KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #8
Health Opportunity Accounts (HOAs)

Background

The Health Savings Account

In recent years, consumer-directed health care has increasingly been used as a means to encourage people to make informed, cost-effective decisions about their health care.[1] One of the primary strategies used within the consumer-directed health care approach is to offer Health Savings Accounts (HSAs). The HSA was authorized through federal legislation in 2003 and is a type of medical savings account that allows consumers to save for medical expenses on a tax-free basis. Both individuals and employers can contribute to the HSA; the contributions are tax-deductible if made by the consumer and tax-exempt if made by the employer. In order to establish an HSA, the consumer must be enrolled in a high deductible health plan (HDHP). Typically, HDHPs are characterized by greater out-of-pocket spending, lower premiums, and higher deductibles. Advantages of establishing an HSA include providing the consumer with a mechanism to save for their health care costs, ownership of the account, rollover of unused funds from one year to the next, and portability (i.e., the consumer may keep their account if they switch jobs or are no longer enrolled in an HSA-eligible plan). Because consumers must pay for most of the medical costs out-of-pocket until they reach the plan's deductible, however, they face increased financial risks. One of the premises behind the HSA is that consumers will be financially motivated to contain their health care costs in light of the financial responsibility they assume.

Basic Features of the HSA

- A savings account that allows the owner to save for medical expenses on a tax free basis.
- In order to establish an HSA, the consumer must choose a high deductible insurance plan; the deductible being the dollar amount at which the insurer begins to cover some or all of the medical bills.
- Funds in the HSA are to be used to pay for the consumer's share of health care costs and generally cannot be used towards the cost of premiums.
- After the deductible is met, health insurance plans typically require additional cost-sharing in the form of co-payments and co-insurance.

Source: Kaiser Commission on Medicaid and the Uninsured
www.kff.org/uninsured/7568.cfm

The Health Opportunity Account

While consumer-directed health care approaches were first introduced into the commercial and Medicare markets, state Medicaid agencies have also begun testing these strategies.[2] Health Opportunity Accounts (HOAs) are among the strategies being explored. HOAs were established as part of the Deficit Reduction Act of 2005 (DRA). Like the HSA, HOAs function as a type of medical savings account and are linked to a high deductible version of Medicaid. Unlike the HSA, however, contributions to the account are made using state funds and federal matching dollars, and may also include contributions from charitable organizations.

The HOA provision established in the DRA became effective on January 1, 2007, and allowed the Centers for Medicare and Medicaid Services (CMS) to approve demonstration projects in up to 10 states. The purpose of the demonstration projects is to determine if HOAs, in combination with high deductible insurance plans, are an efficient way to deliver health care benefits to Medicaid beneficiaries. The Medicaid HOAs incorporate key components of HSAs into the Medicaid demonstration program.

Elements of the HOA demonstration programs include:

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[1] Greene, Jessica, *State Approaches to Consumer Direction in Medicaid.* Center for Health Care Strategies, Inc. July 2007.
[2] *Ibid.*

- Participants must have both an HOA and coverage for medical items and services that are available under the existing Medicaid state plan or Section 1115 waiver authority, after an annual deductible is met.
- The HOA requires the consumer to pay for health care expenses out of the account and then out-of-pocket until the deductible is met.
- Contributions may be made by the state (not to exceed $2,500/adult and $1,000/child including federal match) or others (including charitable organizations).
- Deductibles may not apply to preventive care.

Certain eligibility components are outlined in the DRA, including:

- Eligibility is determined by the state although people who are aged, disabled, pregnant, or receiving terminal or long-term care are ineligible.
- Individuals may continue to make withdrawals from their HOA, under state-specified conditions, for up to three years after Medicaid eligibility termination (no additional account contributions will be made thereafter and balances will be reduced by 25%).
- For individuals who participate in a demonstration for at least one year and later become ineligible, funds from the account can be used for health insurance, job training, or educational expenses.

Source: Joint Commission on Health Care

HSA Implementation

Because the HOA is very similar in design to the HSA, and the HSA was established and implemented prior to the HOA, reviewing outcomes and issues associated with HSA implementation is helpful. As reported in a 2006 issue brief published by the Kaiser Commission in October 2006, "high deductible health plans that meet the HSA requirements are still relatively rare."[3] The statistics presented in a 2008 General Accountability Office (GAO) report support this observation. Findings in the GAO report are based upon industry and Internal Revenue Service (IRS) data and include the following:

- Between September 2004 and January 2007, the number of individuals covered by HSA-eligible plans increased significantly, from about 438,000 to approximately 4.5 million. Despite this growth:
    - Many of the HSA eligible plan enrollees (42 percent to 49 percent) reported they had not opened an HSA (findings were obtained from nationally representative surveys conducted in 2005, 2006, and 2007), and
    - Only a small share of individuals with private health care coverage was represented by these plans (approximately 2 percent in 2006).
- Additionally, tax filers who reported HSA activity in 2005 had higher incomes on average than other tax filers; among the tax filers between the ages of 19 and 64, the average adjusted gross income was approximately $139,000 compared with about $57,000 for all other filers. These income differences were observed across all age groups.

Source: GAO-080474R Health Savings Accounts

Other key findings that were reported in the Kaiser 2006 issue brief included:

- The lower premiums associated with HSA-qualified health plans are lower in part because they shift more of the financial risk to individuals and families through higher deductibles;
- Premiums and out-of-pocket costs for HSA-qualified health plans will consume a substantial portion of a low-income family's budget;

[3] Kaiser Commission on Medicaid and the Uninsured. *"Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?"* October 2006. http://www.kff.org/uninsured/7568.cfm

- Most low-income individuals and families do not experience a high enough tax liability to benefit in a significant way from the tax deductions associated with HSAs (e.g., according to data from the U.S. Department of Treasury, a family of four with an income of $20,000 would receive no benefit from contributing any amount to an HSA);
- People with chronic conditions, disabilities, and others with high-cost medical needs may face even greater out-of-pocket costs under HSA-qualified health plans (i.e., these individuals are much more likely to reach their deductible level each year, which is set at a much higher level in the HDHP);
- Research from the RAND Health Insurance Experiment found that people enrolled in cost-sharing health plans were significantly less likely to see a doctor for services (including general health, vision exams, and treatment for infections) than people enrolled in health plans with no cost-sharing (the gap was greater for those with low incomes - <200 percent of the poverty level); and
- HSAs and HDHPs are unlikely to substantially increase health insurance coverage among the uninsured:
    - Over two-thirds of the nonelderly uninsured are low income; because they earn so little over half have no tax liability;
    - As such, offering plans that offer tax deductions as an incentive will have limited impact on the number of uninsured; and
    - The out-of-pocket spending that is required will not offer the low-income uninsured enough financial protection to offset the premium cost.

Source: *Health Savings Accounts and High Deductible Health Plans: Are They an Option for Low-Income Families?.* Kaiser Commission on Medicaid and the Uninsured, October 2006.

HOA Implementation

Currently, two states offer an HOA to their Medicaid population. Below is a summary of each state's HOA program.

Indiana

Implementation Date	December 2007
Program Type	1115(a) Demonstration Waiver
Incentives	$500 in "first dollar" preventive benefits at no cost to members
Geographic Areas	Statewide
Eligibility	Adults meeting specific eligibility criteria
Benefits	Basic commercial insurance package provided by contracting insurance companies
Deductible	Up to 5% ($1,100) of gross family income
State Contribution	Gap between designated deductible and $1,100
Enrollment	Approximately 28,000

South Carolina

Implementation Date	December 2007
Program Type	State Plan Amendment
Incentives	Preventive care and appropriate ER services are not applied toward the deductible
Geographic Areas	Richland County
Eligibility	Adults and children that have been eligible for three months
Benefits	Traditional Fee-For-Service benefit package
Out of Pocket Expenses	$250 per adult, $100 per child if State Contribution is exhausted

(Deductible)	
State Contribution	$2,500 per adult, $1,000 per child
Enrollment	5

With respect to Indiana's plan (the Healthy Indiana Plan or HIP), it is helpful to note some of its more significant features. The HIP plan is:

- Open to any Indiana resident ages 19 to 64 who:
    - Earns less than 200 percent of the FPL;
    - Has been uninsured for at least six months;
    - Is a U.S. citizen;
    - Does not have access to employer-sponsored health insurance; and
    - Is not eligible for Medicaid or Medicare.
- Indiana's existing Medicaid program, Hoosier Healthwise, restricts income eligibility for non-disabled adults to no more than 22 percent of the FPL – nearly the lowest coverage limit in the U.S.
- The HIP is intended to fill the gap in coverage between Medicaid and private insurance.

Source: *States in Action: A Bimonthly Look at Innovations in Health Policy.* The CommonWealth Fund Organization, February/March 2008.

Internal Analysis of the HOA

Little state-specific information regarding HOA use for the Medicaid population is available. Available resources are most often regarding the availability of the alternative benefit package through the Deficit Reduction Act only. No articles evaluating the success of the HOAs used within state medical assistance programs were located.

The Healthy Indiana Program is very comprehensive and, by enrollment terms, appears to be successful. Indiana contracts with private insurance companies to provide medical services and opens a Personal Wellness and Responsibility (POWER) account where family and/or state contributions are deposited for use. They also complement the program by offering an Enhanced Service Plan to screen and enroll beneficiaries with high risk conditions into the State's high-risk pool.

Resources with the state report South Carolina's Health Opportunity Account enrollment has been very slow. Per the State Plan Amendment, enrollment is capped at 1,000. Although the application process began December 2007, the state just recently enrolled beneficiaries into the program and has not yet processed claims. To date, enrollment includes one family of four (adults, children) and one child. Marketing efforts have included two mailings and county-wide distribution of flyers regarding the program. A third mailing is being planned. State officials attribute the low enrollment to the recent transitioning of the Medicaid population to managed care and the beneficiaries' being less inclined to try this new option.

National Analysis of the HOA

There are few articles or summaries regarding Medicaid enrollment in Health Opportunity Accounts. The most recent are dated 2006. High deductible heath plans are relatively new to the insurance industry; therefore, only summations can be made about their impact on the Medicaid population. The following are conclusions drawn from the most recent literature found on the subject.

"By encouraging individuals and families to choose high deductible health plans and set up HSAs, it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care. However, most low-income individuals and families are already making these tougher cost-benefit decisions as each health need arises. And the research to date shows that unaffordable cost-sharing among the low-income population not only decreases access to needed care but, in some circumstances, can also lead to

poorer health. For low-income families in particular, HSAs and HDHPs may exacerbate, rather than alleviate, the problems they currently face in affording and accessing needed health care."[4]

"The Health Opportunity Accounts could leave some beneficiaries, particularly those in poorer health, responsible for out-of-pocket costs related to health services they need when they have exhausted their accounts but not yet met the deductible. These costs would be on top of the standard copayments that beneficiaries would have to pay once the deductible was exhausted, which themselves would be increased by other Medicaid provisions of the Energy and Commerce reconciliation package. Research indicates that increased cost-sharing particularly affects the ability of low-income individuals to access health care.

At the same time, the Health Opportunity Accounts would add to federal Medicaid costs. By allowing former beneficiaries to keep balances held in their accounts, the federal government would essentially be paying for benefits provided to individuals and families no longer eligible for Medicaid. The demonstration project also would permit, at state option, the use of federal Medicaid dollars to pay for health care services not covered under Medicaid and even for non-medical services." [5]

"Factors other than patient cost-sharing also will impact the development of consumerism in the Medicaid program. Compared to the general population, Medicaid beneficiaries have lower levels of health literacy, less familiarity navigating the health care delivery system, and less experience and support researching and evaluating medical options."

Conclusion

In addition to the local and national analyses on HOAs described above, during September, 2007, the Kansas Health Institute developed a summary of main issues for states to consider when implementing consumer directed health purchasing (CDHP). Listed below are some of the issues and considerations that were identified.

Savings

Within the context of Medicaid reform, there are some reasons to believe that cost-savings may not be as great as in the private sector. Since beneficiaries will be paying for the up-front deductible costs with Medicaid funds, instead of their own money, the financial incentives may not be as great. Furthermore, they may be motivated to spend larger portions of the deductible amount if the incentives for saving are not present (e.g., availability of funds after leaving the Medicaid program; federally required reductions in the account balance upon leaving the program, etc.).

Conversely, if Medicaid recipients are allowed to keep the unexpended funds in their HOAs for up to three years, even if discounted 25 percent (as specified in the DRA), and are able to use the money on future health care expenses, education costs, or job training, they may experience incentives that encourage cost-conscious health care spending.

Eligibility

If Kansas incorporated CDHP into the Medicaid program, most participants would be healthy children and adults as required by the DRA. Although these individuals make up a substantial

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[4] Catherine Hoffman and Jennifer Tolbert, Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families? (The Kaiser Commission on Medicaid and the Underinsured , October 2006)

[5] Edwin Park and Judith Soloman, Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach (Center on Budget and Policy Priorities, November 2005)

percentage of Medicaid beneficiaries, they are responsible for a much smaller portion of Medicaid costs. Most to the Medicaid expenditures come from coverage of other populations which would be excluded from participating in HOAs (e.g., the aged and disabled). Therefore, the net impact on Medicaid spending may be less than expected.

Administrative Costs

Administrative costs associated with implementation of CDHP would need to be considered within the context of the overall fiscal impact of the program. For example, the DRA requires states that implement HOAs to develop and electronic monitoring and funds transfer system for the use of monies in the accounts (i.e., cash is not involved).

Other

Within the context of CDHP, and given the demographics of Medicaid enrollees, experts recommend a heavy emphasis on education, outreach, and quality initiatives to help beneficiaries distinguish between necessary and unnecessary care. Many of the state plans that are emerging include the availability of health counselors to assist in the selection of health plans to better understand available services and incentives.

Source: Memo on Consumer Directed Health Purchasing in Medicaid. The Kansas Health Institute, September 2007.