



**Fresh Thinking on Health Policy**  
**September 28, 2005**

## Bringing Health Savings Accounts to Medicare

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### ABSTRACT

Medicare is in crisis and to date little has been done to address it. Old strategies, such as cutting provider payments, will do little to solve the problem, and may make it worse by driving the best physicians out of Medicare altogether. Ironically the Medicare Modernization Act of 2003 authorized all Americans, except those on Medicare, to try a “consumer directed” approach that has the potential to lower costs by changing patient behavior. It is time for Congress to allow Medicare beneficiaries to join the movement to consumer empowerment.

### INTRODUCTION

It is sadly ironic that the Medicare Modernization Act (MMA)<sup>1</sup>, which was enacted in the 108<sup>th</sup> Congress, extended Health Savings Accounts (HSAs) to all Americans -- except those on Medicare.

HSAs and other forms of consumer driven health care are proving to be very popular with consumers in the under-65 market. In just the first 14 months of availability, more than one million consumers enrolled in HSA-qualified programs<sup>2</sup>, with another two and a half million enrolled in similar Health Reimbursement Arrangements (HRAs), which have been available only since June, 2002.<sup>3</sup> HSAs and HRAs are being accepted in the market at a

rate that may exceed any other benefit innovation of the past, such as Health Maintenance Organizations (HMOs), Flexible Spending Accounts (FSAs), or retirement accounts such as 401(k)s.

Not only are consumers embracing HSAs, but players in the supporting health benefits infrastructure are as well. Insurers, employers, third-party administrators, and insurance brokers already have or are in the process of developing new products, new systems, and new marketing campaigns.<sup>4, 5, 6, 7</sup> In addition, HSAs and HRAs are drawing whole new industries into the health benefits market – including banks, mutual fund companies, credit unions, and software companies – and are spawning a wave of entrepreneurs, funded by new venture capital, many of whom are breaking new ground in patient support and information technologies.<sup>8</sup>

1. Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173)., Signed into law on December 8, 2003 by President George W. Bush.

2. America's Health Insurance Plans, “HSAs More than Double in Six Months, New AHIP Study Shows,” May 4, 2005, [http://www.hsadecisions.org/news/article.asp?article\\_id=134](http://www.hsadecisions.org/news/article.asp?article_id=134)

3. “Enrollment in Account-Based CDH Plans Will Surpass 3 Million Lives on Jan. 1,” *Inside Consumer-Directed Care*, December 17, 2004. Available online at <http://www.aispub.com/Bnow/122204e.html>.

4. Anderson, T. “Taking Your Well-Being to the Bank.” *Baltimore Business Journal*, August 13, 2004. Available online at <http://www.bizjournals.com/baltimore/stories/2004/08/16/focus1.html>.

5. Finkelstein, J. “Health Savings Accounts Make Impressive Strides.” *American Medical News*, January 31, 2005. Available online at <http://www.ama-assn.org/amednews/2005/01/31/gvse0131.htm>.

6. Garrison-Sprenger, N. “Bankers Bet on HSAs to Tap Growing Market.” *The Business Journal* (Minneapolis and St. Paul), January 21, 2005. Available online at <http://twincities.bizjournals.com/twincities/stories/2005/01/24/story1.html>.

7. Price, M. “Saving for Health Care Costs.” *New York Daily News*, December 14, 2004. Available online at <http://www.nydailynews.com/>

Federal employees now have both HSAs and HRAs available through the Federal Employees Health Benefit Program.<sup>9</sup> And state governments are looking at how to apply consumer driven health care to people on public programs such as Medicaid, and to public employees.<sup>10, 11</sup>

Virtually everyone in America can be involved in this new Gold Rush except those on Medicare. The HSA section of the MMA legislation specified that, “The limitation under this subsection [Medicare Eligible Individuals] for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.”<sup>12</sup>

Later regulations clarified that mere eligibility for Medicare was not disqualifying -- one had to be actually enrolled in Medicare.<sup>13</sup> But few individuals who are eligible for the massive retiree health benefit program refuse to enroll because of the extraordinary subsidies the program provides through which taxpayers fund 100 percent of Medicare Part A and 75 percent of Part B expenses, and the fact that failure to enroll means forfeiting Social Security benefits as well.<sup>14</sup>

## PROBLEMS WITH THE MEDICARE MSA OPTION

When Congress enacted the MMA, it reauthorized the original Medical Savings Account (MSA) provision for Medicare that was part of the 1997 Balanced Budget Act.<sup>15</sup> The original MSA provision was enacted as a demonstration project but

had expired without ever being used. The reauthorization is unlikely to be any more successful than the original provision was, although the new version is slightly improved. In this paper we will

## “The original (Medicare MSA) legislation was designed to fail.”

refer to MSAs as the programs named by Congress to be included in Medicare under the Balanced Budget Act and the Medicare Modernization Act, but as those programs have failed, we will refer to similar new approaches as Medicare Health Savings Accounts (HSAs), in keeping with the more widely adopted terminology being used today.

The original legislation was designed to fail. It deemed Medicare MSAs to be a time-limited demonstration project that could enroll no more than 300,000 beneficiaries. Very few carriers were likely to invest development resources in such a tentative program, and none did. These limitations have been removed in the MMA, but the hurdles remain very high. As discussed in earlier research,<sup>16</sup> there are many reasons why private insurance companies were reluctant to develop an MSA product for Medicare, including:

- Smaller insurers are daunted by federal procurement and accounting rules, which are unlike anything used in the private sector.
- The prospect of being the first MSA carrier in Medicare – and having to answer the questions of potentially 39 million beneficiaries – is enough to crush the interest of even the largest private carrier.

8. See, for example, speaker presentations from the the agenda of the Consumer Directed Health Care Conference and Expo, Washington, DC, November 29 - December 1st, 2004. Available online at <http://www.cdhec.com/washington%202004/Default.asp?View=78>.

9. Descriptions are available at <http://www.opm.gov/hsa/index.asp>

10. Deslatte A. “State Plans to Overhaul Medicaid.” *The News-Press*, January 12, 2005. Available online at <http://www.news-press.com/apps/pbcs.dll/article?AID=2005501120454>.

11. Maze, J. “Agency Proposes Medicaid Overhaul.” *The Post and Courier*, November 20, 2004. Available online at <http://archives.postandcourier.com/archive/arch04/1104/arc11202030996.shtml>.

12. Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173). Title XII – Tax Incentives for Health and Retirement Security, Sec. 223. Health Savings Accounts.

13. *Health Savings Accounts – Additional Qs & As*. Internal Revenue Service Notice 2004-50. August 9, 2004. Available online at <http://www.irs.gov/pub/irs-drop/n-04-50.pdf>.

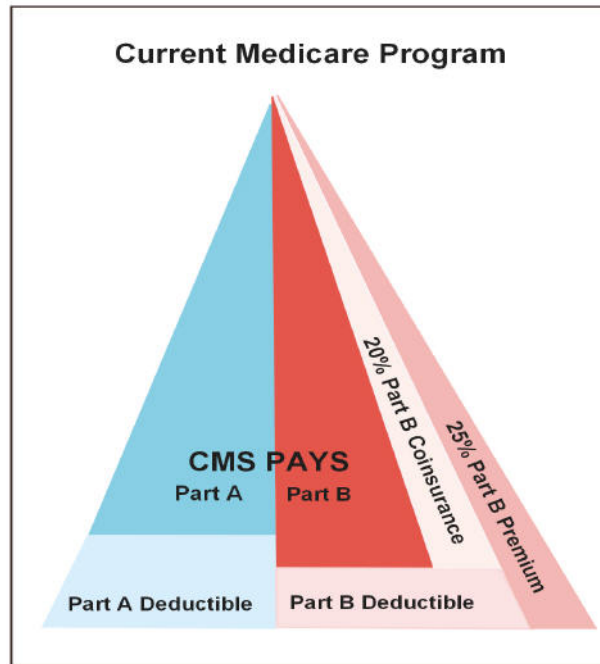
14. Blevins S. *What Every American Needs to Know about Social Security and the Mandatory Medicare-Enrollment Policy: Government Imposes a Huge Financial Penalty on Seniors Who Reject Socialized Medicine*. Institute for Health Freedom, February 11, 2005. Available online at <http://www.forhealthfreedom.org/Publications/MedicareMedicaid/MandatoryEnrollment.html>.

15. Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173). Title II – Medicare Advantage. Sec. 233 Medicare MSAs.

16. Scandlen G. *Consumer Choice in Medicare*. Galen Institute, October 16, 2004. Available online at <http://www.galen.org/m2dicare.asp?docID=489>.

- ◆ Companies have limited research and development resources and will target those resources on the areas with the greatest potential return.
- ◆ Companies are wary of the political volatility of the Medicare program, with public policy lurching between adequate payments to encourage participation in one budget cycle, and draconian cuts to reduce the deficit in the next.

There were other problems with the Medicare MSA demonstration as well. Beneficiaries were not allowed to contribute their own dollars to the Medicare MSA but were confined to using public dollars. And the legislation required that companies offering Medicare MSAs provide quality assurance programs that might have been appropriate for an HMO involved in the delivery of services but not for an MSA, which is confined to financial arrangements.



aid Services (CMS), which administers the Medicare program, to offer a high-deductible alternative to the existing program in which most beneficiaries are currently enrolled.

This alternative would be similar to Medicare's existing benefit structure, but would convert the present cost-control provisions (deductibles, coinsurance, co-payments, coverage gaps) into a single deductible that could be covered by HSA funds.<sup>17, 18</sup>

Such an approach would transform the current perverse incentives of the Medicare program. Very little has been done within Medicare to affect consumer behavior. When Medicare tries to control costs it typically does so by cutting payments to physicians, hospitals and health plans. Other than recent enhancements in preventive services, Medicare has

done nothing to change the way beneficiaries consume health care services. While it has plenty of cost sharing, those elements are scattered and confusing and fail to confront the elderly with the consequences of their spending decisions. For 2005, Medicare cost-sharing provisions include:

done nothing to change the way beneficiaries consume health care services. While it has plenty of cost sharing, those elements are scattered and confusing and fail to confront the elderly with the consequences of their spending decisions. For 2005, Medicare cost-sharing provisions include:

- ◆ \$ 912 Part A deductible
- ◆ \$ 110 Part B deductible
- ◆ 20% Part B coinsurance
- ◆ Co-pay of \$228 per day after 60 days hospitalization and \$446 per day after 90 days
- ◆ Co-pay of \$114 per day after 20 days in a skilled nursing facility
- ◆ Very limited coverage of prescription drugs today, giving way to improved, but still limited, coverage in 2006.
- ◆ No coverage for dental, vision, or non-prescription medications.

### ADDING AN HSA OPTION TO MEDICARE

There is a way to resolve this dilemma. Congress could instruct the Centers for Medicare and Medic-

17. "What are the Medicare premiums and coinsurance rates for 2005?" Centers for Medicare and Medicaid Services, 2005. Available online at [http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std\\_adp.php?p\\_faqid=1560&p\\_created=1095443945](http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=1560&p_created=1095443945).

18. "HHS Announces Medicare Premium, Deductibles for 2005." U.S. Department of Health & Human Services, September 3, 2004. Available online at <http://www.hhs.gov/news/press/2004pres/20040903a.html>.

While these provisions may be effective in getting the elderly to pay more of their total health care bill, they do next to nothing to change the use of health care services.

CMS estimates that Medicare currently pays only 53 percent of an average beneficiary's health care costs.<sup>19</sup> As a consequence of all these gaps in coverage, most beneficiaries carry additional coverage to supplement Medicare benefits. According to a study in *Health Affairs* only 13.5% of the elderly relied on Medicare alone. The rest also had employer-based supplemental coverage (32.5%), private "Medigap" coverage (31.7%), HMO coverage (14.7%), or were also eligible for Medicaid benefits (7.7%).<sup>20</sup>

These supplemental coverages are at risk, however, with employers cutting back dramatically on funding retiree health benefits over the past fifteen years, private Medigap plans becoming more and more expensive, and state Medicaid programs in dire financial straits. In 1988, 66 percent of firms with over 200 workers provided health benefits to retirees. That has dropped to 38 percent in 2003.<sup>21</sup> Smaller firms are even less likely to provide such coverage. Non-employer Medigap plans can cost anywhere from several hundred to several thousand dollars per month.<sup>22, 23</sup>

It is all very confusing and very expensive. It would be much better if CMS were to develop an alternative program that combined all the existing

cost-sharing features into a single deductible (of perhaps \$2,500 or \$3,000) and allowed beneficiaries to put the money they currently spend on MediGap premiums and out-of-pocket expenses into a tax-favored Medicare Health Savings Account (HSA).

### MEDICARE HSAs

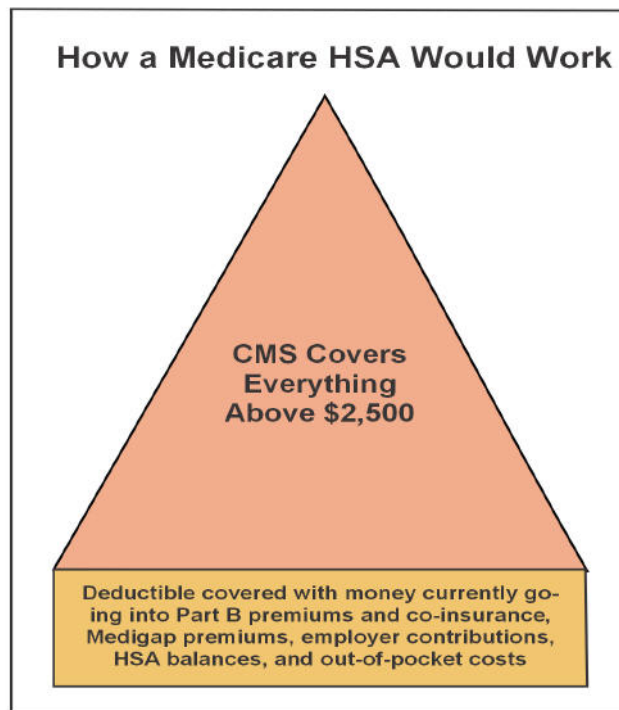
The high-deductible plan could be offered directly by CMS, at least until such time as enrollment is stabilized and beneficiaries become more familiar with the program. Once those conditions are met, CMS could invite private carriers to take over the business on a risk basis.

But the HSAs themselves could be administered by the same companies that currently administer HSAs for those under age 65. In the future, this would have the distinct advantage of making Medicare enrollment seamless for those workers who accumulate significant HSA funds before becoming eligible for Medicare.

It would also bring market forces and private sector competition into Medicare. CMS would

continue to be involved as the provider of high-deductible health coverage, but private companies would take over the administration of routine, low-dollar expenses.

Medicare beneficiaries who are familiar with and comfortable with the existing fee-for-service pro-



19. Centers for Medicare and Medicaid Services, "Program Information on Medicare, Medicaid, SCHIP, and other programs of the CMS," June, 2002. See also: <http://www.cms.hhs.gov/charts/series/sec3-b5.ppt>.

20. Dana Goldman and Julie Zissimopoulos, "High Out-Of-Pocket Health Care Spending by the Elderly," *Health Affairs*, May/June, 2003

21. "Employer Health Benefits, 2003 Annual Survey," Kaiser Family Foundation and Health Research & Educational Trust, September, 2003.

22. Lankford, K. "How to Win the Medigap Pricing Game." *MSN Money*, 2005. Available online at <http://moneycentral.msn.com/content/Insurance/P45537.asp>.

23. 2004 *Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*. The Centers for Medicare & Medicaid Services and the

gram, or with existing HMO and PPO options, could continue to be enrolled in those programs. But beneficiaries who prefer a more consumer-directed approach would gain another option with a Medicare HSA.

Obviously, an actuarial analysis is needed to determine the value of a high-deductible program for the elderly and to estimate the optimal deductible and premium involved in such a program. Any savings to the Medicare program would be converted into a cash deposit to the beneficiaries' HSA account. Medicare was estimated to pay in 2005, \$7,115 per beneficiary on average, with rapid increases over the next twenty years.<sup>24</sup> A \$3,000 deductible might lower that annual outlay to \$5,000, leaving \$2,115 left over to be contributed to the individual's HSA. Even if the annual savings were much lower than that, the deductible could be covered by the HSA with the money that would otherwise go into Medigap premiums and out-of-pocket expenses. The per capita premium and deposit would need to be risk-adjusted at least for age and geography, much as CMS currently does for Medicare Advantage plans.

Actuaries would also need to determine whether to continue the existing 20% Part B coinsurance for physician services, or to eliminate that and provide 100% coverage above the deductible. Alternatively, they may decide the best design would be to require such a coinsurance provision but cap it at some stop-loss level as is common in the under-65 market.

Importantly, the opportunity to save for future needs and the fact that they are spending their own money would encourage people to think twice about how they use health care services – just as it does for non-elderly HSA holders. For the first time ever, Medicare would be addressing expenses by affecting the demand side of the transaction and not just the supply side.

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24. Marilyn Moon, "Growth in Medicare Spending: What Will Beneficiaries Pay?" Urban Institute, January, 1999, <http://www.urban.org/url.cfm?ID=407788>

HSAs in Medicare would also have a profound benefit in solving the intractable problem of reducing waste and fraud in Medicare. Beneficiaries would carefully monitor their bills to ensure they were being charged only for services actually delivered, and they would be unlikely to participate in kick-back scams since it would be their own money at risk.

Congress would likely restrict the use of public funds that are deposited into the Medicare HSA – e.g., not allowing them to be cashed-out for other purposes and not including balances in the beneficiary's estate at the times of death or divorce. Such funds might be made available to offset the costs of long-term care, or revert back to Medicare upon the death of the beneficiary. But the private funds deposited by the beneficiary would have no such restrictions.

Existing prohibitions on private contracting with, or balance billing by, providers would need to be waived for Medicare HSAs. But these restrictions should be repealed for the entire Medicare program

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anyway. Such rules are not good for beneficiaries, for physicians, or for the Medicare program itself. As Medicare continues to reduce payment to physicians, it makes no sense to prohibit beneficiaries from supplementing Medicare payment with their own funds. It also is imperative that Congress lift the restriction on private contracting to allow beneficiaries to purchase the medical care of their choice without the current draconian penalties. Receiving physician services is more than just a matter of dollars. The convenience and manner of the physician are important qualities for which patients may be perfectly willing to pay extra. They should be allowed to supplement the basic Medicare payment with their own funds to access the services and providers who best meet their needs.

## THE NEED FOR INNOVATION

It is past time for Congress to allow experimentation and innovation in benefit design for Medicare. The “Medicare Advantage” part of the MMA was certainly a beginning in that direction, but it doesn’t go far enough. It misses the mark because it still relies on supply-side rationing rather than affecting the behavior of beneficiaries. The fiscal future of the program is dire – far worse than Social Security. The promise of consumer-driven health care is that it will help educate patients about their treatment alternatives and their responsibility for maintaining their own health. It will increase their understanding of, and satisfaction with, the health care services they consume. It will improve quality and lower litigation expense as patients and physicians re-learn how to trust and collaborate with each other. And it will increase efficiency and lower costs as providers strive to please patients better than their competitors do.

Currently, of all Americans, only those on Medicare, are forbidden from trying a consumer-driven approach to health care financing. Of all of us, the elderly may be in the best position to become active participants in health care decision making. They pay more attention to their health conditions, and they have the time to look at alternatives. Congress should encourage them to do so by creating a mechanism through which those who choose to take more control are allowed to do so.

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