Medical Savings Accounts for Medicare: The Adverse Selection Issue

The Republican Medicare reform plan allows the elderly to choose a catastrophic health insurance policy coupled with a Medical Savings Account (MSA) rather than remain in traditional Medicare. Critics of Medicare MSAs argue that retirees who expect to incur few medical expenses would likely choose the MSA option, while those who anticipate high medical costs would remain in traditional Medicare. The process in which healthy people shift to one insurance pool while sick people remain in another is known as adverse selection, and it can lead to escalating premiums in the pool containing a disproportionate number of sick people.

Would Medicare MSAs lead to adverse selection? The Congressional Budget Office (CBO) thinks so and has recently released a report claiming that a Medicare MSA option would increase costs by $2.3 billion over seven years for that reason.

However, hundreds of employers across the nation have implemented some form of Medical Savings Accounts, and there is no evidence that adverse selection is occurring. There is no reason to think it would occur in a properly structured Medicare plan, either. Let's see why.

Better Benefits Than Medicare. Adverse selection occurs only if healthy people can benefit financially by moving to an insurance pool that sick people would want to avoid. However, MSAs provide better benefits for the sick than they receive under Medicare now. Consequently, the sick as well as the healthy are more likely to choose a plan with an MSA. [See “Are Medical Savings Accounts Good for the Sick?” NCPA Brief Analysis No. 182, October 17, 1995.]

A study for the National Center for Policy Analysis by Milliman & Robertson, the nation's top actuarial firm, analyzed the options seniors would have under a Medicare reform plan similar to the one being considered by Congress. The study showed private plans could provide seniors with a high-deductible policy that would pay all expenses above a $3,000 deductible and could deposit as much as $2,100 in the seniors' MSA to pay for expenses below the deductible. [See figure.]

This plan would provide seniors with better benefits than Medicare for several reasons:

- The MSA plan provides complete catastrophic coverage for all expenses over $3,000, while traditional Medicare coverage runs out after various caps and limitations are reached.
- The MSA plan provides a maximum cap of $900 per year on out-of-pocket expenses for the elderly (the difference between the $3,000 deductible and the $2,100 in the MSA), while Medicare has no cap on out-of-pocket expenses.
- Because of gaps in Medicare coverage, 70 percent of the elderly purchase private insurance to supplement Medicare at an average cost of $1,200 per year; with the MSA plan, the elderly could keep the $1,200 in a bank account and would no longer need supplemental (medigap) insurance.
- The funds in the MSA could be used for any health expense, including eyeglasses, prescription drugs and other items not covered by Medicare.
Seniors would have a broader choice of doctors and services with MSAs than with Medicare, because they would be able to pay market prices rather than relying on Medicare’s low payment rates, which already are causing limited access to doctors and hospitals and some health care rationing.

By returning health care money — and therefore decision-making power — to the senior, MSAs would restore the doctor-patient relationship, allowing doctors to become agents of their patients instead of agents of the Medicare bureaucracy.

Employer Experience with MSAs. Fortunately, the question of whether MSAs would result in adverse selection is not hypothetical. Hundreds of employers across the country already offer MSAs to their workers. In every company where a choice is allowed, the overwhelming majority of workers choose MSAs — the sick as well as the healthy. Nor do those who become sick later show any tendency to leave the MSAs. The best example is Golden Rule Insurance Co., which offers MSAs as well as a traditional fee-for-service plan to its 1,300 employees. More than 90 percent of employees have chosen the MSA option, and there is no trend among those who become sick to leave the MSAs.

The Real Adverse Selection Problem. The real adverse selection problem comes from health maintenance organizations (HMOs), not MSAs. In general, the sick are not attracted to HMOs because the HMO bureaucracy sharply restricts their freedom to choose physicians and limits access to diagnostic tests and other treatments in order to control their health care dollars. The healthy tend to pick HMOs because of the lower costs, realizing that when they become sick they can leave the HMO for traditional health insurance.

This has been the experience not only of employees working in the private sector but also of retirees who could choose an HMO for their Medicare coverage. Those choosing HMOs have mostly been younger and healthier seniors, while older and sicker seniors have stayed in traditional Medicare. Because Medicare reimburses HMOs based on the average cost of all retirees (subject to adjustments noted below), studies show that HMOs cost Medicare money under the current payment formulas.

Risk Adjustments. One way of avoiding any adverse selection problem that might arise in the private sector options is by adjusting the payments Medicare makes to private insurers. For example, Medicare already adjusts premium payments to HMOs to reflect the age of the enrollee, the geographic location (some areas have lower costs than others) and other factors.

Such adjustments are never perfect. However, Medicare payments to the private plans could be adjusted over time, based on actual experience.

Budget Savings. Milliman & Robertson estimated that, under a reform plan similar to the one being considered in Congress, 50 percent of Medicare retirees would choose the private option in the first year, with the number increasing to 80 percent by the seventh year. Medicare spending, according to Milliman & Robertson, would be reduced by almost $200 billion over the next seven years.

The CBO Swings and Misses. Since its founding, the CBO has had a history of erroneous forecasts because of its reliance on “static” analyses, which discount the impact of changes in human behavior as a result of changes in incentives.

The CBO predicts that only 1 percent of Medicare beneficiaries would choose MSA plans, while 21 percent would choose HMOs. That prediction flies in the face of employer experience — which the CBO did not consider in developing its estimates.

The CBO also predicts that MSAs would cost the government $2.3 billion (because only healthy people would join them) and that HMOs would save $49.7 billion over seven years.

In fact, MSAs create incentives to control spending by giving people more control over their health care dollars — the type of behavior the CBO refuses to consider in making its estimates. As employer experience has demonstrated, MSAs reduce health care spending, engender employee satisfaction and do not result in adverse selection.

This Brief Analysis was prepared by NCPA Senior Fellow Peter J. Ferrara.

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