Saving the Medicare System With Medical Savings Accounts

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Executive Summary

The Republicans' Medicare reform plan will benefit seniors in two important ways, according to calculations made and peer-reviewed at Milliman & Robertson, an actuarial accounting firm. First, it will give them more protection against health care costs. Second, it will allow them to keep any savings they generate by purchasing health care wisely. This study examines the choices private insurers will be able to offer as alternatives to the government-run program if they are given a voucher for the average estimated per-person Medicare cost of $4,848 in 1996.

Meeting the congressional budget goals without any loss of benefits. The Republican plan can save $273 billion over the next seven years without any loss of health coverage.

- A voucher plan allowing the elderly to obtain Medical Savings Accounts and catastrophic health insurance will save as much as $195 billion.
- Extending the program to the disabled and making other minor program changes account for the remaining savings.

Patient power through Medical Savings Accounts. The plan will encourage the elderly to choose high deductibles and put the premium savings in personal accounts. This will allow them to control their own health care dollars without answering to a health care bureaucracy.

- Without any managed care, private insurers could put about $1,500 into a Medical Savings Account for each beneficiary and could pay for all expenses above $3,000.
- With managed care, private insurers could put about $2,100 in a Medical Savings Account and pay all medical bills above $3,000.

Protection against health care costs. The Republican plan will allow beneficiaries to obtain real catastrophic insurance.

- Under the current system, the elderly can pay thousands of dollars in health bills.
- For example, more than 418,000 Medicare beneficiaries pay more than $5,000 out of pocket every year.
- Under the voucher plan, the out-of-pocket expenses would be limited.

Cash refunds for being prudent purchasers of care. Elderly patients who make wise and frugal choices will realize financial benefits.

- Under the current system, if a patient does something to eliminate waste, the benefit of that action goes to the government.
- With Medical Savings Accounts, people get to keep any money that remains in their accounts at the end of each year.
- Therefore, Medicare beneficiaries can receive up to $2,100 a year in cash.

Coverage for prescription drugs and other services. For no extra premium, beneficiaries can have coverage for services not currently covered by Medicare.

- Under the current system, Medicare does not cover most costs of prescription drugs — leaving the elderly at risk for limitless out-of-pocket expenses.
- The voucher plan would allow private insurers to extend coverage to drugs and other items.
- For example, instead of a $2,100 MSA deposit, people could have drug coverage above their deductible with a Medical Savings Account deposit of about $1,500.

Introduction

Medicare, the federal health insurance program for the elderly, is going bankrupt. As Table I shows, the program currently provides health insurance for about 32.4 million seniors (age 65 and over) at an annual cost of $142 billion. The program also covers 4.3 million disabled individuals at an annual cost of $17 billion. Without fundamental change, its future is bleak. If left unchecked, Medicare spending will continue to escalate, costing $1.6 trillion over the next seven years. In its latest annual report, the Board of Trustees for the Medicare program, including three members of President Clinton's own cabinet, projected that the program will run out of funds in 2002.[1] [See Table II.]

"If left unchecked, Medicare spending will cost $1.6 trillion over the next seven years."

While that fact has been widely reported, what is not widely understood is how enormous the financial shortfall will be in the future. Unless this problem is addressed, by the time today's young workers retire, paying all of their promised benefits would require:

- Increasing the Medicare payroll tax to about three times what it is now.
- Increasing the Medicare premiums paid by the elderly to about $4,000 per year per elderly couple in today's dollars.
- And still running a Medicare deficit, financed by general revenue contributions, equal to about $250 billion in 1995 dollars — larger than the entire federal deficit today.

These projections come under the so-called intermediate assumptions made by the trustees. Under the pessimistic assumptions, which may be more realistic, the deficit is far worse.

TABLE I

Medicare Expenditures — 1994

	Population (millions)	Total Cost (billions)	Cost Per Person
Aged	**32.4**	**$142**	**$4,390**
Disabled	**4.3**	**$ 17***	**$3,953**
Total	**36.7**	**$159**	**$4,332**

Source: Health Care Financing Administration.

* Estimate by Milliman & Robertson.

TABLE II

Medicare Projected Costs

	1996	1997	1998	1999	2000	2001	2002	Total
Aged								
Cost (Billions)	$172	$189	$208	$229	$ 252	$277	$ 305	$1,632
Population (Millions)	33.3	33.8	34.2	34.7	35.2	35.7	36.2	
Disabled								
Cost (Billions)	$ 21	$ 23	$ 25	$ 28	$ 30	$ 33	$ 37	$ 197
Population (Millions)	4.4	4.5	4.6	4.6	4.7	4.8	4.8	

Source: Milliman & Robertson.

This financial collapse is occurring even though Medicare already in effect rations health care to the elderly in order to contain costs. For example:

- According to the Congressional Budget Office (CBO), Medicare pays, on the average, about 70 percent of the cost of the services doctors and hospitals provide to the elderly,[2] causing cutbacks in the quality of and access to care.[3]
- All providers get the same reimbursement for a given procedure, which reduces the incentive to provide quality care.
- The Medicare reimbursement system allows hospitals to maximize net income by discharging patients earlier, regardless of their health condition.[4]
- Medicare is slow to approve new medical technologies, leaving the elderly without access to the latest and best treatments.[5]

Congress has set 1995 budget targets for Medicare that begin to address this financial crisis. The targets would reduce the rate of growth of Medicare from more than 10 percent per year to 6.4 percent per year. This lower rate of growth approximates the level of increases in private sector plans in recent years, where costs have grown at about half the rate of Medicare. [See Figure I.] As a result, Medicare would spend $273 billion less than it otherwise would over the next seven years.

"The budget targets would reduce Medicare growth from more than 10 percent per year to 6.4 percent per year."

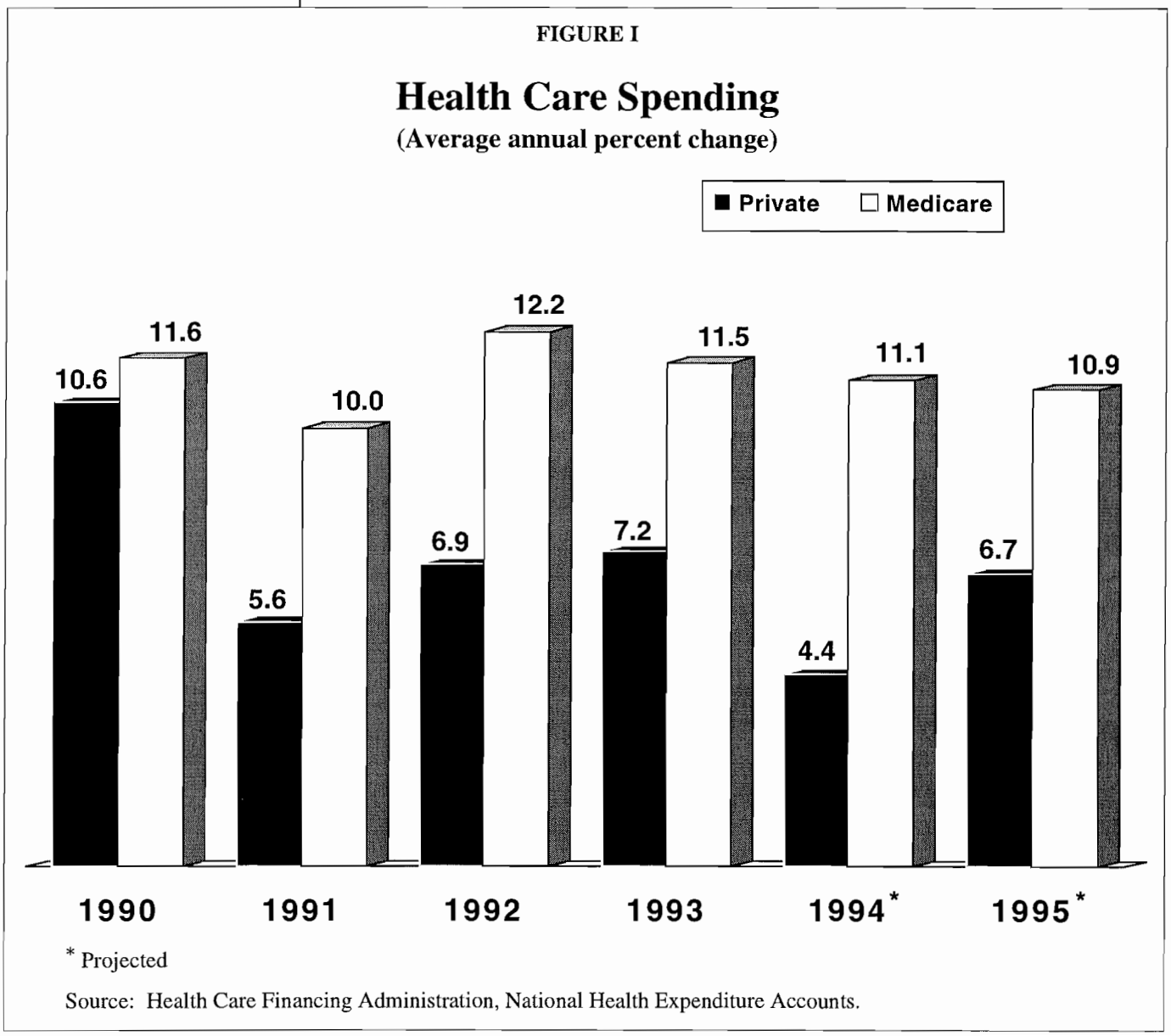
"Even at the lower growth rate, spending per beneficiary would still grow about 40 percent between now and 2002."

Even at the lower growth rate, spending per Medicare beneficiary would still grow from about $4,800 this year to about $6,700 in 2002, an increase of about 40 percent. Because of increasing numbers of beneficiaries, total spending under the program would grow by more than 50 percent during the seven-year period, from almost $200 billion in 1995 to almost $300 billion in 2002.

Providing Seniors With Options

Earlier this year, the National Center for Policy Analysis advanced a proposal to address the Medicare financing crisis. Under this plan, retirees could stay in the current Medicare program, but the per capita share of Medicare spending would grow no faster than is permitted by the congressional budget targets. As a result, those who stayed in traditional Medicare would likely see their premiums and copayments rise over time.[6]

FIGURE I



* Projected

Source: Health Care Financing Administration, National Health Expenditure Accounts.

"Retirees would be able to withdraw their share of Medicare spending each year and purchase coverage from a full range of options."

More importantly, the elderly could be given a voucher, in effect allowing them to withdraw their share of Medicare spending each year and purchase coverage from the full range of private sector managed care or fee-for-service options. For example, they could sign up with a Health Maintenance Organization (HMO) or other managed care program. Seniors also could use part of their Medicare funds to purchase a catastrophic health insurance policy with a deductible of, say, $3,000, and place the premium savings in a Medical Savings Account (MSA). A third option would permit seniors to purchase coverage from a present or former employer after retirement. Associations such as the American Association of Retired Persons (AARP) or labor unions also could sell health plans to their members.[7]

This study, which describes more fully how the MSA option would work, is based on a peer-reviewed analysis by the consulting firm of Milliman & Robertson.

MSAs With Managed Care

Current law already allows some Medicare beneficiaries to withdraw from Medicare and join an HMO instead. When they do, Medicare is supposed to pay the HMO 95 percent of the average per-person cost to the program.[8] While no one should be forced to leave Medicare, we should build on this precedent and offer each Medicare beneficiary private insurance options.

The private health plan should cover services now covered by Medicare and receive 95 percent of the actuarial value of Medicare spending. People could add the funds with which they now pay supplemental Medicare (Medigap) premiums (about $1,200 per person per year) and out-of-pocket medical expenses (about $1,500 per person per year).[9] The additional premiums plus cost savings could finance such extra benefits as long-term home health care, complete catastrophic coverage and prescription drugs.

The Milliman & Robertson analysis shows that the most cost-effective way to control Medicare spending would be to combine MSAs with managed care. Under this option, part of the funds withdrawn from Medicare would be used to purchase catastrophic coverage from a managed care institution. [See the sidebar on MSAs With Managed Care.] This coverage would reimburse all expenses over a certain deductible. Under the proposal, the elderly could choose any deductible level they preferred, but this analysis assumes a deductible of $3,000 for the first year, 1996, increasing yearly to $4,388 in 2002.

Each year the Medicare funds left over after purchasing the high-deductible policy would be deposited in an MSA to pay medical expenses below the deductible. Milliman & Robertson calculated how much would be left for the annual deposit to the MSA. As Table III shows, in 1996, $4,848 would be available for each Medicare participant. After deducting the cost of

MSAs and Managed Care

Many people believe that Medical Savings Accounts (MSAs) and managed care are mutually exclusive. But employers around the country are now *combining* Medical Savings Accounts and managed care. In 1995, the National Center for Policy Analysis adopted an MSA-managed care plan for its own employees. The plan limits employees' exposure and gives them more control over their health care dollars. *At no extra cost to the employer*, the plan creates a $1,500 deductible and deposits $1,125 to an MSA for individual employees. For family coverage, the deductible is $2,000 and the MSA deposit is $1,500. Thus the total out-of-pocket exposure is $375 per individual and $500 per family.

NCPA employees may use their MSA funds to see any doctor, enter any hospital or pay any medical bill. However, spending counts toward satisfying the deductible only if the service or procedure is covered under the health plan. For example, employees can pay for dental care or eyeglasses with their MSAs, but those expenses do not apply toward the deductible. Furthermore, all spending counts toward the deductible only if employees see doctors within a network. If they go outside the network, only 75 percent of each "usual and customary" fee counts toward the deductible.

In the future, the buildup of MSA funds will give NCPA employees important options with respect to expensive medical procedures. For example, the health plan will pay the full costs above the deductible only if the procedure is done by a network doctor in a network hospital. But employees will be able to use their MSA funds outside the network to pay that portion of the bill not covered by the insurance.

This example of MSAs with managed care is only the beginning. In the future, the two concepts will likely be combined to produce even greater "patient power."

a $3,000 deductible policy and administrative costs,[10] $2,108 would be left for the MSA. [See Figure II and Appendix A.] The most an elderly beneficiary would have to pay out of pocket, therefore, would be $892, the difference between the $3,000 deductible and the $2,108 in the MSA.

"The most a beneficiary would have to pay out of pocket would be $892 — less than the average premium for Medigap insurance."

In addition, Medicare beneficiaries could "top up" their MSAs with funds they are currently spending. For example, about 70 percent of the elderly now buy private (Medigap) insurance. With the MSA, they would not need supplemental insurance because the catastrophic policy would not leave them exposed for major expenses, and they would pay smaller expenses from their MSA. The funds they now spend for supplemental insurance could go into the MSA.

Under the existing Medicare program, the average premium for a Medigap policy would be $1,178 in 1996. If this were contributed to the MSA in addition to the funds placed there by Medicare, the beneficiary would have $3,286 in the account to cover the $3,000 deductible, leaving him at least $286 better off than under the current program.

Now look at the year 2002, when the deductible would be $4,388 and the MSA deposit $2,452. The most an elderly beneficiary would have to pay out of pocket in that year would be $1,936.[11] Adding the average Medigap premium of $1,719 to the funds from Medicare would leave $4,171 in the account to meet the $4,388 deductible. The beneficiary's maximum out-of-pocket expense for the year would be only $217.

It is unlikely that most beneficiaries would spend all of the money in their MSA in any given year. With funds left from one year carrying over to the next, beneficiaries would have no out-of-pocket expenses in future years. For example, suppose a person is healthy and spends only half the funds in the MSA in each of the first two years. After those two years, the retiree would have more than enough in the account to cover all expenses below the deductible, with no need to add the equivalent of a Medigap premium.

This MSA option is better than traditional Medicare in at least five ways:

"It is unlikely that most beneficiaries would spend all the money in their MSA in any given year."

FIGURE II

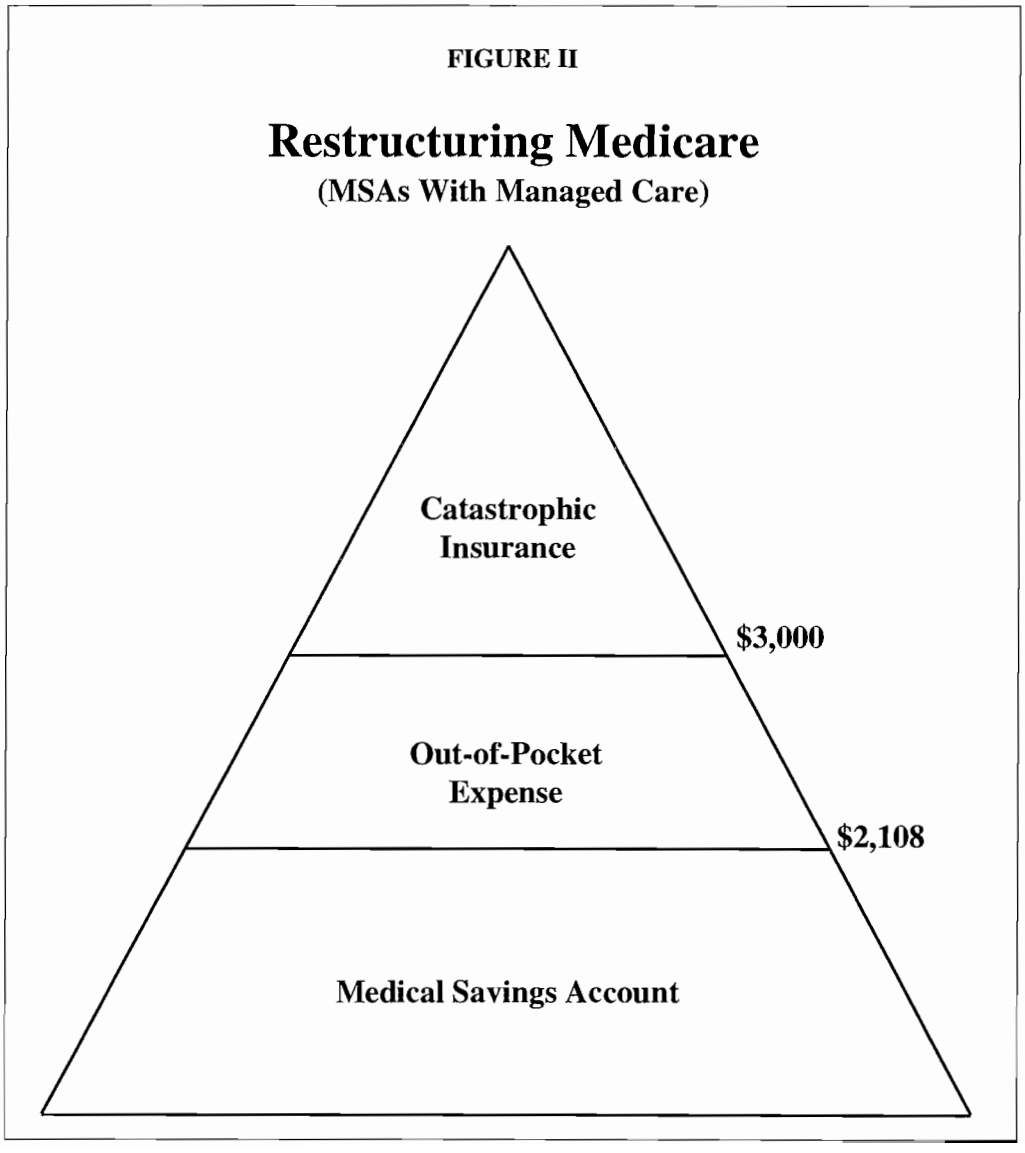


TABLE III

MSAs With Managed Care

	1996	1997	1998	1999	2000	2001	2002
Voucher Amount and Part B Premium	$4,848	$5,220	$5,599	$5,940	$6,302	$6,686	$7,092
Annual Deductible for Catastrophic Protection	3,000	3,230	3,464	3,676	3,900	4,137	4,388
Remaining Medicare Funds Available for MSA	2,108	1,810	1,657	1,761	1,906	2,201	2,452
Premiums for Standard Medicare Supplemental Policy	1,178	1,255	1,337	1,423	1,516	1,615	1,719
Total MSA With Medicare Supplemental Premium	3,286	3,065	2,994	3,184	3,422	3,816	4,171

- The MSA plan provides complete catastrophic coverage for expenses over the deductible, while Medicare leaves seniors exposed to catastrophic expenses that could devastate their savings.
- The MSA plan provides an annual cap on out-of-pocket expenses equal to the difference between the catastrophic insurance deductible and the amount in the MSA. In the above example, the cap ranged from $892 to $1,936 per year. Medicare, by contrast, has no cap on out-of-pocket expenses. With the MSA, out-of-pocket exposure can be virtually eliminated simply by encouraging the 70 percent of the elderly now paying for private Medigap insurance to contribute their Medigap premiums to their MSA.
- The MSA funds could be used to pay for health expenses such as prescription drugs, which are not covered by Medicare.

"The MSA funds could be used to pay for health expenses such as prescription drugs, which are not covered by Medicare."

- At the end of the year, the beneficiary could withdraw unspent MSA funds and use them for any purpose, subject to normal income taxes. This enables people to share directly in the reward for keeping Medicare costs down.
- People with MSAs plus catastrophic coverage would be free from Medicare rationing restrictions and from concerns about quality of and access to care.

The assumptions underlying the Milliman & Robertson calculations are presented in Appendix A.

MSAs With Fee-for-Service Catastrophic Coverage

MSAs are often shown in combination with traditional fee-for-service coverage for all expenses above the deductible. Fee-for-service insurance is more expensive than managed care because it lacks the latter's ability to negotiate lower prices with providers.

However, seniors should be free to purchase fee-for-service policies, though savings would not be as large. Under this option, the MSA plan again starts with a deductible of $3,000 in 1996 that rises to $4,388 in 2002. A health insurance policy would cover all expenses over this deductible.

Milliman & Robertson calculated the amount remaining to be deposited in the MSA.[12] Their results are shown in Table IV. In 1996, with a

"With a fee-for-service option, about $1,500 would be available for the MSA."

FIGURE III

Restructuring Medicare
(MSAs With Fee-for-Service)

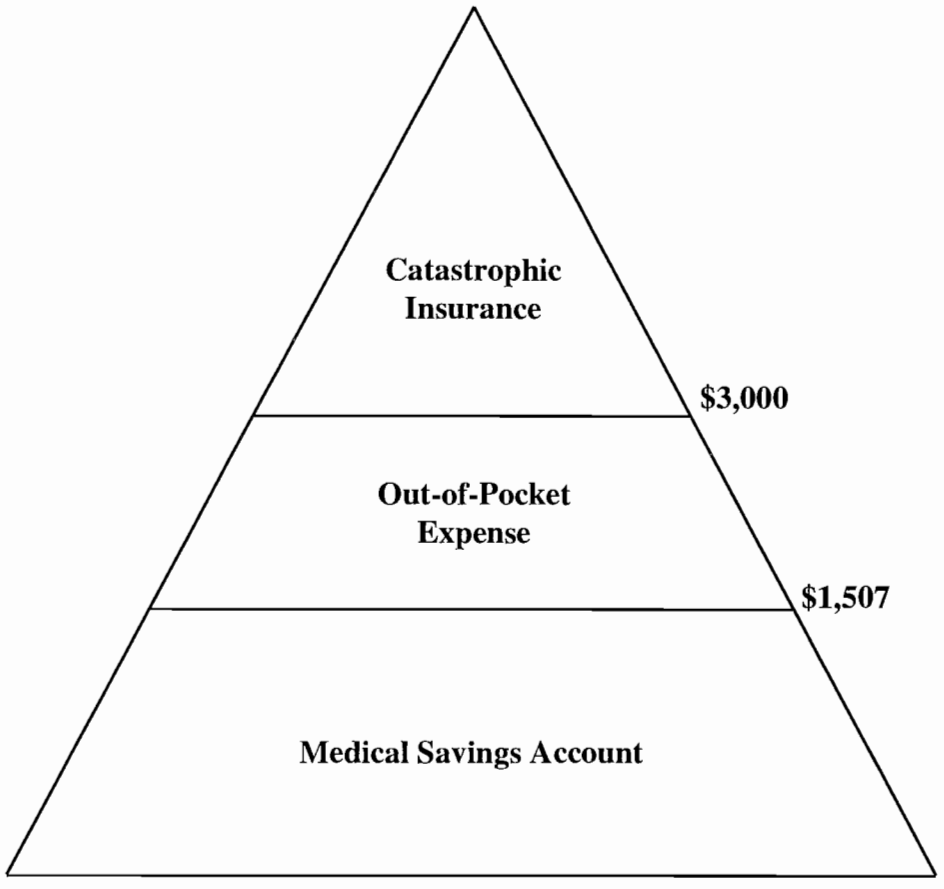


TABLE IV

MSAs Without Managed Care

	1996	1997	1998	1999	2000	2001	2002
Voucher Amount and Part B Premium	**$4,848**	**$5,220**	**$5,599**	**$5,940**	**$6,302**	**$6,686**	**$7,092**
Annual Deductible for Catastrophic Insurance	**3,000**	**3,230**	**3,464**	**3,676**	**3,900**	**4,137**	**4,388**
Remaining Medicare Funds Available for MSA	**1,507**	**1,066**	**1,036**	**1,092**	**1,190**	**1,177**	**1,390**
Premiums for Standard Medicare Supplemental Policy	**1,178**	**1,255**	**1,337**	**1,423**	**1,516**	**1,615**	**1,719**
Total MSA With Medicare Supplemental Premium	**2,685**	**2,321**	**2,373**	**2,515**	**2,715**	**2,792**	**3,109**

"If the average Medigap premium were contributed to the MSA, the maximum out-of-pocket expense would be $315."

$3,000 deductible, about $1,500 would be deposited into the MSA. [See Figure III.] Thus the most an elderly beneficiary would have to pay out of pocket would be about $1,500 (the $3,000 deductible minus the $1,500 in the MSA). If the average Medigap premium of $1,178 in 1996 were contributed, the beneficiary would have an MSA of $2,685 to cover expenses below the $3,000 deductible, leaving a maximum out-of-pocket expense of only $315.

By 2002, with a deductible of $4,388, the MSA deposit would be $1,390. Adding the Medigap premium would produce an MSA total of $3,109, leaving a maximum out-of-pocket exposure of $1,279. This gap would be completely eliminated if the beneficiary spent only half the MSA funds for two years and saved the remainder for future health expenses. [See Appendix B.]

How MSAs Work

MSAs are very effective in reducing costs because they contain powerful cost control incentives, which in turn stimulate powerful cost-reducing competition. Since beneficiaries would be able to spend whatever MSA funds they did not use for health care for any purpose they chose, they would tend to avoid unnecessary health care spending. For example, they would most likely avoid excessive doctor visits and tests, look for doctors and hospitals that would provide the best values and weigh the worth of potential health care

services against the costs. Perhaps most importantly, their increased concern would lead doctors and hospitals to compete on price in order to attract consumers with MSAs.

"MSAs contain powerful cost-control incentives, which in turn stimulate powerful cost-reducing competition."

Several studies predict that such incentives and competition would produce savings more than sufficient to hold costs within the 6.4 percent per year growth rate targeted under the budget for Medicare. For example, from 1974 to 1982 the Rand Corporation conducted a rigorous scientific study of the health expenditures of 2,500 families. Each family was provided with one of four different insurance plans, ranging from a zero deductible and all health expenses paid to 5 percent of the first $1,000 in expenses paid and 100 percent after that. The families with no deductible incurred 53 percent more in hospital expenses and consumed 63 percent more in doctor visits, drugs and other health services than the families with the highest deductible. Yet the study found no difference between these families' health outcomes.[13] The Rand study suggests that families today with a deductible of about $3,000 would consume 30 percent less health care than families with no deductible — and would be equally healthy.

In addition to the findings of the Rand study:

- The Congressional Budget Office (CBO) estimates that Medicare enrollees with private Medigap insurance that shields them from Medicare deductibles and copayments use about 24 percent more services than those who do not have such coverage.[14]
- A 1992 study by the National Center for Policy Analysis estimated that if most people switched from traditional third-party insurance to MSAs, the resulting cost control incentives and competition would reduce health spending by about 30 percent.[15]
- A study by Milliman & Robertson estimated that if most private sector individuals switched to MSAs, national health care spending would be reduced by $600 billion over five years.[16]
- A recent Cato Institute study estimated that if MSAs were widely adopted, national health care costs would be reduced by about 40 percent per year.[17]

Another recent Cato Institute study examined the experience of employers across the country who had already adopted MSAs.[18] In this study, the employers all reported greater cost reductions with MSAs than are targeted for Medicare in the congressional budget. Perhaps the best example is Golden Rule Insurance Company in Indianapolis, Ind., which offers MSAs to its 1,300 employees.[19] The employees can still choose traditional insurance with a $500 annual deductible and 20 percent copayment on the next $5,000 in expenses. This leaves an individual with a maximum out-of-pocket cost each year for health care of $1,500 (the $500 deductible plus 20 percent of the next $5,000), or $4,500 for a family of three.

But for employees with families who choose an MSA instead, Golden Rule purchases a catastrophic policy paying all expenses over $3,000 per year and deposits $2,000 in an MSA. This leaves the family with a maximum annual out-of-pocket cost of $1,000 (the $3,000 deductible minus the $2,000 in the savings account). For individuals, Golden Rule purchases a catastrophic policy covering all expenses over $2,000 per year and deposits $1,000 in an MSA, again leaving a maximum annual out-of-pocket cost of $1,000. The MSA funds can be used to pay health expenses below the deductible, and funds remaining at year's end can be withdrawn for any use.

About 80 percent of the company's employees chose the MSA option in 1993, the first year it was offered. Each of them withdrew an average of $600 in remaining MSA funds at the end of the year. In 1994, about 90 percent of workers chose the MSA and each withdrew on average about $1,000 in remaining MSA funds at the end of the year. The MSA plan had no cost increases in either of the first two years.

"More than 1,000 employers have adopted MSAs for their employees and have reported cost savings."

Golden Rule has now sold similar plans to dozens of small businesses across the country, which have reported similar or even better results.

Other examples include:[20]

- Dominion Resources, a Virginia utility company, cut its health costs by almost one-third through an MSA system.
- *Forbes* magazine reduced its health costs by 30 percent using a similar system.
- A health insurance marketing firm in Kansas, Thompson and Associates, sells an MSA plan that has reduced costs for small employers by as much as 50 percent.
- An insurance marketing firm in Maryland, Plan 3, has sold MSA plans to almost 100 small businesses, reducing their health costs by as much as 30 percent.
- Windham Hospital in Willimantic, Conn., reduced its health costs by 50 percent after adopting an MSA plan in 1993.
- Mayor Bret Schundler of Jersey City, N.J., recently encouraged adoption of an MSA plan that costs the city less but provides city employees with better benefits than their old, traditional health plan.[21]

In fact, more than 1,000 employers across the country have adopted MSAs for their employees, with similar results.

Such effective cost control incentives and competition are the reason the MSA benefits described above can be financed while still staying within the Medicare budget limits. Moreover, with MSAs the elderly would be able

to share directly in the cost savings they achieve, as remaining MSA funds at the end of the year will be theirs to use as they choose. Because of these factors, MSAs will be a highly popular component of the Medicare reform plan.

Total Cost Savings

If all retirees covered by Medicare chose the private options, Milliman & Robertson calculated that the total cost savings for Medicare over seven years would be more than $195 billion. If the 11.7 percent of Medicare beneficiaries who are the nonelderly disabled chose the private options as well, then the additional savings to Medicare would be $15 billion greater. [See Table V.]

The savings are achieved entirely through the limits on the amounts that could be withdrawn from Medicare for the private options. No other changes in Medicare are assumed.

"If all retirees chose private options, total cost savings over seven years would be more than $195 billion."

Of course, some may choose to stay in the current Medicare program. To the extent this occurs, the savings would be less, unless further changes were made in Medicare. The budget savings would be assured, however, if the amount spent per beneficiary, on the average, were the same for those who stayed in the program as for those who opted out. Making that change also would eliminate bias against the private options.

Milliman & Robertson calculated that the following changes in Medicare would be needed to provide the same average spending per remaining beneficiary as for those who chose a private option:

- The current Part B deductible would be increased from $100 today to an average of $750 over the next seven years.
- The Part B coinsurance fees would be increased from 20 percent today to an average of 24.5 percent over the next seven years.
- This means an additional $133 would be added in 2002 to the Part A deductible, which is estimated to grow under current law from $716 today to $1,267 in 2002.

In addition, Medicare Part B premiums would be maintained over time at their current level of 30 percent of program costs.

These increases in Medicare deductibles and coinsurance fees are not unreasonable and could be avoided if Medicare beneficiaries choose MSAs, with HMOs or other private managed care alternatives.

"The cost savings could be accomplished without any loss of health coverage or additional costs for the elderly."

TABLE V

Seven Years of Cost Savings for the Federal Government

(Billions)

Base estimate: MSAs for the elderly	**$195**
MSAs for the disabled	**15**
Increase age of eligibility by one month per year	**30**
Means testing	**33**
	$273

Conclusion

Substantial progress can be made toward meeting the congressional budget goal of eliminating $270 billion from projected Medicare spending without any loss of health coverage or additional costs for the elderly. As Table V shows:

- Medical Savings Accounts for the elderly will save about $195 billion over seven years.
- Extending the program to the disabled will add another $15 billion of savings.
- In making these estimates, Milliman & Robertson were conservative; more realistic assumptions would add another $25 billion in savings — for a total of $235 billion.
- Such options as means testing benefits by requiring the highest-income elderly to pay higher premiums or increasing the age of eligibility (currently 65) by one month per year would add at least $30 billion more savings.

We conclude, therefore, that solving the Medicare crisis is painless, provided that we take full advantage of the options the private sector already uses to control health care costs.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

APPENDIX A

Assumptions for MSAs With Managed Care

	1996	1997	1998	1999	2000	2001	2002
1994 Cost (Billions)	$ 5,146	$ 5,146	$ 5,146	$ 5,146	$ 5,146	$ 5,146	$ 5,146
Selection Factor	0.806	0.859	0.885	0.926	0.962	0.997	0.997
Utilization and Managed Care Factor	0.629	0.595	0.576	0.555	0.541	0.533	0.526
Trend and Price Controls	1.354	1.630	1.780	1.872	1.944	2.043	2.147
Deductible Adjustment	0.665	0.684	0.727	0.727	0.729	0.692	0.690
Administration	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Policy Premium	$ 2,699	$ 3,373	$ 3,908	$ 4,144	$ 4,359	$ 4,441	$ 4,591

APPENDIX B

Assumptions for MSAs Without Managed Care

	1996	1997	1998	1999	2000	2001	2002
1994 Cost (Billions)	$ 5,146	$ 5,146	$ 5,146	$ 5,146	$ 5,146	$ 5,146	$ 5,146
Selection Factor	0.806	0.859	0.885	0.926	0.962	0.997	0.997
Utilization and Managed Care Factor	0.726	0.690	0.670	0.647	0.631	0.624	0.616
Trend and Price Controls	1.354	1.630	1.780	1.872	1.944	2.043	2.147
Deductible Adjustment	0.707	0.723	0.727	0.727	0.729	0.730	0.728
Administration	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Policy Premium	$ 3,311	$ 4,132	$ 4,542	$ 4,827	$ 5,089	$ 5,486	$ 5,674

Notes

[1] *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington, DC: U.S. Government Printing Office, April 1995).

[2] Projection based on Sandra Christensen, *CBO Staff Memorandum: Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates* (Washington, DC: Congressional Budget Office, April 1993).

[3] See Michael A. Morrisey, *Price Sensitivity in Health Care: Implications for Health Care Policy* (Washington, DC: NFIB Foundation, 1992).

[4] Evidence suggests that premature discharges have harmed some patients. See, for example, Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association* 265, no. 7 (February 20, 1991), pp. 909-10; Philip J. Held, *Journal of the American Medical Association* 265, no. 7 (February 20,1991), pp. 871-75; and Ron Winslow, "Cost Control May Harm Dialysis Patients," *Wall Street Journal,* February 20, 1991.

[5] For example, cochlear implants are far superior to previous technology for treating some types of hearing loss. But Medicare does not pay for the implants, which are somewhat more costly than hearing aids. See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992), p. 309.

[6] See Peter J. Ferrara and John C. Goodman, "Medical Savings Accounts for Medicare," National Center for Policy Analysis, NCPA Brief Analysis No. 160, April 17, 1995.

[7] It is widely expected that congressional leaders will offer a similar Medicare reform proposal and attempt to pass it as part of this year's budget reforms.

[8] There is some evidence that Medicare pays more than expected costs because HMOs are succeeding in attracting healthier enrollees, whose expected costs are below average. See Randall Brown et.al., *Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs* (Mathematics Policy Research, Inc., December 1993), p. 1; and Gail R. Wilensky, testimony before Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 7, 1995.

[9] "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," prepared by the Public Policy Institute, American Association of Retired Persons and the Urban Institute, April 19, 1994.

[10] In 1996, the cost of the policy is estimated to be $2,697 and administrative costs an additional 2.0 percent.

[11] By that year, the trend will have stabilized so that the maximum out-of-pocket expense can be expected to continue at that level in real terms, or perhaps even decline. The out-of-pocket expense increases more sharply in the early years because of the one-time impact of shifting out of Medicare's price-controlled reimbursement system into an open market system.

[12] Again, these projections are consistent with the spending targets Congress intends to impose on Medicare.

[13] See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Healthcare Economics*, June 1987.

[14] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," Washington, DC, February 1995, p. 287.

[15] John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," NCPA Policy Report No. 168, National Center for Policy Analysis, Dallas, Texas, January 1992.

[16] Mark Litow, Milliman & Robertson, "Financial Impact of Medical Savings Accounts on Health Care Spending in the Federal Budget," Council for Affordable Health Insurance, October 1993.

[17] Stan Liebowitz, "Why Health Care Costs Too Much," Cato Institute, Washington, DC, Policy Analysis No. 211, June 13, 1994.

[18] Peter J. Ferrara, "More Than a Theory: Medical Savings Accounts At Work," Cato Institute, Washington, DC, Policy Analysis No. 220, March 14, 1995.

[19] Ibid.

[20] Ibid.

[21] Employees get catastrophic insurance along with a savings account equal to the deductible on that insurance, providing complete first dollar coverage. The MSA funds can also be used for check-ups, preventive care, dental care, eye exams, eyeglasses and other health services not covered by the old policy. And, of course, employees can withdraw their remaining MSA funds at the end of each year.

About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute, funded exclusively by private contributions. The NCPA developed the concept of Medical Savings Accounts, the health care reform that has wide bipartisan support in Congress and in a growing number of states. Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. Its forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free enterprise health care task force report, written by 40 representatives of think tanks and research institutes, and a first-of-its-kind, pro-free enterprise environmental task force report, written by 76 representatives of think tanks and research institutes.

The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.