United States General Accounting Office

GAO

Report to Congressional Committees

December 1998

MEDICAL SAVINGS ACCOUNTS

Results From Surveys of Insurers

GAO/HEHS-99-34

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-281613

December 31, 1998

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Bill Archer
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a demonstration of Medical Savings Accounts (MSA) and directed GAO to contract for a study of MSAs. We issued an interim report last year.[1] This is the final report of the study.

HIPAA required the study to address the effects of MSAs on

- selection, including adverse selection;
- health costs, including any impact on premiums of individuals with comprehensive coverage;
- use of preventive care;
- consumer choice;
- the scope of coverage of high-deductible plans purchased in conjunction with such accounts; and
- other relevant items.

Our original evaluation design called for conducting surveys of MSA enrollees and employers to obtain a consumer perspective on MSAs, and surveys of insurers and financial institutions to obtain the perspective of suppliers. We competitively awarded four contracts to companies with experience in health economics, health insurance, and actuarial science and selected Westat and its partners to design an enrollee survey and to complete a study of insurers' responses to MSAs. However, the relatively low enrollment in MSAs made it impossible to conduct useful surveys of enrollees, employers, or financial institutions at a reasonable cost.

[1]Medical Savings Accounts: Findings From Insurer Survey (GAO/HEHS-98-57, Dec. 19, 1997).

Consequently, as agreed with your offices, we did not initiate them. The information obtained for this study comes only from insurers, limiting the extent to which the evaluation can address the issues in the mandate.

We will make copies of this report available to other interested parties on request.

Please contact me on (202) 512-6806 or William J. Scanlon, Director, Health Financing and Systems Issues, at (202) 512-7114 if you or your staff have any questions.

Richard L. Hembra
Assistant Comptroller General

Westat Report on Surveys of Insurers

COMPREHENSIVE STUDY OF THE MEDICAL SAVINGS ACCOUNT DEMONSTRATION

Task Order 97-2—INSURER SURVEY

FINAL REPORT

Contract No. 97-1275-015

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November 1998

MEDICAL SAVINGS ACCOUNT DEMONSTRATION
FINAL REPORT ON INSURER SURVEY

EXECUTIVE SUMMARY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a four-year demonstration program for Medical Savings Accounts (MSAs). HIPAA required as well that the General Accounting Office (GAO) contract for an evaluation of the MSA demonstration, and report the results to Congress by January 1, 1999. This report presents the results of that evaluation.

Key findings from the evaluation include:

- Consumer demand has been lower than many in the industry anticipated. Lower demand reflects, in part, the complexity of the qualifying plan/MSA product for both agents and consumers. Insurers and the Internal Revenue Service report that product sales have continued in the second year of the demonstration, but remain well below the HIPAA-imposed limits.
- The insurance industry responded to the legislation rapidly, with more than 50 companies offering qualifying products by the summer of 1997; between 1997 and 1998 the total number of companies offering qualifying products declined slightly.
- A wide range of insurers offer qualifying plans, and both traditional indemnity products and plans with managed care features (principally preferred provider organizations) are available.
- A minority of insurers offering qualifying plans are marketing them aggressively and remain optimistic that MSAs will be an important option in the market; other insurers are currently more passively in the market and have more of a "wait-and-see" view of MSAs.
- Insurers report that the supply of qualifying plans available and the enthusiasm with which they are marketed have been limited by features of the demonstration design.
- A majority of insurers sell qualifying plans bundled with the Medical Savings Accounts; the accounts themselves are offering a wider variety of investment options and banking features as the demonstration matures.
- Qualifying plans have somewhat more generous benefits than other high deductible products offered by the same insurers; premiums for qualifying plans, initially set very similarly to non-qualifying high deductible plans, have dropped in some cases between 1997 and 1998.

Background – The MSA Demonstration

MSAs are trusts or custodial savings accounts that may only be opened in conjunction with purchase of qualifying high deductible health insurance plans (qualifying plans). Qualifying plans must be comprehensive health insurance plans with the following provisions:

- Annual deductible of at least $1500 and not more than $2250 for individual coverage, and an annual deductible of at least $3000 and not more than $4500 for family coverage;
- Annual out-of-pocket maximum (OPM) expenses cannot exceed $3000 for individual coverage or $5500 for family coverage.
- Lower deductibles or first-dollar coverage are allowed only for state-mandated preventive care.

The MSA demonstration began on January 1, 1997, and is limited to self-employed individuals and employees of small businesses with 50 or fewer employees. Either the employee or his/her employer (but not both) may contribute to the MSA in a given year. For individual coverage, the maximum amount that may be contributed to an MSA is 65 percent of the deductible. For family coverage, the maximum contribution is 75 percent of the deductible. A spouse of an eligible individual who is covered under the qualifying plan (but no other plan) may also open an MSA, but the combined contributions to the family's accounts in a year may not exceed these maximum amounts.

Employer contributions to eligible employees' MSAs are not counted towards gross income, and are not subject to withholding for income tax and other federal employee taxes. Contributions made by self-employed individuals and employees of small firms are tax-deductible. MSA funds used for qualifying medical expenses are not counted towards gross income when calculating federal income taxes.

HIPAA imposed limits on enrollment in the demonstration. For 1997, total enrollment in the demonstration was capped at 375,000 MSAs by April 30, 1997, and 525,000 accounts by June 30, 1997. For 1998, enrollment is capped at 600,000 accounts by April 15, 1998. Finally, the overall demonstration cap is 750,000 accounts[1]. MSAs opened by previously uninsured individuals and by spouses of primary insured persons are not included in determining whether these statutory limitations have been exceeded. The IRS determines if the caps have been reached based on filings required of MSA trustees.

[1]The December 1997 report, published as "Medical Savings Accounts: Findings from Insurer Survey," GAO/HEHS-98-57, incorrectly stated the overall demonstration cap as 725,000 enrollees.

Background – The Evaluation

This report is based on surveys of the insurance industry conducted by Westat and its partners Barents Group of KPMG, HayGroup, and the Project HOPE Center for Health Affairs in the summers of 1997 and 1998. The objective of these Insurer Surveys was to examine the early development of the market for MSA products. The Westat team interviewed more than 300 organizations each year in the health insurance and health maintenance organization (HMO) industry who make product decisions for nearly 700 insurers and HMOs.[2] The survey asked all responding organizations whether they were offering or planning to offer MSA-qualifying health plans, and about the factors leading to the decision. It also asked those offering qualifying plans about the products offered, the markets they operated in, and their marketing strategies.

It is important to note that the statistics derived from the surveys are not "national estimates" in a true statistical sense. The Insurer Surveys were essentially censuses of organizations making comprehensive health insurance product decisions, with the exception of small HMOs, for whom a one-third sample was contacted. However, because some insurers and HMOs refused to participate and because those who did participate did not always answer all of the survey questions, the survey cannot reliably estimate, for example, the number of qualifying plans sold. The research team is confident, however, that the study design identified virtually, if not literally, all insurers offering qualifying high deductible plans at the time of the survey, and that the experiences of those insurers and HMOs who were interviewed are representative of the industry as a whole.

How is the MSA Market Developing?

MSA-qualifying plans are widely available, but the number of insurers offering them has declined somewhat. The number of insurers offering qualifying plans has changed only slightly between 1997 and 1998, from about 54 to 48[3]. However, there is little evidence that new insurers will enter the market unless demand for MSAs increases, features of the demonstration design are changed, or both. Only one insurer and one HMO plan reported that they still planned to enter the market as of the 1998 survey. On the other hand, two of the 48 current offerors indicated that they were leaving the MSA

[2]Some 290 screening interviews were conducted with eligible decision-making entities, and another 453 subsidiary insurers and HMOs were represented in these interviews. The screener response rate was 80 percent. Follow-up interviews were conducted with 34 offerors of qualifying plans, including 27 in-depth, in-person interviews.

[3]The 1997 Report listed 57 insurers, of whom four were identified in 1998 as never having offered a qualifying plan. In addition, one offeror in the 1997 list was actually an association group. This group should not have been listed as an insurer; two insurers who offer qualifying plans for this group should have been listed instead.

market in the near future. Table 1 presents the offerors as of the summer of 1998 identified by the Insurer Survey.

Despite the slight decline in the number of offerors, qualifying plans are widely available. Although not all offerors provided information on their geographic markets, approved plans are available in all but four states from those who did respond. More than half the states have at least six approved plans available from responding insurers. Figure 1 shows the number of approved qualifying plans by state offered by responding insurers. The geographic availability of qualifying plans changed little between 1997 and 1998.[4]

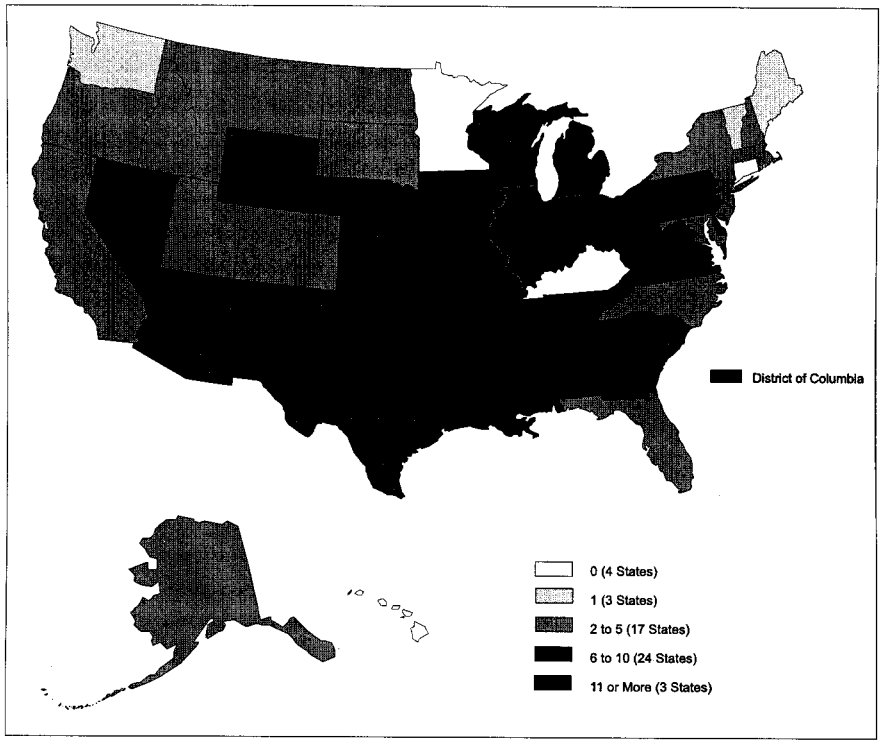
[4]The 1997 report showed a similar map with at least one plan offered in each state. This and other slight differences between the 1997 map and the one presented here are largely due to differences in which plans provided the relevant information in the two survey years.

Table 1. Insurers and HMOs Offering Qualifying High Deductible Plans, Summer 1998

Blue Cross/Blue Shield Insurers	Insurers (Non-BC/BS)
Blue Cross of CA	American Community Mutual Ins. Co.
Blue Cross of WA & AK	American Medical Security Ins. Co.
Blue Shield of CA	American National Life Ins. Co. of TX
Blue Shield of Idaho	American Republic Insurance
Blue Cross Blue Shield of IL	American Union Life
Blue Cross Blue Shield of IA	Anthem Health & Life Ins. Co.
Blue Cross Blue Shield of LA[1]	Central Reserve Life Insurance Company
Blue Cross Blue Shield of MI	Connecticut National Life
Blue Cross Blue Shield of MT[1]	Continental Corporation (CNA)[2]
Blue Cross Blue Shield of NJ	Continental Insurance Group
Blue Cross Blue Shield of NE NY	Freedom Life/Westbridge Marketing
Blue Cross Blue Shield of SC	Golden Rule Ins. Co.
Blue Cross Blue Shield of TX	GHI
Blue Cross Blue Shield of UT	Life Investor Ins. Co. of America
Blue Cross Blue Shield United of WI[3]	Medical Benefits Mutual Life Ins. Co.
Blue Cross Blue Shield of VT[1]	Medical Mutual of OH[1]
Rochester Blue Cross Blue Shield	Medical Savings Ins. Co.
Trigon Blue Cross Blue Shield of VA	Mega Life and Health Ins. Co.
	Mennonite Mutual Aid
	Mutual of Omaha Ins. Co.
	National Travelers Life Company
HMO	NYLCare Health Plans[2]
	Philadelphia American Life/New Era Enterprises
Tower Health Services[4]	Starmark
	Teachers Protective Mutual
	Time Ins. Co.\Fortis Benefits Ins. Co.
	UNICARE
	United Chambers Life Ins. Co.
	United Healthcare

[1]New offeror since 1997
[2]Will be leaving market imminently
[3]Offers HMO as well as non-HMO qualifying plans
[4]Offeror status not confirmed in 1998

Figure 1. Number of Approved Qualifying Plans by State, Summer 1998



Note: This figure represents available products for 31 responding insurers only.

Among insurers offering qualifying plans, the number of products available has changed little between 1997 and 1998, with insurers offering an average of about three qualifying plans per market (individual and small group). Preferred provider organizations (PPOs) are the most common type of qualifying plan, but traditional indemnity plans are also widely available. Other plan types, including health maintenance organizations (HMOs), exclusive provider organizations (EPOs), and point-of-service (POS) plans, are only very rarely available as qualifying plans.

While some insurers believed strongly in the MSA concept and entered the market aggressively, many offerors entered the demonstration primarily to protect market share or for similar defensive reasons. For many insurers, having made the investment in a qualifying plan, staying in the market meant little additional effort. About 20 percent of offerors report continuing to pursue the market actively as of summer 1998, using multiple marketing techniques, while the remainder report a more passive approach, simply making their qualifying products available.

Low expected sales was the most frequently mentioned reason for insurers not entering the MSA market in 1997, and actual sales have reinforced this decision for most insurers since then. Other factors contributing to the decision not to participate in the MSA market included difficulty in locating financial institutions to partner with, lack of presence in the individual and small group markets, and general uncertainty about the market and/or products. Several insurers indicated that aspects of the demonstration design limited their desire to participate. State and regulatory factors were not considered very important in the offering decision. The most common reason mentioned by responding HMOs for not entering the MSA market was that a high deductible plan was inconsistent with the concept of the HMO.

How Have Sales of Qualifying Plans Progressed?

Sales of qualifying plans have remained well below the legislative caps over the first year and a half of the demonstration, and the rate of sales appears to have slowed in the first half of 1998. IRS estimates of MSAs opened during several time periods are shown in Table 2. The first two estimates, 9,720 as of April 30, 1997, and 22,051 as of June 30, 1997, are taken from MSA trustee reports required under HIPAA. These estimates include persons who are not counted against the cap: persons previously uninsured and spouses of primary insured individuals opening MSAs. The counts against the caps were 7,383 as of April 30 and 17,145 as of June 30. The third estimate in Table 2 is from 1997 Federal income tax returns. IRS has adjusted these numbers upward by about 16 percent to account for taxpayers filing after the April 15 deadline. This estimate shows 41,668 MSAs opened, of which 26,160 count against the

cap of 600,000 for the end of 1997[5]. The IRS reported 13,034 MSAs opened between January 1 and July 1, 1998 (from trustee reports), with 10,651 counting against the cap. This report seems to indicate that the pace of opening MSAs is slowing somewhat. Although it is not clear how comparable the trustee reports and tax return figures are, enrollment for the first six months of the demonstration was about 22,000, for the second six months just under 20,000, and for the third six months about 13,000. The total count against the June 30, 1998, enrollment cap of 750,000 accounts appears to be less than 40,000. The IRS announcement also projected enrollment through 1998 at 50,172 plans to count against the final enrollment cap of 750,000.

Insurer Survey reports of sales of qualifying plans are fairly consistent with the various IRS-reported figures. In the 1997 survey, 25 of 32 responding offerors reported that sales of qualifying plans were lower than expected, and these perceptions did not change in the 1998 survey. Some insurers report that the sales figures are not surprising given the limitations of the demonstration and the complexity of the product.

Table 2. Number of Medical Savings Accounts Opened, According to IRS Reports

Counts as of	Cumulative Number of MSAs opened	Previously Uninsured Individuals	Spouse Also Has MSA	Total Count Against Cap	Cap
April 30, 1997[1]	9,720	1,787	550	7,383	375,000
June 30, 1997[1]	22,051	3,670	1,236	17,145	525,000
Dec. 31, 1997[2]	41,668	15,508	N/A	26,160	600,000

[1]From trustee reports
[2]From 1997 income tax returns

Most offerors had sold fewer than 1,000 qualifying plans as of the 1998 interview. Among 32 responding insurers, only six had sold more than 1,000 qualifying plans by their most recent counts before the Summer 1998 interview, with one insurer's report accounting for more than half of the total sales reported in the survey. Fifteen insurers reported fewer than 100 qualifying plans sold.

[5]The proportion of previously uninsured is considerably higher in the tax return numbers than in the trustee reports, and the tax return numbers do not include any spousal accounts. The IRS announcement does not offer explanations of these differences in the estimates.

Features of Qualifying Plans in 1997 and 1998

Benefit Structure of Qualifying Plans

Most insurers developed qualifying plans by modifying an existing product. In 1997, 87 percent of insurers offering qualifying plans reported they had modified existing products. The most common modifications were increasing the deductible, reducing the out-of-pocket maximum, and eliminating coverage for prescription drugs below the level of the deductible.

In 1997, 30 insurers provided brochures describing their qualifying plans; 17 of these insurers also provided brochures for their non-qualifying high deductible plans. In 1998, 29 insurers provided details of their qualifying plans; 24 of these insurers also reported on their non-qualifying products. The findings that follow are based on detailed review of the plan brochures.

Qualifying plans have somewhat more generous benefits than other high deductible plans offered by the same insurers. In brief, qualifying plans differ from non-qualifying high deductible (at least $1000 individual deductible) plans in the following features:

- The range for deductibles of qualifying plans is limited by the law, to between $1500 and $2250 for individuals and between $3000 and $4500 for families. Non-qualifying plans examined had a wider range of deductibles, both higher and lower than the ends of the qualifying range.
- Out-of-pocket maximums are lower for qualifying plans, again attributable to the demonstration design.
- Coinsurance rates for qualifying PPO plans are generally more generous than for non-qualifying PPO plans.

There is little difference between qualifying and non-qualifying high deductible plans in what services are covered.

Several plans offered as MSA-qualifying have features that appear to be in conflict with the allowable design. Specifically, one or more plans examined in both 1997 and 1998 included:

- Coverage (subject to co-payment) for physician office visits before the plan deductible is reached;
- First dollar coverage for preventive care where such care is not a state mandated benefit;
- Cost sharing for out-of-network services above the out-of-pocket maximum;

In the 1997 survey, about a third of qualifying plans examined did not yet comply with the Treasury ruling on embedded deductibles; insurers were given a grace period through November 1997 to comply

with the ruling. Non-complying plans began paying benefits under family coverage either when the family deductible had been satisfied or when an individual had satisfied the individual deductible. Under the Treasury ruling, the family deductible has to be satisfied before any benefits are paid under family coverage. By the 1998 survey, all responding offerors had modified their qualifying plans to be in compliance.

Premium Structure of Qualifying Plans

Insurers initially followed similar strategies in pricing both qualifying and non-qualifying high deductible plans; in 1998 some qualifying plans were priced lower than non-qualifying high deductible plans. Project team actuaries evaluated plan benefits and premiums for qualifying and non-qualifying high deductible plans from offerors in both the 1997 and 1998 surveys. In 1997, the actuarial value of qualifying plans compared to their premiums was quite similar to that of other high deductible products. This finding is consistent with the pricing and underwriting practices reported by insurers in the survey. In 1998, some insurers reported, and analysis of premium and benefit data confirm, that premiums for qualifying plans have dropped compared with premiums for other high deductible plans. This trend appears to reflect both a desire to make qualifying plans more competitive and an expectation that purchasers' claims experience will be more favorable than for participants in the insurers' other high deductible plans. However, the difference in premium between qualifying high deductible plans and low deductible plans for respondents reporting both in 1998 is not as large as the difference in plan deductibles, which some insurers report as a barrier to marketing qualifying plans.

Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans. Analysis of plan benefits and premiums shows that the ratios of actuarial value to premium (the relationship between the value of the benefit and the enrollee's purchase cost for the benefit) for high deductible plans are significantly greater than the ratios for low deductible plans. Insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans and price their products accordingly. Insurers confirmed this conclusion in the survey.

How are Qualifying Plans Being Sold?

Insurers rely primarily on independent brokers and agents to sell qualifying plans. In 1997, 90 percent of insurers offering qualifying plans reported selling them through brokers and agents. A wide variety of other marketing techniques was also reported, including formal sales presentations, direct mail, seminars, print and broadcast media advertisements, the Internet, and telephone solicitations, although none of these methods was used by as many as half of responding offerors.

Insurers in 1998 continued the same kinds of marketing methods used in 1997, but at somewhat lower intensity overall. Use of brokers and agents remained the most popular marketing strategy, although the proportion of insurers naming them as a method declined. Among all marketing methods reported, only the Internet was used more frequently (by about eight percentage points) in 1998 than in 1997.

Some insurers reported misjudging the eagerness of the broker community to sell qualifying plans and MSAs. Several issues were raised by insurers in 1997:

- Brokers need more training to sell qualifying plans effectively because of the added complexity of the tax effects of MSAs.
- Commissions, which are often a percentage of premiums, are generally lower for high deductible products than for more comprehensive products. In general, brokers also receive little or no commission for selling the savings vehicle component of the MSA product.
- Agents and brokers also seem to spend more time on average selling the qualifying plans and MSAs than selling other health insurance products.

Some respondents in 1998 indicated that only a small percentage of their broker forces had proved to be skilled at selling qualifying plans, but that some of these were quite creative and successful, even in some cases developing their own partnerships with financial advisors.

Some insurers also reported shifting the focus of their marketing efforts between 1997 and 1998, concentrating on the affordability of the high deductible health plan rather than the tax advantages and savings features of the MSA. This change was a response to the perceived complexity of the MSA.

What Groups are the Focus of Product Marketing?

Insurers reported targeting some segments of the insurance market, including highly-paid professionals, farmers and ranchers, partnerships firms, and association groups. Some insurers report

using only association groups and Chambers of Commerce as marketing venues. According to the IRS estimates from income tax returns, about one-third of MSAs opened in 1997 were by previously uninsured individuals. Insurers did not report targeting uninsured individuals when marketing qualifying plans, however.

What are the Costs and Features of MSAs Themselves when Offered by Insurers?

A majority of insurers offer their qualifying high deductible plans together with MSAs. In the 1998 survey about 15 percent of insurers reported that MSAs **must** be opened at the time of purchase of a qualifying high deductible plan, and about 42 percent responded that MSAs **may** be opened concurrently with the purchase of a qualifying high deductible plan. The remaining insurers offered only the high deductible plan portion of the MSA product, leaving it up to the purchaser to open an MSA from a separate source or not.

Features of MSAs have become more varied between 1997 and 1998, and more trustees are available. The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses. MSAs in 1998 are also more likely to have features resembling those of bank accounts than they were in 1997, such as checks, debit or ATM cards, and telephone banking.

Conclusions

Forty-seven insurers and one HMO were offering qualifying health plans as of the summer of 1998. Qualifying plans were available in almost all states, with several plans available in most states. The number of insurers offering qualifying plans has decreased slightly between 1997 and 1998, however. The survey did not find any evidence that major changes in the number of insurers or plans are likely.

The demand for qualifying plans and MSAs has continued to develop, but well below insurers' expectations and the progressive caps imposed by HIPAA. A few insurers have pursued the market aggressively throughout 1997 and 1998, while a few others have moved from an active position in 1997 to a more passive approach in 1998. Most insurers, though, have taken a passive approach since the demonstration period started in 1997. From IRS figures, it appears that MSA sales have slowed somewhat in the first half of 1998.

The benefit structure of qualifying plans has changed little between 1997 and 1998, but the price for qualifying plans compared with plan value has come down in some sectors. More investment options are becoming available for MSA holders, and accounts offer more features.

Overall, while some insurers continue to be optimistic about the future of MSAs, the majority opinion among insurers surveyed is that the market will not develop dramatically under the current demonstration design.

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