can use account money to pay for services of non-network health care providers, for services not covered by original Medicare, or for services not specifically covered by their plan's policy.<sup>8</sup> This flexibility allows beneficiaries to seek the type of treatment they believe is best for them, and to practice preventative healthcare, which currently is not covered by original Medicare.

A second benefit of a MSA plan is that it ties a beneficiary directly to the cost of the services used and forces the beneficiary to play a greater role in determining health care purchases until the deductible is met. A primary cause of rapidly increasing healthcare costs is thought to be the ability of individuals to purchase insurance coverage for almost all their health care expenses, which reduces the personal cost of health care services so greatly that individuals overuse these services.<sup>9</sup> MSAs have the potential to discourage over-utilization of health care services. Because beneficiaries have a limited amount of money in their account, it is thought they will be more prudent in the type of service requested, the doctors and hospitals selected, and the frequency of utilization of health care services. Additionally, MSA plans require a greater investment of a beneficiary's own money before the deductible is met, another factor that should limit utilization and overall costs.

The third benefit of the MSA program is that government costs are the same under a MSA plan as they are under a M+C plan. HCFA pays the same total amount under both plans; however, under a MSA plan, cost-cutting responsibilities are divided between the

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<sup>8</sup> It is intended that the policy will include more covered services than original Medicare.

<sup>9</sup> GAO/T-HEHS-99-130, page 3.

M+CO and the beneficiary. This allows HCFA to spread its risks slightly rather than relying solely on the M+COs to control costs. Having two parties responsible for controlling costs can also serve as a benchmark. If the beneficiary is able to obtain necessary services at lower cost than the M+CO either can or does, HCFA will have reason to more carefully monitor the M+CO, and will gain greater information to use in developing more accurate payment rates for the county in which the M+CO operates.

### III. Inherent Conflicts in the MSA Program

The MSA plan reallocates HCFA funds from the M+CO to the beneficiary, and relieves the beneficiary of a monthly or annual policy premium in exchange for a high deductible policy. The following model provides an explanation for why M+COs will not offer MSA plans. The model shows that an M+CO's preference for offering the plan type providing greater profits is in direct conflict with a beneficiary's preference for the least costly plan. If both parties act in their own best interest, their preferences for a particular plan type are incompatible. The following notation is required to prove this result formally.

Let  $b$  denote the annualized demographically adjusted M+C payment rate for an individual beneficiary (i.e., the amount the M+CO receives from HCFA over the course of a year for a specific beneficiary). Let  $r$  denote the annualized M+C countywide payment rate.<sup>10</sup> Define  $p$  as the annualized premium charged by the M+CO, where  $0 \leq p \leq r$ .  $d_i$  is the annual deductible the beneficiary must pay prior to the plan policy paying

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<sup>10</sup> The annualized premium is required to be no greater than the annualized M+C countywide payment rate as determined by HCFA.

any or all benefits under plan  $i$ , where  $i \in \{\text{M+C plan, MSA plan}\}$ , and  $0 \leq d_i \leq \$6,000$ .<sup>11</sup>  $c_i$  is the coinsurance the beneficiary must pay for services received under plan  $i$ , where  $i \in \{\text{M+C plan, MSA plan}\}$ . Coinsurance payments are given by  $c_{M+C} = .20$  and  $c_{MSA} = 0$ .<sup>12</sup> Define  $m$  as the annual medical expenses incurred by a beneficiary. Let  $\pi_i$  denote the annual per beneficiary profit the M+CO earns under plan  $i$ , where  $i \in \{\text{M+C plan, MSA plan}\}$ . Finally, let  $C_i$  denote the total annual direct beneficiary cost under plan  $i$ , where  $i \in \{\text{M+C plan, MSA plan}\}$ . The M+CO and the beneficiary are risk neutral.<sup>13</sup>

Under a M+C plan, the M+CO receives the beneficiary's premium payment ( $p$ ) and HCFA's demographically adjusted M+C payment rate for that beneficiary ( $b$ ). The M+CO must pay eighty percent of all medical expenses ( $m$ ) incurred after the deductible ( $d_{M+C}$ ) has been met. Therefore, the per-enrollee profit of a M+CO offering a M+C plan is given by the equation:

$$\pi_{M+C} = [p + b - .80(m - d_{M+C})] \quad (1)$$

Under a MSA plan, the M+CO receives HCFA's demographically adjusted M+C payment rate for that beneficiary ( $b$ ) minus the lump sum amount HCFA deposited directly into the beneficiary's account (the monthly countywide payment rate minus the

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<sup>11</sup> The maximum allowable deductible is \$6,000 per year for MSA plans. There is no minimum allowable deductible.

<sup>12</sup> No coinsurance is permitted with a MSA plan. For most services, the current coinsurance rate for Medicare beneficiaries under original Medicare is twenty percent.

<sup>13</sup> If the beneficiary is risk averse, the central conclusion of the model still holds. If expected medical costs are greater than actual costs, the beneficiary maximizes utility by selecting a MSA plan, while the MCO maximizes profit by choosing a M+C plan. If expected medical costs are less than actual cost, the beneficiary maximizes utility by selecting a M+C plan, while the M+CO maximizes profit by selecting a MSA plan.

beneficiary's monthly premium for twelve months =  $(r - p)$ ). The M+CO must pay 100 percent of all medical expenses ( $m$ ) incurred after the deductible ( $d_{MSA}$ ) has been met.

Therefore, profit of a M+CO offering a MSA plan is given by the equation:

$$\pi_{MSA} = [b - (r - p) - (m - d_{MSA})] \quad (2)$$

A MSA plan is more profitable than a M+C plan if  $(2) > (1)$ , i.e., if and only if  $\pi_{M+C} <$

$\pi_{MSA}$ , or  $[p + b - .80(m - d_{M+C})] < [b - (r - p) - (m - d_{MSA})]$ , which reduces to

$$.20m + .80d_{M+C} + r < d_{MSA} \quad (3)$$

Therefore, a M+CO's profit under a MSA plan is greater than its profit under a M+C plan iff equation (3) holds.

Under a M+C plan, the beneficiary is responsible for paying the M+C plan premium ( $p$ ) plus twenty percent of all medical expenses ( $m$ ) incurred after the deductible ( $d_{M+C}$ ) has been met, plus the deductible. Therefore, the cost incurred by a beneficiary enrolling in a M+C plan is given by the equation:

$$C_{M+C} = [p + .20(m - d_{M+C}) + d_{M+C}] \quad (4)$$

Under a MSA plan, the beneficiary is responsible for paying the deductible ( $d_{MSA}$ ). He receives for use toward the deductible the lump sum HCFA deposits into his account (the monthly countywide payment rate minus his monthly premium =  $(r - p)$ ). Therefore, the cost incurred by a beneficiary enrolling in a MSA plan is given by the equation:

$$C_{MSA} = [d_{MSA} - (r - p)] \quad (5)$$

A MSA plan is less costly for a beneficiary than a M+C plan if  $(4) > (5)$ , i.e. if and only if

$$C_{M+C} > C_{MSA}, \text{ or}$$


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$[ p + .20m - .20d_{M+C} + d_{M+C} ] > [ d_{MSA} - ( r - p ) ]$ , which reduces to

$$.20m + .80d_{M+C} + r > d_{MSA} \quad (6)$$

Therefore beneficiary costs under a MSA plan are less than costs under a M+C plan iff equation (6) holds.

The M+CO will prefer the most profitable plan. The beneficiary will prefer the least costly plan. Comparing equations (3) and (6), it is clear that the M+CO and the beneficiary will not prefer the same plan. For the M+CO to prefer a MSA plan, the MSA deductible must be greater than the M+C plan deductible plus twenty percent of medical expenses plus the annualized countywide payment rate. For a beneficiary to prefer the MSA plan, the MSA deductible would have to be less than this sum. Consequently, there are no instances in which it is in both the M+CO's and the beneficiary's best interest to adopt a MSA plan.

**Proposition:** Given rational beneficiaries, a M+CO will always earn at least as great a profit offering a M+C plan as it will earn offering a MSA plan.

Since both M+COs and beneficiaries know the value of the countywide payment rate and the deductibles for both plans, the beneficiary should have greater knowledge of the values of plans. The beneficiary should have greater knowledge of his health status and therefore a more accurate estimate of the costs of his medical expenses for the year. Given this knowledge, the beneficiary will select the plan that costs him the least, which is the plan that provides the M+CO a lower profit. Therefore, there is no incentive for the

M+CO to offer a MSA, as it could never earn greater profits by doing so than it could earn by offering only a M+C plan.<sup>14</sup>

#### **IV. Program Reform**

While the current structure of the MSA program discourages M+COs from offering MSA plans, the program could be reformed to provide participation incentives to the M+COs. One possible reform is the provision of an additional payment to M+COs offering a MSA plan in a county previously unserved by a MSA plan. Such a reform would be similar in nature to the bonus payment program enacted in the 1999 Balanced Budget Refinement Act. Under the bonus payment program, the M+CO that offered the first M+C plan in a previously unserved county was paid a five- percent bonus payment for twelve months, followed by a three- percent bonus payment in the next twelve months. The goal was to provide an incentive to M+COs to offer M+C plans in counties that would otherwise not have a M+C option for Medicare beneficiaries.<sup>15</sup>

To provide an incentive to offer a MSA plan, M+COs would be given an additional payment of a certain percentage of the countywide payment rate for each beneficiary enrolled in a new MSA. Like the bonus payment program, the MSA incentive program could be restricted to MSA plans offered in counties without any current MSA plans. Such an incentive would create conditions under which both a M+CO and a beneficiary

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<sup>14</sup> There is no effect of asymmetric information (by which the beneficiary has greater knowledge of his health status than the M+CO does). It serves no purpose for a beneficiary to hide health status since the M+CO must allow any enrollee to select any plan offered within its service area, regardless of health. Whenever it costs the beneficiary less to join a MSA, it will cost the M+CO more.

<sup>15</sup> The bonus payment program required plans to be offered between January 1, 2000 and December 31, 2001. The bonus was a percentage of the countywide payment rate.

might prefer a MSA plan to a M+C plan. This result can be shown formally using the same notation as above.

Under the new MSA incentive program, the M+CO would receive HCFA's demographically adjusted M+C payment rate for that beneficiary ( $b$ ) minus the lump sum amount HCFA deposited directly into the beneficiary's account (the monthly countywide payment rate minus the beneficiary's monthly premium for twelve months =  $(r - p)$ ), plus some percent  $\alpha$  of the annualized countywide payment rate ( $r$ ), where  $\alpha = 1$ . The M+CO would still pay 100 percent of all medical expenses ( $m$ ) incurred after the deductible ( $d_{MSA}$ ) is met. Therefore, the profit of the M+CO offering a new MSA plan is given by the equation:

$$\alpha_{MSA} = [b - (r - p) - (m - d_{MSA}) + \alpha r] \quad (2a)$$

A MSA plan would be more profitable than a M+C plan if  $(2a) > (1)$ , i.e., if and only if

$[p + b - .80(m - d_{M+C})] < [b - (r - p) - (m - d_{MSA}) + \alpha r]$ , which reduces to

$$.20m + .80d_{M+C} + \alpha r < d_{MSA} \quad (3a)$$

The beneficiary's incentives would not be affected by this plan. A MSA plan is less costly for a beneficiary than a M+C plan if equation (6) holds. Comparing equations (3a) and (6), it is clear that the M+CO and the beneficiary no longer have mutually exclusive preferences. For the M+CO to prefer a MSA plan, equation (3a) must hold. Under the new incentive plan, these preferences are no longer incompatible:

$$.20m + .80d_{M+C} + \alpha r < d_{MSA} < .20m + .80d_{M+C} + r$$

By reforming the MSA program to provide incentives to the M+CO, HCFA may be able to encourage M+COs to participate in the MSA plan and may in turn realize some of the potential benefits thought to result from the MSA program.

Another potential solution to the incompatibility is to provide M+COs greater incentive to offer MSA plans by allowing the MCOs to retain above normal earnings. Currently, MCOs are required each year to reconcile costs with payments and to reimburse HCFA for payments made to them in excess of the cost of treating their Medicare beneficiaries. MCOs are permitted to retain 15% of above normal earnings in a benefit stabilization fund to use in offsetting costs in future years; however, this benefit stabilization fund is a non-interest bearing account, which deters MCOs from utilizing the fund. Permitting MCOs to retain a greater portion of above normal earnings in both their MSA and M+CO programs, and to invest these earnings in an interest bearing account or other profitable investment would help to offset the losses incurred from catastrophic illnesses of beneficiaries enrolled in a MSA plan.

A M+CO earning above normal profits will therefore have an incentive to offer a MSA plan along with its M+C plan. The potential benefits of the MSA plan must be weighed against the cost of allowing M+COs to profit from Medicare managed care; however, it is possible that the benefits of this new program will outweigh the costs of encouraging implementation of the program.

## **V. Conclusion**

One of the goals of the Medicare+Choice program was to provide Medicare beneficiaries with a wider range of options for Medicare managed care. The Medical Savings Account program was thought to be able to help achieve this goal by providing an alternative to traditional managed care plans. Additionally, the program allows greater flexibility in treatment options for beneficiaries since they are permitted to use their

account money however they choose. There are other potential benefits to the program as well. MSA plans discourage over-utilization of services and encourage overall cost savings by making beneficiaries more aware of the costs of health care services. These plans might also enable HCFA to better determine costs of services within counties and thereby contribute to more accurate development of countywide payment rates. Unfortunately, the structure of the program is such that M+COs earn less profit under a MSA plan than they might otherwise earn offering a M+C plan; therefore, there are no incentives for a M+CO to participate in the MSA program. By reforming the program to include incentives to M+COs offering MSA plans, the benefits of the MSA program may yet be realized. Without reform, the MSA program will not succeed in enlisting M+COs to participate and any potential benefits of the program will be missed.

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