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Medicare Savings Account: Medicare's Private Alternative Low-Cost Plan Option

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Introduction

As fiscal pressure continues to weigh heavily on the premiums of traditional Medicare Advantage (MA) plans, some insurers are looking to alternative products to attract the new wave of eligible beneficiaries. Given the combination of reduced federal funding, unit price inflation and an increased demand for services, some insurers have chosen to explore the feasibility of Medicare Medical Savings Account (MSA) plans in order to offer a low-cost option in areas where low premiums for traditional MA products are unsustainable.

In short, MSA plans are the Medicare equivalent of a consumer-directed, high-deductible health plan. The following article discusses some of the nuances of an MSA plan and offers an opinion regarding recent interest expressed by many insurers.

Medicare Savings Accounts 101

As previously mentioned, an MSA plan is a high-deductible health plan offered by a private insurer. The standard services covered are consistent with traditional Medicare (e.g., inpatient hospital, outpatient hospital, professional, etc.). For the standard Medicare covered services, an MSA plan cannot charge a member premium. However, MSA plans may offer supplemental coverage for non-Medicare-covered benefits (e.g., dental, hearing, vision, etc.) for which they can charge a premium.

Similar to MA HMO/PPO options, only individuals who have both Medicare Part A and Part B are eligible to enroll in an MSA plan. However, Medicare individuals who are also eligible for Medicaid (i.e., dual eligible), suffer from end-stage renal disease, or currently receive hospice care are not permitted to enroll in an MSA plan.

The enrollment period is consistent with other private Medicare products. Therefore, individuals can either join when they become eligible for Medicare or during the Annual Coordinated Election Period (AEP), which occurs between Oct. 15 and Dec. 7 of each year.

Upon enrollment, a special bank account is opened on behalf of the member. The MSA plan then deposits funds into the member's account in January. The members are not permitted to deposit funds into their own accounts. The amount of the deposit is determined through a designated process similar to the MAPD bid process. The deposit is calculated by taking the difference between the Centers for Medicare & Medicaid Services (CMS) benchmark adjusted for the contract's Star rating and the MSA plan's bid (inclusive of non-benefit cost and margin). No rebate percentage is applied to the traditional "savings" between the benchmark and bid; which now represents the deposit. The MSA plan essentially gets the whole benchmark, but must fund the deposit from this difference, which could be as much as a few thousand dollars per member per year.

As needed throughout the year, the member then spends the funds to pay for approved medical care. After the end of the year, any remaining funds in the member's account are retained in the account for subsequent years. Even if the member leaves the MSA product or insurer, the balance of the MSA is portable and can be used for future medical expense.

Once the individual's expenses have exceeded the designated deductible, the MSA plan covers the full cost of additional treatment with no additional cost sharing.

MSA plans do not provide outpatient prescription drug coverage. Therefore, individuals are eligible to enroll in a stand-alone Medicare prescription drug plan (PDP). As a Qualified Medical Expense, individuals can use MSA funds to pay for Medicare Part D prescription drugs; however, such expenses do not contribute toward the MSA deductible.

Medicare Advantage Market Tightening

Given the variety of external forces influencing the Medicare marketplace, contract year 2015 is another year of potential changes in available offerings for members. With the loss of the Medicare Star rat-

ing bonus payments for plans with fewer than four stars, decreases in the county-specific benchmarks, establishment of maximum benchmarks for counties meeting certain criteria and general core utilization and unit price trend increases, many members may be forced to shop alternative plans in order to balance premium and benefit expenses.

For example, for an insurer that had unfavorable revenue pressure and historically offered a product with no premium, the organization had limited options to maintain the product at the current premium. The plan may have been forced to:

- Reduce benefits;
- Reduce non-benefit expenses;
- Reduce profit; or
- Pair multiple plans (if possible).

In addition, CMS has a number of other standardized tests that also may have restricted the plan's flexibility in developing a solution (e.g., the Total Beneficiary Cost test). Therefore, by definition, MSA plans are a potential alternative to offer a zero-premium product.

Baby Boomers

There is little doubt that the influx of the baby boomers into Medicare will change the landscape of the marketplace. For the baby boomers that are new to the Medicare market, the concept of a consumer-directed, high-deductible product may neither be daunting nor unfamiliar, given the recent trends in the commercial markets. Baby boomers may actually welcome the opportunity to have more autonomy over their own care spectrum and choice in providers.

While the volume of MSA business has been limited in relation to the overall MA marketplace, the recent growth has definitely been noticed by a number of insurers. Very few products can boast of roughly doubling in size each year over the previous five years. With 53.7 million Medicare eligible and 16.5 million members enrolled in MA as of October 2014, the opportunity for enrollment growth is substantial for years to come.

Table 1 illustrates the total enrollment, as defined as the May cohort, over the past five years for all MSA plans.

Table 1:
Enrollment in Medicare Savings Account Plans

Year	2010	2011	2012	2013	2014
Members	562	1,543	2,858	5,809	11,278

The historical membership trend could continue into 2015 and beyond as premiums for traditional Medicare products increase steadily.

Keys to an MSA Plan's Success

There are four critical steps to a successful MSA product:

1. The MSA plan must remain attractive to an "age-in," better risk population. As the MSA plan matures, aging members will both accumulate account balances and incur benefits above the deductible. When the account balances accrue beyond the deductible, the members essentially have a 100 percent benefit, where induced utilization could emerge. The aging population will ultimately increase plan cost, which may lead to an unattractive plan offering (i.e., higher deductible).

2. The MSA plan needs to focus on cost containment at the higher spend intervals. For example, assume an MSA plan has a deductible of $4,000. One hospital admission for a member is likely to incur approximately $10,000 of allowable charges. Thus, there is $6,000 of plan cost just with that one hospital admission. Therefore, active primary care intervention models and care management efforts to reduce the likelihood of hospital readmissions are critical to control plan cost.

3. An MSA plan within an insurer must have its own unique "H" contract number; and thus is tied to a specific Star rating. Due to the mem-

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ber's ability to receive services from any provider, the insurer does not have significant ability to influence physician practice patterns. Without strong physician support, the quality metrics (which drive the Star rating) are difficult to achieve. Without a high Star rating, the insurer's ability to offer a competitive product is increasingly difficult due to lower available revenue.

4. As providers are not tied to a given MSA plan (i.e., no incentives or support), the likelihood to optimally capture diagnoses of a given patient is decreased. The MSA plan's ability to properly reflect the ultimate risk of the population is challenged, which translates to a misalignment of risk and revenue for the MSA plan.

Conclusion

With the ever-changing nature of the U.S. health care market, private insurers are constantly looking for the next product that addresses the needs of their members. This concept is especially true with Medicare as the demographics undergo a fundamental shift to a younger generation of baby boomers.

Given all of the recent challenges that private insurers face with their respective Medicare products, an MSA plan may be an appropriate alternative that combines the cost-containment mechanisms of a high-deductible health plan and the affordability of a zero-premium option. However, this product may not be for all insurers, given its operational challenges.

On The Research Front

SOA POSTS UPDATED MODEL ON LONG-TERM HEALTHCARE COST TRENDS

The SOA released an updated resource model on long-term healthcare cost trends. The SOA Pension Section and Health Section Research teams originally commissioned this model developed by Thomas E. Getzen. The model can be used as a resource for the estimation of reportable liabilities for retiree healthcare benefits under FAS 106 and GASB 45 accounting statements.

https://www.soa.org/research/research-projects/health/research-hlthcare-trends.aspx