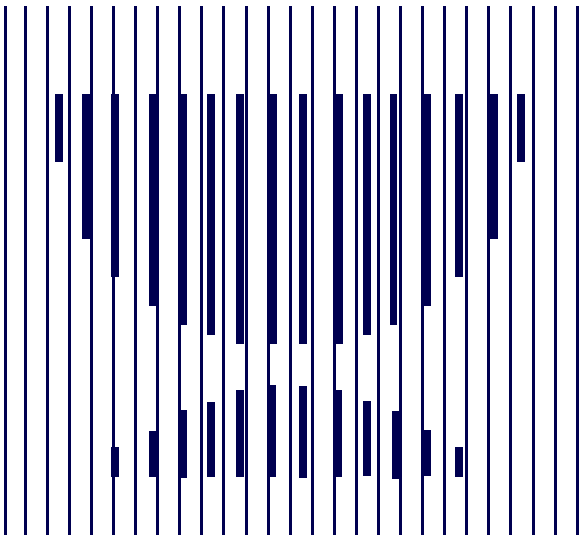
CBO MEMORANDUM

THE HIGH-DEDUCTIBLE/MSA OPTION UNDER MEDICARE: EXPLORING THE IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1995

March 1996



CONGRESSIONAL BUDGET OFFICE

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CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

The Balanced Budget Act of 1995 would allow Medicare beneficiaries to choose a high-deductible health insurance plan with a medical savings account (MSA). The Congressional Budget Office (CBO) prepared this memorandum in response to Congressional interest in the topic and to several requests for further information about CBO's cost estimate of the Balanced Budget Act. The memorandum examines the design features of a high-deductible/MSA option that would affect its attractiveness to beneficiaries and explores the overall impact of the provision on program costs. Based on the limited evidence available, the memorandum concludes that the particular specification of the high-deductible/MSA option in the Balanced Budget Act would tend to raise Medicare's costs.

The memorandum was written by Linda Bilheimer of CBO's Health and Human Resources Division under the direction of Joseph Antos, and by Frank Sammartino of the Tax Analysis Division under the direction of Rosemary Marcuss. Len Burman and Larry Ozanne contributed to the analysis. Sandra Christensen, Harriet Komisar, Julia Matson, Murray Ross, and Paul Van de Water provided valuable suggestions.

Sherwood Kohn edited the manuscript, and Christian Spoor provided editorial assistance. Ronald Moore prepared the final version of the memorandum. Questions about the analysis may be addressed to Linda Bilheimer at (202) 226-2673 or to Frank Sammartino at (202) 226-2680.

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The Medicare program is one of the fastest-growing components of the federal budget. Medicare outlays, less premiums from enrollees, will account for about 11 percent of federal outlays in fiscal year 1996. Under current law, Medicare spending is projected to grow at an average annual rate of more than 9 percent between 1996 and 2002 (the latter being the year in which the Congress and the Administration are seeking to balance the federal budget). By 2002, Medicare is expected to account for 15 percent of federal outlays. That rapid growth will take place during a period in which Medicare enrollment is growing slowly, at slightly more than 1 percent a year. Far more explosive growth in Medicare spending is anticipated after 2010 when the baby-boom generation begins to retire.

Policymakers have been seeking ways to reduce the rate of growth of Medicare spending by improving the efficiency of the program and restructuring it for the long term. A potential strategy for achieving those goals is to make Medicare more competitive by allowing beneficiaries to choose from a greater range of private-sector health plans. Under current law, Medicare beneficiaries can generally choose from only two types of health insurance: traditional fee-for-service coverage and health maintenance organizations (HMOs). Moreover, for some beneficiaries, fee-for-service is the only option available; more than one-third live in counties where no Medicare HMOs with risk contracts operate. (Under risk contracts, HMOs

receive a fixed monthly payment--known as a capitation payment--for each enrollee, regardless of the actual cost of the health care that the enrollee may use.) Although HMO enrollment is growing rapidly, about 90 percent of Medicare beneficiaries are still enrolled in the traditional fee-for-service program. The majority of fee-for-service beneficiaries have little financial incentive to constrain their use of Medicare-covered services because they have supplementary coverage that pays for some or all of Medicare's deductibles and coinsurance.

The Balanced Budget Act of 1995, passed by the Congress but vetoed by the President, would provide beneficiaries with more choices among private health plans. Those choices could include HMOs, preferred provider organizations, provider-sponsored organizations, union- and association-sponsored plans, private fee-for-service insurance, and high-deductible insurance with a medical savings account (MSA). The act is designed to slow the rate of growth of Medicare spending by reducing payments to providers in the traditional fee-for-service sector, making fixed capitation payments to all nontraditional health plans (referred to as MedicarePlus plans), and prompting Medicare beneficiaries to consider price in choosing health insurance.

If Medicare beneficiaries faced the real differences among plans in costs and benefits and made their choices accordingly, the new system could improve the efficiency of the Medicare program. But greater choice could also have undesirable

consequences if payment rates to different plans were not adjusted to reflect that selection process. Some plans, for example, might attract a disproportionate share of healthier beneficiaries, and relatively more higher-risk beneficiaries would remain in the traditional fee-for-service sector. Medicare's costs for enrollees in Medicare-Plus plans would rise if the capitation payments made on their behalf exceeded the costs they would have incurred in the fee-for-service sector. Such an outcome would be particularly likely with the high-deductible/MSA option.

Adjusting the capitation payments to MedicarePlus plans for differences in risk could reduce the additional costs that would result if healthier people selected high-deductible plans. But Medicare's current risk-adjustment mechanisms are limited, and substantial improvements in the near future appear unlikely. Consequently, effective risk adjustment may remain elusive, in which case the effects of selection would be a continuing problem.

The magnitude of those effects would depend on features of the program's design that affect the attractiveness of MedicarePlus plans and, hence, enrollment patterns among beneficiaries of different risk levels. Although new Medicare options could be designed to lessen the adverse consequences of selection, any such design features would necessarily diminish the attractiveness of Plus plans in general and high-deductible plans in particular. Thus, policymakers designing Medicare proposals with a high-deductible option face a trade-off between increasing the

attractiveness of that option and ensuring a level playing field for all other Medicare options, including the traditional fee-for-service sector.

THE PROPOSED HIGH-DEDUCTIBLE/MSA OPTION UNDER MEDICARE

Under current law, Medicare beneficiaries can enroll in either the traditional fee-for-service sector, consisting of the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) programs, or in a health maintenance organization. The Balanced Budget Act of 1995 would make additional private health insurance options available to Medicare beneficiaries under a new MedicarePlus program. Plan options under MedicarePlus might include preferred provider organizations, point-of-service plans, provider-sponsored organizations, private low-deductible indemnity plans, and a combination of high-deductible health insurance plans with medical savings accounts.

As with any of the MedicarePlus options, beneficiaries choosing a high-deductible/MSA option would be eligible for capitation payments from Medicare. Those payments, which would be adjusted by age, sex, disability status, institutional status, and other factors, would be the same for all Plus plans in an area. If the premium for the high-deductible policy was less than the capitation payment, the difference would be paid into an MSA. Enrollees in high-deductible plans could use

the MSA funds to pay expenses that fell below the deductible limit, as well as other cost-sharing expenses and medical expenses that were not covered. Withdrawals for such expenditures would not be subject to taxes. Withdrawals for nonmedical expenses would not generally be subject to taxes, although financial penalties would be incurred under certain circumstances. (This is the Congressional Budget Office's interpretation of the act as written, but it may not reflect the conferees' intent. The House bill would have included in taxable income withdrawals for purposes other than qualified medical expenses. But the final legislative language would generally exclude nonmedical withdrawals from taxable income.)

SELECTION AND RISK-ADJUSTMENT ISSUES

The availability of a health insurance option that combined a high-deductible policy with an MSA would provide financial incentives for Medicare beneficiaries to enroll in lower-cost plans and to assume greater financial risk for their health care. Although those beneficiaries who chose high-deductible plans might spend less than if they had remained in traditional fee-for-service, their lower expenditures would not necessarily translate into savings for the Medicare program. Whether Medicare realized any savings would depend on how well the capitation payment reflected beneficiaries' average program costs in the traditional fee-for-service sector. If beneficiaries in high-deductible plans were healthier than those who stayed in the

traditional program, and if the capitation payments made on their behalf did not reflect that favorable risk status, Medicare would end up paying more for them, on average, than if they had stayed in traditional fee-for-service. The likelihood of that outcome would depend critically on the effectiveness of risk-adjustment mechanisms and on the plans selected by people who had different health risks.

Factors Affecting Beneficiaries' Choice of Plans

In selecting a plan from among the choices available under the Balanced Budget Act, Medicare beneficiaries would have to compare the likely out-of-pocket costs that they would incur under each alternative (apart from the Part B premium, which everyone would pay). For beneficiaries choosing traditional fee-for-service Medicare, those costs could include the Part B deductible (currently $100 a year), the Part A deductible ($736 this year), coinsurance for services covered by Medicare, any balance-billing amounts (costs that are above the charge allowed by Medicare), and costs of services not covered by Medicare.

In practice, however, most fee-for-service beneficiaries have supplementary policies that cover a significant portion of their out-of-pocket medical expenses. In some cases, they may pay nothing for that additional coverage, either because they are covered by a former employer who does not require them to contribute or because

they are enrolled in the Medicaid program. (In recent years, employers who offer health insurance to their retirees have started reducing support for that coverage. As a result, the share of premiums that retirees must pay is increasing.) However, many Medicare beneficiaries--more than 40 percent in 1992--purchase supplementary medigap coverage in the private market. Their fee-for-service costs are increased by the supplementary premium amount, but may be offset by reductions in their out-of-pocket expenditures.

Beneficiaries' costs (above the Part B premium) under a high-deductible policy would consist of costs up to the deductible (up to $6,000 in 1997 under the act), cost-sharing amounts above the deductible, out-of-pocket expenditures for services not covered by the policy, and any balance-billing amounts, offset by the amount deposited in the MSA. The amount that providers could charge over the costs allowed by Medicare would be tightly constrained in both the traditional fee-for-service sector and in managed care plans, but there would be no such constraints for fee-for-service providers in the MedicarePlus market.

Beneficiaries would face marked uncertainties in assessing their plan alternatives. The financial advantages and disadvantages of different options would depend, in part, on any changes in their health status that might necessitate greater or less use of health services. Nonetheless, beneficiaries might have a fairly accurate notion of their need for health services one or two years in the future. But in addition

to projecting their need for health services, they would have to consider the differences in balance billing and other out-of-pocket costs that they would confront under different alternatives. Those differences could be difficult to predict but extremely important when weighing the relative merits of traditional fee-for-service and a high-deductible insurance option. Beneficiaries would have a financial incentive to select the high-deductible option if they projected that their total out-of-pocket expenditures in excess of the MSA contribution would be less than the out-of-pocket costs, including any medigap premium, that they would otherwise have incurred.

Other considerations would also influence beneficiaries' choice of plans. Some physicians and other providers might drop out of traditional fee-for-service Medicare, and patients might prefer to follow their physicians into MedicarePlus rather than establish a relationship with a new provider. In addition, beneficiaries would have to weigh the terms of participating in low-deductible Plus options, including coverage of optional services and any limitations imposed by plans on access to providers.

Characteristics of Beneficiaries Choosing a High-Deductible Plan

Although the characteristics of Medicare beneficiaries who would select high-deductible plans are unknown, indirect evidence suggests that such beneficiaries would tend to be healthier than those who stayed in traditional fee-for-service. That conclusion is supported by the work of economists, actuaries, and researchers who have studied the potential effects of offering high-deductible/MSA options in general and their implications for Medicare in particular. Important findings from recent literature are discussed below.

Medicare beneficiaries generally appear to have a strong aversion to financial risk, as demonstrated by the eagerness with which they purchase Medicare supplementary insurance. More than three-quarters of Medicare beneficiaries living in the general community in 1992 had private insurance coverage obtained through an employer or purchased in the private medigap market.[1] More than half of those beneficiaries purchased at least one supplementary policy in the medigap market. Moreover, almost one-quarter of them had two or more private policies, and in the majority of those cases, at least one of the policies was purchased in the medigap market.

1. See George S. Chulis, Franklin J. Eppig, and John A. Poisal, "Ownership and Average Premiums for Medicare Supplementary Insurance Policies," *Health Care Financing Review,* vol. 17, no. 1 (Fall 1995), pp. 255-275.

The extent of Medicare beneficiaries' aversion to risk is also indicated by the comprehensiveness of the medigap policies that they choose. A survey conducted in the 1992-1993 period showed that almost 60 percent of beneficiaries who bought medigap coverage chose policies that covered the Part A and Part B deductibles, in addition to Part A and Part B coinsurance.[2] At $100, however, the Part B deductible is extremely low, and the majority of Medicare beneficiaries expect to spend more than that amount. Consequently, insurance policies that cover the $100 deductible are, in effect, prepaying the amount rather than insuring against it.

The tendency of policyholders to choose among health insurance plans according to their expected use of health services is readily apparent in the Federal Employees Health Benefits (FEHB) program. In 1989, the actuarial value of the benefits in nine FEHB plans varied by no more than 35 percent, but the premium of the highest-cost plan was almost two and one-half times greater than the premium of the lowest-cost plan, a degree of difference caused primarily by selection effects.[3] For instance, the values of the benefits in the Blue Cross and Blue Shield high-option and standard-option plans were virtually identical, but because a disproportionate number of high-risk enrollees selected the high-option plan, the high-option premium was almost twice the standard option. Moreover, that risk-selection effect has not

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2. See Peter D. Fox, Thomas Rice, and Lisa Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law,* vol. 20, no. 1 (Spring 1995), pp. 31-48.

3. See Stanley B. Jones, "Why Not the Best for the Chronically Ill?" *Research Agenda Brief,* Health Insurance Reform Project, George Washington University (January 1996).

proved to be a transitional phenomenon; the variations in benefit values and premiums for Blue Cross and Blue Shield high-option and standard-option plans are about the same now as they were six years ago.

In a study of the cost implications of high-deductible/MSA plans, the American Academy of Actuaries explored the effects of selection on premiums in employment-based plans.[4] Under the academy's assumptions about selection, the premium for a low-deductible plan would be about 60 percent higher if employees could choose between that plan and a high-deductible plan (without an MSA) than it would be if the low-deductible plan was their only option. If an MSA was offered in conjunction with the high-deductible plan, the assumptions might be modified, depending on the design of the different insurance options and on the steps taken by employers to limit risk selection. A few companies, for example, have been able to attract most of their insured workers to a high-deductible/MSA option, thereby limiting selection effects. They may have been able to achieve that result because their insured populations are relatively small and homogeneous, and because they have limited the terms under which each option is offered.

In a recent study of the implications of MSAs for the Medicare program, researchers at Lewin-VHI, Inc., concluded that a high-deductible/MSA option would

4. See Edwin C. Hustead and others, *Medical Savings Accounts: Cost Implications and Design Issues*, Public Policy Monograph No. 1 (Washington, D.C.: American Academy of Actuaries, May 1995).

attract only beneficiaries expecting to have low expenses during the year.[5] The researchers estimated that even after adjusting Medicare's payments for age, sex, and disability status, payments on behalf of enrollees in a high-deductible/MSA option would be twice the costs that those enrollees would have incurred had they remained in the current Medicare program.

Jack Rodgers of Price Waterhouse and James Mays of the Actuarial Research Corporation also concluded that selection problems would be a major concern if a high-deductible/MSA option was offered in the Medicare program.[6] In their study of this issue, they argued that healthy people would be more likely to benefit from MSA plans, both because their expected medical expenses would be less than in the traditional plan and because they would have more discretion to reduce their health expenditures further.

In a study for the Council for Affordable Health Insurance, actuaries Mark Litow and Peter Hendee outlined a proposal to restructure the Medicare program.[7] Under their proposal, beneficiaries could choose between traditional Medicare and a voucher program that would enable them to purchase health insurance from a range

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5. See John F. Sheils, Gary J. Claxton, and Randall A. Haught, "Changes in Medicare Program Spending Under Alternative Medical Savings Account Models" (monograph prepared for the National Committee to Preserve Social Security and Medicare by Lewin-VHI, Inc., Fairfax, Va., September 22, 1995).

6. See Jack Rodgers and James W. Mays, "Medical Savings Accounts for Medicare Beneficiaries" (monograph prepared for the Henry J. Kaiser Family Foundation, Washington, D.C., August 1995).

7. See Mark E. Litow and Peter G. Hendee, *Restructuring Medicare: A Long-Term Plan to Save the Medicare Program* (Alexandria, Va.: Council for Affordable Health Insurance, August 1995).

of private options (including plans with MSAs). The authors assumed that higher-cost beneficiaries would generally remain in the traditional fee-for-service sector and lower-cost beneficiaries would opt out. Under their assumptions, if 70 percent of beneficiaries chose the voucher program, the costs of beneficiaries remaining in the traditional fee-for-service program would, on average, be 2.7 times the costs of those in the voucher program. That cost difference reflects a combination of the lower average health risks of beneficiaries choosing vouchers and their response to incentives to lower their health care costs.

Effectiveness of Risk-Adjustment Mechanisms

In theory, the cost-increasing effects of favorable selection in high-deductible/MSA plans could be mitigated by adjusting Medicare's payments to those plans for differences in the risks of their enrollees. Under the Balanced Budget Act, for example, the capitation payments to MedicarePlus plans would be adjusted using Medicare's traditional demographic risk adjusters. Unfortunately, those factors are limited in their ability to predict actual differences in health expenditures. Moreover, many insurance industry experts are pessimistic about the prospects for developing a practical and effective risk-adjustment system in the near term, as the following examples indicate.

Testifying in November 1993 before the Subcommittee on Health of the House Committee on Ways and Means, Henry Bachofer of the Blue Cross and Blue Shield Association stated that simple demographic adjustments accounted for only a small part of the differences in health insurance premiums that can be attributed to risk selection.[8] Using additional information, such as an individual's previous use of health services, only modestly improved the adjusters' ability to predict variation in health costs. Actuarial models were more promising, but they required substantial amounts of accurate data on each subscriber as well as the judgment of trained actuaries.

Testifying at the same hearing, representatives of the American Academy of Actuaries voiced similar concerns.[9] The academy maintained that many models for assessing health risks would require vast amounts of data, be costly to carry out, and have problems of timeliness, as well as potentially rewarding inefficiency and inappropriate treatment. Moreover, such models had not generally been fully tested for accuracy and practicality.

A group of researchers from the Harvard School of Public Health and Coopers and Lybrand recently released a major study on methods of risk assessment

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8. Statement of Henry Bachofer about the Blue Cross and Blue Shield Association's views on risk adjustment, before the Subcommittee on Health, House Committee on Ways and Means, November 9, 1993.

9. Statement of the Risk Adjustment Work Group of the American Academy of Actuaries before the Subcommittee on Health, House Committee on Ways and Means, November 9, 1993.

and their implications for recent health care reform proposals.[10] The researchers concluded that, even using the best risk-assessment models available, health plans would have opportunities for profitable selection among risks. Moreover, they did not believe that enough improvement could be achieved in the foreseeable future so that risk adjustment alone could remove all incentives for selection among risks.

Commenting on Medicare's risk-adjustment technology, Harvard economist Joseph Newhouse argued that although that technology was the most sophisticated employed, it was ineffective.[11] According to Newhouse, health plans should be able to predict 15 percent to 20 percent of the variance in health spending among a random sample of the population. But prospective risk adjusters could predict only a fraction of that amount, and major advances in those adjusters were unlikely.

Health insurance expert Stanley Jones has made similar points, arguing that the Medicare risk-adjustment system is "flawed and easily outflanked by health plans."[12] Like Newhouse, he believes that prospects are not good for the development and use of practical risk-adjustment systems in the near term.

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10. See Daniel L. Dunn and others, "A Comparative Analysis of Methods of Health Risk Assessment: Final Report" (Society of Actuaries, October 12, 1995).

11. See Joseph P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs* (Spring I 1994), pp. 132-146.

12. See Jones, "Why Not the Best for the Chronically Ill?"

The Lewin-VHI researchers, mentioned previously, focused on the particular problems of risk adjustment raised by a high-deductible/MSA option in the Medicare program.[13] They expressed doubts about the abilities of risk-adjustment methods now under development "to correct for the extreme selection invited by an MSA program that rewards low health services utilization with cash balances." (The researchers also pointed out that if an effective risk-adjustment mechanism could be developed, Medicare's payments on behalf of beneficiaries enrolled in high-deductible plans would probably be low enough to make contributions to the MSA small. Consequently, both plans and beneficiaries would be discouraged from participating.)

A more recent Lewin-VHI monograph reiterates that full implementation of effective risk-adjustment systems is probably several years away.[14] Consequently, the authors suggest that it might be appropriate for Medicare to incorporate more limited approaches to risk adjustment--such as mandatory reinsurance--that are being tried in some states.

Inadequate risk adjustment coupled with the systematic selection of healthier individuals into the high-deductible option would tend to raise Medicare's costs. The

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13. See Sheils, Claxton, and Haught, "Changes in Medicare Program Spending Under Alternative Medical Savings Account Models."

14. See Gary Claxton and Larry Levitt, "Risk Selection Issues Under Medicare Reform Proposals" (monograph prepared for the Henry J. Kaiser Family Foundation, Washington, D.C., January 1996).

effect on Medicare outlays under the Balanced Budget Act, however, would depend on whether the annual Medicare budget targets established under the act were binding. If the targets were not binding, any increases in costs associated with the high-deductible option would result in higher Medicare spending. But in years in which the budget targets would otherwise be exceeded, a failsafe mechanism would kick in, reducing payments to traditional fee-for-service providers. Under those circumstances, the high-deductible option would probably result in greater reductions in spending in the fee-for-service sector than would otherwise have occurred.

Medical Expenditures of Enrollees in High-Deductible Plans

The cost-increasing effects of offering a high-deductible/MSA option in the Medicare program would result from the inadequacies of the payment mechanism, which could not accurately predict the expenditures that enrollees would have incurred if they had remained in the traditional fee-for-service sector. Beneficiaries' actual expenditures for health care under the high-deductible/MSA option would probably be lower than if they had remained in fee-for-service. But inferences about their potential behavioral responses must be drawn from the information available on the population under age 65, which may have only limited relevance for the Medicare population.

Research on the population under age 65 indicates that--other things being equal--higher coinsurance requirements result in lower health expenditures.[15] Thus, high-deductible insurance should curtail health spending. It is not clear how such behavior would be modified by the inclusion of an MSA. That would depend on the design of the MSA option. If the MSA was designed with low barriers for non-medical expenses (by not taxing the interest buildup and by imposing no penalties on withdrawals for nonmedical purposes, for example), one would expect the incentives for lower health expenditures to prevail. By contrast, if the MSA was designed primarily to be a health insurance supplement, health expenditures would probably be higher than under the high-deductible option alone.

Although Medicare beneficiaries enrolled in high-deductible plans would have financial incentives to reduce their health care spending, any such reductions might be temporary. That is, given the generally higher rates of chronic illness among the elderly population, initial reductions in the use of health care might merely postpone health expenditures for later years. Moreover, given the likelihood that high-deductible enrollees would have relatively low expenditures if they remained in fee-for-service (at least in the early years), some might actually increase their health spending if they had an MSA, which might be used to purchase medical

15. See, for example, W. G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (June 1987), pp. 251-277.

benefits that traditional fee-for-service Medicare did not cover, such as dental care and eyeglasses.

DESIGN CONSIDERATIONS

Certain design features of a proposal to restructure Medicare could mitigate the selection effects of high-deductible insurance and would also affect the marketability of that insurance to Medicare beneficiaries. Those features fall into four categories: terms of enrollment and disenrollment from plans, benefit design, requirements for MSA contributions and withdrawals, and policies affecting the fee-for-service sector.

Terms of Enrollment and Disenrollment

In a system that offered a choice of health plans, the easier it was for beneficiaries to move between options, the more likely they would be to enroll in high-deductible plans at some time. Beneficiaries might enroll in high-deductible plans when they were healthy and move back to the traditional fee-for-service program if they got sick, lowering the average health status of the fee-for-service pool. With inadequate adjustment for risk, costs would rise in the traditional fee-for-service sector, but there would not be a corresponding shift in Medicare funds from the Plus pool.

Various mechanisms could be used to limit movement of enrollees among plan types, including:

- Making the high-deductible MSA choice a one-time, irrevocable decision (possibly allowing an initial "cooling-off" period, during which the decision could be revoked);

- Requiring advance notice and a waiting period before allowing beneficiaries to disenroll from a high-deductible plan;

- Requiring beneficiaries to pay back any remaining MSA funds (or MSA funds that had been used for benefits not covered by Medicare) upon disenrolling from a high-deductible plan;

- Limiting fee-for-service coverage of preexisting conditions, for some specified period, for those who left high-deductible plans and enrolled in the traditional fee-for-service sector;

- Imposing a premium surcharge on high-deductible plans to compensate for the additional fee-for-service costs caused by switching; and

- Imposing a surcharge on Part B premiums for beneficiaries who switched from high-deductible plans into the traditional fee-for-service sector.

The Balanced Budget Act would place only limited constraints on enrollment and disenrollment in high-deductible plans. Under the act, enrollees in high-deductible plans could generally enroll or disenroll under similar terms as enrollees in plans of other types; that is, they could enroll and disenroll without penalty during annual open-enrollment periods, but no more frequently than that. Beneficiaries selecting a MedicarePlus option for the first time, however, could generally change their decision within 90 days of the date when coverage became effective. But those choosing a high-deductible option would not be granted such a cooling-off period. The act would, moreover, constrain high-deductible enrollees more than enrollees in other plans during the period of transition to the new Medicare system. During that period, enrollees in other Medicare plans could switch plans at any time. But beneficiaries could select high-deductible plans only during annual open-enrollment periods (or during October 1996). In addition, Medicare beneficiaries selecting a high-deductible plan during the transition period could switch to another Plus plan (that was not a high-deductible plan) only after that coverage had been in effect for at least 12 months.

Benefit Design

The greater the potential financial risk associated with high-deductible policies, the more likely it would be that only healthy people would enroll. Important benefit design features affecting the riskiness of a high-deductible plan include:

- How large the deductible would be and what types of expenses would count toward it;

- How big out-of-pocket expenditures (cost sharing and balance billing) would be after the deductible had been met; and

- Whether supplementary policies would be permitted to cover the deductible or cost sharing above the deductible and, if so, whether MSA funds could be used to purchase supplementary coverage.

Under the Balanced Budget Act, the deductible could not exceed $6,000 in 1997. (In later years, that threshold would be indexed to the growth in Medicare's average per capita expenditures.) Plans would be required to count at least the amount that would have been paid under traditional fee-for-service Medicare toward the deductible expenses. But if plans adopted no more than the minimum requirements, an enrollee's potential financial exposure before insurance coverage

was effective could be considerably more than the deductible amount. Moreover, supplementary insurance policies covering the deductible in a high-deductible plan would be prohibited. Once the deductible was met, plans could impose additional cost-sharing requirements, would not be required to have a catastrophic limit, and would not be required to cover benefits not covered by Medicare. In addition, providers would face no limits on balance billing as they would in most other plans and in the traditional fee-for-service sector.

Requirements for MSA Contributions and Withdrawals

The more flexibility Medicare beneficiaries had to accumulate funds in their MSAs and to spend those funds on whatever they chose, the greater the likelihood of attracting enrollees primarily interested in the MSA as a savings vehicle rather than as part of a health insurance package. Options that would make an MSA more attractive include:

- Exempting contributions from federal income tax and allowing beneficiaries to make additional contributions;

- Allowing the interest buildup in the account to be tax-exempt;

- Allowing withdrawals for nonmedical expenses without a tax penalty or additional charges;[16] and

- Allowing a surviving spouse to maintain funds in the MSA for his or her medical expenses after the account holder's death.

Under the Balanced Budget Act as written, MSA withdrawals for nonmedical expenses would be permitted and beneficiaries would generally face no tax penalty for such withdrawals. They would, however, incur a 50 percent penalty if nonqualified withdrawals reduced the MSA balance carried over from the previous year to less than 60 percent of the deductible. The interest buildup would be tax-exempt. If an account holder died, a surviving spouse could keep the fund as an MSA, but other heirs would be required to withdraw the funds and pay income tax on them. The act does not specify whether unqualified withdrawals would face a penalty if the account holder was no longer enrolled in a high-deductible plan.

16. Even if a tax penalty was imposed, however, allowing withdrawals from MSAs for nonmedical expenses might attract low-income beneficiaries to high-deductible options, if they faced no other financial penalties. They could cash out their medical benefits for other purposes and, if their income was sufficiently low, would pay little or no additional tax on those withdrawals.

Policy Changes Affecting the Fee-for-Service Sector

Policy changes could result in a migration of both traditional fee-for-service providers and beneficiaries to the MedicarePlus sector. But the potential effects on the growth and average health-risk status of enrollees in high-deductible plans are highly uncertain. If beneficiaries switched from traditional fee-for-service to Plus plans in order to stay with their existing providers, high-deductible plans might attract some less-healthy enrollees. Also, if premiums or cost-sharing requirements for traditional fee-for-service benefits increased in relation to those for Plus plans, such plans might become more attractive to enrollees. In those circumstances, the relative financial risks associated with high-deductible plans would be reduced, possibly increasing the willingness of less-healthy beneficiaries to shift into them.

Policies that might result in increased migration of providers to the Medicare Plus sector include direct reductions in payments to traditional Medicare fee-for-service providers; failsafe mechanisms that would further reduce payments to traditional fee-for-service providers both prospectively and retrospectively, causing uncertainty about future payment rates; and limits on balance billing for traditional fee-for-service providers (but not for fee-for-service providers in the Plus market). The Balanced Budget Act includes all those provisions but would not require additional payments on the part of beneficiaries remaining in traditional fee-for-service

(apart from the increase in the Part B premium that would affect all Medicare beneficiaries).

CBO'S COST ESTIMATE

Some features of the Balanced Budget Act would make the high-deductible option appealing to Medicare beneficiaries, but others would have the opposite effect. In particular, the relative ease with which beneficiaries could disenroll from high-deductible plans and the policies that would make the MSA an effective savings vehicle might attract beneficiaries to the high-deductible option. By contrast, if insurers met no more than the minimum requirements under the act, the benefit-design features of the high-deductible option would probably be unattractive to all but the healthiest beneficiaries and those who were least averse to risk. The effects of policies affecting the traditional fee-for-service sector on incentives to enroll in high-deductible plans are unclear. Moreover, the interactive effects of these various incentives and disincentives render forecasts of Medicare enrollment in high-deductible plans--and the programmatic consequences of that enrollment--extremely uncertain.

The success of high-deductible plans in attracting beneficiaries would depend on their own design features, those of other new MedicarePlus plans, and the

circumstances facing the traditional fee-for-service program. It is difficult to anticipate all the innovations that might arise in the Plus market, or the resulting beneficiary response to those innovations. It is equally difficult to anticipate providers' responses to changing market incentives and the fiscal restraint in traditional fee-for-service Medicare that the act would require. The available information on high-deductible insurance is limited to a few companies that have offered such insurance to their employees. This experience provides little guidance for assessing the impact of high-deductible insurance in a substantially transformed Medicare program. As mentioned earlier, those companies typically have small, homogeneous populations and have strictly controlled the terms under which different insurance options are offered. The Medicare program, by contrast, has a diverse population of about 38 million people, and it would have limited ability to control the terms under which different plans were offered in local MedicarePlus markets across the country.

The Congressional Budget Office (CBO) estimated that under the Balanced Budget Act about 800,000 beneficiaries (roughly 2 percent of the eligible population) would choose high-deductible insurance by 2002. That low estimate of participation reflects the overt aversion to risk displayed by the Medicare population and the fact that, under a high-deductible plan, most Medicare beneficiaries would be exposed to a greater risk of out-of-pocket medical expenses than they would under other Medicare options. Moreover, because there is strong reason to believe that, even

after adjusting for their demographic characteristics, those who enrolled in the high-deductible option would use fewer health services than the average Medicare beneficiary, CBO assumed that the average fee-for-service costs of enrollees in high-deductible insurance would be one-third lower than the capitation payments made by Medicare on their behalf. Consequently, CBO projected that the high-deductible/ MSA option would cost $4.5 billion between 1996 and 2002.

Changes in design could reduce the increased costs attributed to the high-deductible option. That outcome could be accomplished through a blending of design features that discouraged excessive movement of enrollees into and out of high-deductible plans, placed appropriate financial responsibility on beneficiaries who selected the option, imposed acceptable limits on MSA contributions and withdrawals, and leveled the playing field for both traditional fee-for-service Medicare and the new MedicarePlus sector. The adoption of such features would, however, render the high-deductible option unattractive to many Medicare beneficiaries. Using better risk-adjustment methods in Medicare's capitation formula would also help reduce the selection problem, but the evidence suggests that substantial improvements in those methods are unlikely in the foreseeable future.