

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-06)
Health Savings Accounts in the Medicaid Program
(Resolution 705, I-05)
Reference Committee J
(November 2006)

EXECUTIVE SUMMARY

At the 2005 Interim Meeting, the House of Delegates referred Resolution 705 to the Board of Trustees. Introduced by the Florida Delegation, Resolution 705 (I-05) calls for the AMA to “endorse the concept that the Medicaid population of each state should be allowed to participate in Health Savings Accounts (HSAs), and develop model legislation which could be used by the states to allow the Medicaid population to participate in HSAs.” The Board of Trustees referred the resolution to the Council on Medical Service for a report back at the 2006 Interim Meeting.

Burgeoning Medicaid expenditures, rapid expansion of HSAs and similar plans in the private market, and success of Medicaid “Cash and Counseling” have generated interest in offering HSAs to Medicaid beneficiaries. Because standard Medicaid rules prohibit high deductibles, states have, until recently, had to obtain federal waivers to provide high-deductible coverage, and a number of such waiver programs are planned or under way. The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) established a Medicaid demonstration of “Health Opportunity Accounts” (HOAs), based on HSAs, in up to ten states, starting January 1, 2007.

The goals of the HOA demonstration are to raise patient cost-consciousness, reduce inappropriate utilization of services, and promote patient responsibility for health outcomes. States have flexibility to structure HOAs within federal guidelines set forth by the DRA. Eligibility is limited primarily to healthy children and adults under 65, with eligibility criteria excluding well over 25% of the Medicaid population that accounts for over 70% of all Medicaid expenditures, most notably the elderly and the disabled. As with HSAs, HOA enrollees will have personal accounts earmarked for medical expenses, coupled with high-deductible coverage, with standard Medicaid coverage taking effect once the deductible has been met. States can make annual account contributions of up to \$2,500 per adult and \$1,000 per child, and are required or permitted to waive the deductible for certain preventive services. HOA enrollees who go off of Medicaid have limited access to any remaining account balances, which can be used to purchase private insurance, and for other state-approved uses such as job training or tuition. The Congressional Budget Office estimates that HOAs will increase federal Medicaid spending by \$57 million during the first five years, and a total of more than \$260 million over ten years if all states are permitted to offer HOAs after the five-year demonstration period.

Although HOAs are not expected to reduce rising Medicaid spending, the Council on Medical Service believes that HOAs could help achieve other important goals such as beneficiary choice, control, and cost-consciousness. Although the Council remains supportive of introducing elements of consumer-driven health care into the Medicaid program, including HOAs, it believes that certain safeguards are necessary to protect beneficiaries from harmful reductions in use of services and undue financial burden. Accordingly, the Council recommends a set of thirteen principles for design of Medicaid HOAs, which include offering positive incentives for obtaining recommended care and making healthy lifestyle choices; providing aggressive outreach, information, and decision-making support; and ensuring that physicians have up-to-date information to verify beneficiary enrollment and benefits coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - I-06
(November 2006)

Subject: Health Savings Accounts in the Medicaid Program
(Resolution 705, I-05)

Presented by: Ronald P. Bangasser, MD, Chair

Referred to: Reference Committee J
(John H. Vassall, MD, Chair)

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2 Trustees. Introduced by the Florida Delegation, Resolution 705 (I-05) calls for the AMA to
3 “endorse the concept that the Medicaid population of each state should be allowed to participate in
4 Health Savings Accounts (HSAs), and develop model legislation which could be used by the states
5 to allow the Medicaid population to participate in HSAs.” The Board of Trustees referred the
6 resolution to the Council on Medical Service for a report back at the 2006 Interim Meeting.

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8 Burgeoning Medicaid expenditures, rapid expansion of HSAs and similar plans in the private
9 market, and success of Medicaid “Cash and Counseling” have generated interest in offering HSAs
10 to Medicaid beneficiaries. Since referral of Resolution 705 (I-05), the Deficit Reduction Act
11 (DRA) of 2005 (P.L. 109-171) has established a Medicaid demonstration of “Health Opportunity
12 Accounts” (HOAs), based on HSAs. It also should be noted that in July 2006, the Centers for
13 Medicare and Medicaid Services (CMS) announced a demonstration of Medicare HSAs, planned to
14 start in 2007.

15
16 This report provides background on factors contributing to support for Medicaid HSAs;
17 summarizes Medicaid consumerism experience to date; describes HOAs; examines their potential
18 impacts; discusses various approaches to Medicaid consumerism; and presents several
19 recommendations.

20
21 BACKGROUND

22
23 The Medicaid program provides health insurance and long-term care services to nearly 60 million
24 low-income families, disabled individuals, and seniors, a small portion of which are “dually
25 eligible” to receive Medicare coverage as well. Since 2000, Medicaid expenditures have grown
26 from about \$200 billion to more than \$300 billion, with shares financed by federal and state
27 governments consistently around 55% and 45%, respectively. Combined federal and state
28 Medicaid spending is now on par with Medicare, each accounting for 16% of national health
29 expenditures. Despite a recent leveling off, state spending growth continues to outstrip sluggish,
30 sometimes negative state revenue growth. In 2003, Medicaid surpassed primary and secondary
31 education as the largest single expenditure by states, on average accounting for 22% of state
32 budgets (Kaiser Family Foundation, 2005).

33
34 During the 1990s, Medicaid cost containment efforts focused on enrolling beneficiaries in managed
35 care plans. During the first half of the 2000s, all states and the District of Columbia implemented

1 additional measures to contain Medicaid costs (Smith et al., KFF, October 2004). All states froze
2 or reduced payments rates to hospitals, physicians, managed care companies, and/or nursing
3 homes, and all implemented prescription drug cost controls such as preferred drug lists or higher
4 co-payments. Thirty-four states imposed tighter eligibility restrictions, 38 reduced coverage of
5 optional benefits such as adult dental and vision services, and 20 imposed new or higher
6 beneficiary co-payments. Other strategies included disease management programs and initiatives
7 to reduce long-term care expenditures for seniors and the disabled.
8

9 Medicaid spending mirrors the private market, where growth has been even faster. Rising health
10 care costs and erosion of employment-based coverage have contributed to rapid enrollment in
11 HSAs and similar Health Reimbursement Arrangements (HRAs), forms of coverage that combine
12 tax-advantaged health care spending accounts with high-deductible, low-premium health plans.
13 (Detailed descriptions of HSAs and HRAs, including comparisons of the two types of coverage, are
14 provided in Council on Medical Service reports 3 [I-03], 6 [A-04], and 3 [I-05].) Initially,
15 consumer-driven health care was often considered synonymous with HSAs and HRAs, later
16 including other attempts to curb spending through patient cost-sharing, for example, tiered benefits
17 or penalties for inappropriate use of emergency services. Although consumer-driven coverage
18 gives patients greater control over their health care, a major concern has been that high deductibles
19 or other cost-sharing will prevent patients from obtaining needed services.
20

21 As health care consumerism has evolved, some of the emphasis on cost containment has shifted to
22 clinically appropriate use of care. Accordingly, alongside negative incentives to curb utilization,
23 positive incentives are being used to encourage healthy behaviors and increase utilization of certain
24 services. For example, insurers and employers may offer financial rewards for obtaining
25 recommended preventive care in order to promote health and productivity, and to avert future
26 costs. Accordingly, consumer-driven health care is now seen as encompassing a broad range of
27 tools and incentives to promote wellness, engage patients in managing their own health, and
28 provide consumer information and decision-making support. These approaches are often aimed at
29 HSA and HRA enrollees, but are also being adopted by health plans more generally, and are
30 sometimes offered as stand-alone tools by employers, insurers, entrepreneurs, private
31 organizations, and government agencies.
32

33 PROTOTYPES OF MEDICAID CONSUMERISM

34 Medicaid “Cash and Counseling” Demonstrations

35
36
37 In the late 1990s, a three-state “Cash and Counseling” demonstration was established to study
38 whether disabled and elderly Medicaid patients could do a better job managing their own personal
39 care services than agencies traditionally contracted by Medicaid. New Jersey, Arkansas, and
40 Florida were granted federal (Section 1115) waivers from standard Medicaid program requirements
41 in order to implement Cash and Counseling programs. The three programs differed slightly but
42 were all designed to give long-term care beneficiaries the option of arranging their own assistance
43 with everyday activities such as bathing, dressing, grooming, cooking, and housekeeping.
44 Volunteers for the demonstrations were randomly split, half receiving personal care services
45 through agencies, and half arranging their own services with the help of “cash and counseling.”
46 The 6,700 Cash and Counseling participants included disabled adults, the frail elderly, and a small
47 number of developmentally disabled children.

1 Participants or their representatives were given a state-determined monthly budget based on an
2 assessment of the beneficiary's need for community-based long-term care services. Budgets were
3 lowest in Arkansas and highest in New Jersey, ranging from about \$300 to \$1,300. Beneficiaries
4 used these funds to hire personal assistants, which could include family caregivers, and make
5 purchases that would enable them to live more independently and avoid institutionalization.
6 Participants gained greater control over the type of help they received, who provided it, and when.
7 Funds could be used flexibly, for example to purchase a microwave or to hire an aide to cook
8 meals. Participants received counseling on managing their budgets, and states provided oversight
9 of expenditures.

10
11 Cash and Counseling appears to have resulted in better care and higher quality of life for long-term
12 care patients, along with possibly higher Medicaid program costs, at least in the short-run.
13 Compared to beneficiaries receiving agency-arranged services, Cash and Counseling participants
14 reported better access to personal care services and higher levels of satisfaction with their care, and
15 their family caregivers reported less physical and emotional strain. Cash and Counseling recipients
16 appeared to be "prudent purchasers," but because they obtained more hours of help, often the full
17 amount authorized, their average Medicaid expenditures were 8% to 12% higher in two of the three
18 states (New Jersey and Florida). On the other hand, in Arkansas, the Cash and Counseling group
19 experienced a decline in nursing home admissions over time, with average Medicaid expenditures
20 18% less than the traditional Medicaid group.

21
22 On the basis of these initial results, the Cash and Counseling demonstration was expanded to 12
23 additional states in 2004 (Alabama, Illinois, Iowa, Kentucky, Michigan, Minnesota, New Mexico,
24 Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia). Demonstration results
25 also spawned a plethora of similar programs designed to increase patient control of Medicaid and
26 Medicare services in nearly every state, most frequently involving individual accounts or
27 allowances. Recently, all states were granted permission to implement Cash and Counseling
28 programs without first seeking a federal (HIFA) waiver, by the Deficit Reduction Act (DRA).

29 30 Other State Consumerism Initiatives

31
32 As states seek innovative ways to control their Medicaid expenditures, many have looked to HSAs
33 and HRAs as models. States also have considered similar "defined contribution" approaches, in
34 which beneficiaries receive a fixed-dollar account to purchase health insurance from a choice of
35 private health plans, possibly including a high-deductible plan. Since standard Medicaid rules
36 prohibit high deductibles, a number of states seeking to incorporate high-deductible or account-
37 based coverage into their Medicaid programs had obtained or applied for federal waivers prior to
38 DRA authorization of HOAs. State proposals typically include both negative and positive
39 incentives to control costs and promote health.

40
41 Florida: Florida has received a federal waiver to implement a "defined contribution" approach to
42 Medicaid in order to more individually tailor benefits and to promote competition among private
43 health plans. The demonstration started in two counties in 2006, with mandatory participation for
44 low-income families and those disabled beneficiaries not dually eligible for Medicare.
45 Beneficiaries choose from a set of approved managed care plans, with help available from
46 enrollment counselors. Plans receive risk-adjusted capitated payments and have limited authority
47 to determine benefits coverage and cost-sharing. The state sets an annual maximum benefit limit
48 for adults, above which beneficiaries become responsible for all health care expenses. When

1 available, beneficiaries can opt for employer-sponsored insurance by applying their risk-adjusted
2 payment to the employee share of premium. Beneficiaries also earn credits deposited to an
3 “Enhanced Benefit Account” by obtaining recommended preventive care, keeping appointments,
4 and meeting other specified goals. Credits can be used for non-covered services such as smoking
5 cessation classes and adult dental care, but not for copayments or co-insurance. Individuals who
6 lose Medicaid coverage but whose income remains under 200% of the federal poverty level can use
7 their enhanced benefit credits toward premiums for private insurance. The University of Florida
8 has been contracted to conduct a five-year evaluation of the program’s impact on access to care,
9 program cost, patient choice of health plan, quality of services, consumer satisfaction, health
10 literacy, and health outcomes. Florida has expressed interest in conducting an HOA demonstration
11 in addition to the waiver program demonstration.
12

13 South Carolina: South Carolina was granted a federal waiver to provide Medicaid beneficiaries
14 with defined contributions to buy health insurance. The state would make risk-adjusted deposits
15 into “Personal Health Accounts,” which beneficiaries use to purchase coverage from a list of
16 approved health plans. Plan choices include a “self-directed care” option resembling an HSA,
17 more comprehensive conventional health plans, Medical Home Networks resembling HMOs, and
18 employer-sponsored coverage if available. Medicaid benefits are limited by the account
19 contribution so that once the account is exhausted, beneficiaries become responsible for any health
20 care expenses. Enrollment counselors are available to assist beneficiaries. Dual eligibles and
21 foster care children will be excluded from the program. South Carolina recently withdrew its
22 waiver request in order to conduct similar reforms under DRA provisions.
23

24 West Virginia: West Virginia has received approval to implement an account-based approach that
25 explicitly does not involve high deductibles, with eligibility restricted to low-income families. In
26 addition to standard Medicaid benefits, beneficiaries are given “Healthy Rewards Accounts.” The
27 state will add credits to accounts for obtaining prenatal care, well-child checkups, vaccinations, and
28 recommended treatment of targeted conditions such as diabetes and asthma. Credits are deducted
29 for inappropriate use of emergency services, missed appointments, use of non-preferred drugs, and
30 smoking. Beneficiaries can use credits to pay copayments, which are higher than before, and to
31 receive an enhanced benefit package that includes services such as cardiac rehabilitation, smoking
32 cessation classes, weight loss programs, substance abuse treatment, and nutrition education. In
33 addition, beneficiaries choose or are assigned a “medical home,” through which they receive
34 counseling on appropriate use of health services. The program was scheduled to start in three
35 counties in mid-2006.
36

37 HEALTH OPPORTUNITY ACCOUNTS

38 Deficit Reduction Act of 2005

39
40
41 The DRA contained numerous, wide-ranging provisions affecting multiple sectors of the economy,
42 projected to reduce federal spending by about \$40 billion over five years and \$100 billion over ten
43 years (Congressional Budget Office, January 27, 2006). More than three-quarters of projected
44 federal savings are in education, Medicaid and the State Children’s Health Insurance Program
45 (SCHIP), and Medicare. Key Medicaid provisions limit prescription drug reimbursements, tighten
46 eligibility requirements for Medicare beneficiaries seeking long-term care coverage, increase
47 efforts to reduce fraud and waste, and give states greater flexibility in determining covered benefits
48 and cost-sharing requirements, without the need to apply for federal waivers. Beneficiaries who

1 may be offered reduced benefits, or required to pay higher coinsurance or premiums are, for the
2 most part, healthy children and adults. While the DRA removed Medicaid prohibitions against
3 cost-sharing or premiums for children, states are still required to ensure coverage of early, periodic,
4 screening, diagnosis and treatment (EPSDT) services for children, with state wrap-around coverage
5 for beneficiaries enrolled in private plans not providing these services. Additional DRA provisions
6 established the HOA demonstration, granted all states the ability to implement Cash and
7 Counseling programs without a waiver, and made various other changes to the Medicaid program.
8 The DRA is expected to reduce federal Medicaid and SCHIP spending by \$4.7 billion over five
9 years and \$26 billion over ten years (General Accountability Office, 2006). Potential savings are
10 constrained by the fact that cost-containment provisions generally do not apply to the most
11 medically vulnerable beneficiaries, who account for most Medicaid spending and spending growth.
12 Although the net effect of the DRA will be to reduce federal spending, some provisions authorize
13 relatively modest spending increases, including those pertaining to HOAs and Cash and
14 Counseling.

15
16 Medicaid HOA Demonstration

17
18 Because standard Medicaid rules prohibit high deductibles, states were required to obtain federal
19 waivers to provide high deductible coverage prior to authorization of HOAs. The DRA authorized
20 a demonstration of HOAs in up to ten states, starting January 1, 2007. After five years, the
21 Secretary of Health and Human Services will have the authority to implement HOAs nationwide
22 and on a permanent basis, without Congressional approval. As with HSAs, HOA enrollees have a
23 personal account earmarked for medical expenses, coupled with high-deductible coverage. HOAs
24 were modeled after Medicaid initiatives in South Carolina, Iowa, and Florida, and although states
25 are permitted to implement HOAs and waiver programs simultaneously, South Carolina chose to
26 withdraw its waiver application in order to participate in the HOA demonstration instead. Florida,
27 Georgia, Kentucky, Texas, and West Virginia also have shown interest in participating in the HOA
28 demonstration. HOAs are expected to increase federal Medicaid spending by \$56 million during
29 the first five years, and more than \$260 million over ten years if all states are permitted to offer
30 HOAs after the five-year demonstration period (Congressional Budget Office, January 27, 2006).

31
32 As shown in the Appendix, the basic structures of HOAs and HSAs are similar, but different rules
33 and limitations apply. States have flexibility in structuring HOAs within the federal guidelines set
34 forth by the DRA. Although not required by the DRA, CMS is likely to provide additional
35 guidance through a State Medicaid Directors letter or by issuing regulations. Main features of the
36 HOA program are as follows:

37
38 Goals: The stated goals are to raise patient cost-consciousness, reduce inappropriate utilization of
39 services, and promote patient responsibility for health outcomes.

40
41 Eligibility: In contrast to Cash and Counseling, the target group is children and some adults. Many
42 Medicaid beneficiaries are ineligible for HOAs, including: those over 65, the disabled, the blind,
43 long-term care beneficiaries, hospice patients, those living in institutions, medically frail and
44 special needs populations, women enrolled due to pregnancy, parents receiving Temporary
45 Assistance to Needy Families (TANF), foster children, and those enrolled in Medicaid for less than
46 3 months. SCHIP beneficiaries covered through Medicaid (30% of total) can be made eligible for
47 HOAs, whereas those enrolled in separate state SCHIP programs appear to be ineligible. A cap is

1 placed on the number of beneficiaries enrolled in Medicaid managed care plans able to participate
2 in the HOA demonstration.

3
4 Benefits Coverage: HOAs will cover the state's standard Medicaid benefits. States are permitted
5 but not required to provide first-dollar coverage of preventive services (i.e., before the deductible
6 has been met).

7 Account Funding and Deductibles: The state will deposit up to \$2,500 per adult and \$1,000 per
8 child per year into an HOA, to be used to pay for health services before the deductible has been
9 met. The state sets the deductible at 100% to 110% of the account contribution, and once the
10 deductible has been met, the state's standard Medicaid coverage takes effect. If the account is
11 exhausted before the deductible has been met, the beneficiary must pay out-of-pocket for any
12 additional services until the deductible has been met. So for example, if the state sets both account
13 contributions and deductibles at maximum levels, a family of one adult and two children will
14 receive an HOA account deposit of \$4,500, face a deductible 10% higher or \$4,950, and face
15 potential out-of-pocket expenses up to \$450. If on the other hand, account balances remain at the
16 end of the year, these balances roll over. The state may limit account contributions once balances
17 reach a specified level.

18
19 Incentives: States may provide additional account contributions or other incentives for patients
20 who obtain recommended preventive care.

21
22 Variation by Beneficiary Income and Health Status: States can vary levels of the deductible and
23 account contribution by beneficiary income. States are permitted to adjust the gap between account
24 contributions and deductibles based on the expected health needs of beneficiaries.

25
26 Patient Cost-Sharing: The state's standard Medicaid copayments or coinsurance applies for
27 services obtained after the beneficiary has met the deductible, and standard family out-of-pocket
28 spending limits apply.

29
30 Enrollment and Vesting: Beneficiaries enroll in HOAs for one-year increments, between which
31 they may switch to standard Medicaid coverage. Beneficiaries who, for any reason, disenroll from
32 an HOA are barred from re-enrolling in an HOA for one year.

33
34 Portability: Upon losing Medicaid eligibility due to increased income or assets, 75% of account
35 funds continue to be available to the individual for up to three years, so long as the individual was
36 enrolled in the HOA for at least one year. In contrast to HSAs, funds can be used to purchase
37 private insurance, and for other state-approved uses such as job training or tuition. The state would
38 continue to administer the account during this period.

39
40 Payment: Beneficiaries pay participating providers Medicaid rates. Beneficiaries are also
41 permitted to use account funds to pay non-participating providers up to 125% of Medicaid rates.
42 Account withdrawals cannot be made in cash and must be made electronically.

43 44 Comparison Of HOAs and Cash and Counseling

45
46 Although Cash and Counseling and HOAs share the broad goal of allowing patients to take greater
47 control and financial responsibility for their health care decisions, the two programs have very
48 different origins, primary objectives, target populations and services, and beneficiary incentives.

1 Cash and Counseling grew out of the early disability rights movement of the 1960s, with the
2 primary objective of improving patients' quality of life. HOAs are an extension of the more recent
3 consumer-driven health care movement that has emerged in response to rising health care costs and
4 erosion of employment-based health insurance coverage. Cost-containment is of secondary
5 concern in the Cash and Counseling program, whereas it is a central and explicit objective of
6 consumer-driven health care, HSAs, and HOAs. As noted earlier, eligibility criteria in the two
7 programs are reversed, with Cash and Counseling available only to the sickest, frailest Medicaid
8 beneficiaries, and HOAs only to those most likely to be healthy (e.g., children and some adults).

9
10 Although participation in both types of demonstration is voluntary, beneficiaries have the freedom
11 to leave Cash and Counseling at any time, whereas HOA enrollees cannot revert to traditional
12 Medicaid mid-year without penalty. Regarding incentives, both programs encourage beneficiaries
13 to spend wisely when they do use services, shopping around for the best values in types and
14 sources of care, but the two programs exert opposite pressures to spend vs. save. Cash and
15 Counseling beneficiaries have no reason to conserve their budgets, whereas HOA enrollees face an
16 incentive to conserve funds because they keep unused account balances. Perhaps most importantly,
17 Cash and Counseling covers non-medical services, while HOAs cover medical services. Compared
18 to non-medical services, medical services are generally much more complex, and the patient's
19 well-being is more directly at stake in decisions regarding medical care.

20 21 AMA POLICY

22
23 Consistent with extensive, longstanding AMA policy on health system reform and on consumer-
24 driven health care (H-165.920, H-165.852, H-180.957, and H-285.998[1], AMA Policy Database),
25 the AMA advocates pluralism in the financing and delivery of Medicaid services, with individual
26 beneficiary choice, including but not limited to HSAs (H-290.982[3], D-165.958). Policy D-
27 280.990[6] encourages states to support consumer-driven care programs within Medicaid, such as
28 the Cash and Counseling demonstration project. AMA policy also supports state-based
29 demonstration projects to test alternative approaches to covering low-income individuals (D-
30 165.959, D-165.966). Other AMA policies advocate providing very low-income individuals with
31 coverage subsidies generous enough to allow little-to-no patient cost sharing (H-165.855);
32 expanding use of HSAs for long-term care coverage, generally and within Medicaid (D-
33 280.990[4]); making HSAs available to the Medicare population (D-165.962); and ensuring that
34 Medicaid EPSDT benefits remain intact (D-290.987[1,2]). Policy H-165.852 advocates that
35 insurers be permitted to offer high deductible HSA coverage that applies individual deductibles to
36 individual family members rather than applying a larger family deductible.

37 38 DISCUSSION

39
40 Existing AMA policy provides direct but qualified support for giving Medicaid beneficiaries the
41 option to enroll in an HSA, and for establishing state-based demonstrations of HOAs. However,
42 analysis of AMA policy and preliminary research suggest potential risks of HOAs, including
43 possible clinically inappropriate reductions in beneficiary use of services, and increased
44 expenditures for the Medicaid program. Due to the recent enactment of federal law authorizing
45 state HOA demonstrations, the Council on Medical Service believes that there is no longer a need
46 to develop model state legislation as proposed by Resolution 705 (I-05).

1 **Impact Of HOAs on Patients**

2
3 The RAND Health Insurance Experiment, conducted during the 1970s, showed that increased
4 patient cost-sharing reduced spending primarily through reduced utilization, rather than substitution
5 with less expensive services (Newhouse, *Health Affairs*, November/December 2004). The RAND
6 study also found that low-income people were more sensitive to increased patient cost-sharing,
7 responding with sharper reductions in use of health care services. Furthermore, although cost-
8 sharing did not impact health status of the overall study population, it did harm the 6% who were
9 both low-income and chronically ill. Subsequent research has confirmed that low-income patients
10 with chronic medical conditions are especially likely to forgo prescribed medications and check-
11 ups when faced with increased cost-sharing (Fronstin, Employee Benefits Research Institute,
12 2006). Fortunately, the most medically vulnerable Medicaid beneficiaries, and some of the most
13 economically vulnerable, are ineligible for HOAs, at least during the five-year demonstration
14 period. In addition, HOAs might not dampen utilization as much as high deductibles in the RAND
15 experiment because HOA enrollees have access to specially earmarked funds to pay for health care
16 and because of considerable innovation of tools and incentives to foster appropriate utilization and
17 health behavior (Newhouse, 2004). For example, beneficiaries could be offered financial rewards
18 for obtaining prenatal care, well-child checkups, vaccinations, and recommended treatment of
19 targeted conditions such as diabetes and asthma. Rewards also can be given as coverage of
20 additional benefits such as adult dental care, cardiac rehabilitation, or smoking cessation classes.
21 Account deductions or other penalties can be used to discourage inappropriate use of emergency
22 services, missed appointments, and use of non-preferred drugs.

23
24 Another factor impacting beneficiaries is the deductible or deductibles that apply to families
25 enrolled in HOAs. The DRA appears to require a family to meet one large deductible that
26 combines deductible limits for each family member, rather than applying lower deductibles to
27 individual family members. For example, a family of three with one adult and two children could
28 be required to meet a deductible as high as \$4,950 (\$450 more than maximum account
29 contributions of \$4,500). In contrast, standard Medicaid coverage would take effect for any family
30 member who meets the individual deductible limit (\$2,750 for the adult, \$1,100 for each child),
31 without the requirement that additional funds from the family account be spent. Applying
32 individual deductibles to family members would temper the impact of HOAs on utilization and
33 make it easier for families to roll over account balances.

34
35 Given the lack of evidence of widespread overutilization by Medicaid beneficiaries, and evidence
36 of possible underutilization of certain services, the Council believes that states offering Medicaid
37 beneficiaries HOAs should buffer the effects of high deductibles by: making participation
38 voluntary; providing first-dollar coverage of preventive services; offering robust rewards for
39 compliance with recommended care and healthy behaviors; fully funding accounts up to
40 deductibles; counting payments to non-Medicaid-participating providers, up to 125% of standard
41 Medicaid rates, toward fulfillment of the deductible and out-of-pocket limits; applying deductibles
42 to individuals rather than requiring families with multiple HOA enrollees to meet larger, combined
43 family deductibles; and limiting copayments, coinsurance, and total out-of-pocket expenses.

44
45 Factors other than patient cost-sharing also will impact the development of consumerism in the
46 Medicaid program. Compared to the general population, Medicaid beneficiaries have lower levels
47 of health literacy, less familiarity navigating the health care delivery system, and less experience
48 and support researching and evaluating medical options. They also face greater challenges

1 traveling to available services. Accordingly, the Council supports aggressive outreach,
2 information, and decision-making support that incorporates financial and clinical considerations, as
3 well as assisting beneficiaries with administrative or logistical demands of choosing and accessing
4 care. This support should be available through a variety of formats (e.g., written, telephone,
5 online), and in multiple languages. Beneficiaries should also be encouraged to establish a “medical
6 home” to ensure coordination and continuity of care. The medical home could be a primary care
7 physician or a specialist who manages a beneficiary’s chronic medical condition. By assisting
8 beneficiaries in making treatment decisions and complying with recommended care, medical
9 homes can increase the value and effectiveness of Medicaid expenditures.

10 Impact Of HOAs on Medicaid Program Expenditures

11
12 The Council believes that HOAs are unlikely to bring direct savings to the Medicaid program, and
13 may actually increase Medicaid expenditures. Nevertheless, HOAs could help achieve other
14 important goals such as enhancing beneficiary choice and control. The Congressional Budget
15 Office estimates that the HOAs will increase federal Medicaid spending by nearly \$60 million
16 during the five-year demonstration, and an additional \$200 million over the next five years once all
17 states are able to offer HOAs, not including corresponding increases in state Medicaid
18 expenditures. Program costs will be driven up in part by the portability and flexibility of HOA
19 accounts, and because beneficiaries can pay non-participating providers 125% of ordinary
20 Medicaid rates. The potential use of Medicaid funds for purposes other than health care raises
21 troubling concerns about erosion of Medicaid budgets, and the possibility that states will leverage
22 non-medical expenditures to obtain increased federal matching funds. The Council believes that
23 use of HOA funds should be restricted to health care services, and should be applicable to the
24 employee share of job-related coverage for former Medicaid enrollees who still have access to
25 HOA balances. The Council is optimistic that, in the long run, HOAs may lead to reduced
26 Medicaid spending by averting future treatment costs through increased use of recommended
27 preventive services and healthy lifestyle choices.

28
29 The inability of HOAs to directly impact Medicaid spending is not surprising if one considers that
30 HOA eligibility criteria exclude well over 25% of the Medicaid population who account for over
31 70% of all Medicaid expenditures, most notably the elderly and the disabled. The overwhelming
32 majority of high-cost beneficiaries are aged or disabled, whereas the overwhelming majority of
33 low-income children and adults are low-cost (Sommers and Cohen, Kaiser Family Foundation,
34 March 2006). Similarly, the elderly and disabled accounted for more than half of Medicaid
35 spending growth between 2000 and 2004, primarily due to rising per-person treatment costs rather
36 than new enrollment (Holahan and Cohen, Kaiser Family Foundation, May 2006), with projections
37 showing intensification of these trends over the next decade (Table 4 of Congressional Budget
38 Office testimony to the Senate Committee on Aging, July 13, 2006). Between 2000 and 2004, the
39 two biggest drivers of Medicaid spending growth were increased spending per aged and disabled
40 beneficiary, and expanded enrollment of low-income children and adults – neither of which are
41 affected by HOA incentives (Table 6, CBO, July 2006).

42
43 Among low-income children and adults, inpatient hospitalization is the biggest spending category
44 and cost driver. HOAs are unlikely to have much effect on the number or cost of hospital stays,
45 since most hospital stays are not discretionary, and hospital patients almost by definition have
46 surpassed HOA deductibles. The second biggest spending category among low-income families,
47 prescription drugs, is more amenable to patient cost-sharing, although the DRA already authorizes
48 states to control drug spending with tiered drug copayments. Acute care services such as

1 hospitalizations and prescription drugs currently account for 60% of Medicaid spending and
2 contribute more to total spending growth than long-term care such as nursing home services and
3 home health care. However, virtually all long-term care services are for the elderly and the
4 disabled, and Medicaid enrollment is projected to grow fastest for the elderly over the next decade,
5 making it possible that long-term care will surpass acute care as a share of total spending and
6 spending growth (based on Table 6, CBO, July 2006).

7
8 Given the potentially harmful impact on patient access and utilization, and the lack of cost-
9 containment potential, the Council believes that clearer articulation of HOA objectives appears
10 warranted. Some goals are more appropriate or achievable for different beneficiary populations.
11 HOAs appear to have little immediate cost-containment potential but could be an appropriate
12 mechanism for fostering appropriate use of preventive and primary care – if benefit design includes
13 positive as well as negative incentives.

14
15 In summary, the Council on Medical Service remains supportive of introducing elements of
16 consumer-driven health care into the Medicaid program, including Health Opportunity Accounts
17 and other forms of coverage modeled after HSAs. However, the Council also believes that certain
18 requirements are necessary to safeguard against harmful reductions in use of vital health care
19 services, protect beneficiaries from undue financial burden, ensure appropriate use of health care
20 resources, and promote the health and well-being of the Medicaid population.

21 RECOMMENDATIONS

22
23
24 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
25 705 (I-05), and the remainder of the report be filed:

- 26
27 1. That our American Medical Association encourage state medical associations to assist in the
28 design, monitoring, and evaluation of state Health Opportunity Account (HOA)
29 demonstrations. (Directive to Take Action)
30
- 31 2. That it is the policy of our AMA that states offering Medicaid beneficiaries Health Opportunity
32 Accounts (HOAs) or similar coverage modeled after Health Savings Accounts (HSAs) should
33 adhere to the following principles:
 - 34 (a) Make beneficiary participation voluntary;
 - 35 (b) Provide first-dollar coverage of preventive services regardless of whether the
36 beneficiary has met the deductible;
 - 37 (c) Offer positive incentives to reward healthy behavior and offset beneficiary cost-
38 sharing, provided that such incentives do not result in punitive cuts in standard benefits
39 or increased cost-sharing to enrollees who are unable to achieve improvements in
40 personal behavior affecting their health;
 - 41 (d) Set deductibles at 100% of account contributions, but no higher;
 - 42 (e) Allow payments to non-Medicaid providers by beneficiaries to count toward
43 deductibles and out-of-pocket spending limits;
 - 44
 - 45
 - 46
 - 47
 - 48

- 1 (f) Allow the deductible limits for families to be the lower of either the individual or
2 family combined deductible;
- 3
- 4 (g) Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket
5 spending limits;
- 6
- 7 (h) Provide outreach, information, and decision-support that is readily accessible through a
8 variety of formats (e.g., written, telephone, online), and in multiple languages;
- 9
- 10 (i) Encourage HOA enrollees to establish a medical home, in order to assure provision of
11 preventive care services, coordination of care and continuity of care;
- 12
- 13 (j) Prohibit use of HOA funds for non-medical purposes, but consider allowing HOA
14 balances of enrollees who lose Medicaid coverage to be used to purchase private
15 insurance, including the employee share of premium for employer-sponsored coverage;
- 16
- 17 (k) Monitor the impact on utilization and beneficiary financial burden;
- 18
- 19 (l) Test broadening of eligibility to include currently ineligible beneficiary groups; and
- 20
- 21 (m) Ensure that physicians and other providers of health care services have access to up-to-
22 date information verifying beneficiary enrollment and covered benefits, and are paid at
23 point-of-service, or are allowed to use their standard billing procedures to obtain
24 payment from the insurer or account custodian. (New HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Encourage state medical associations to assist in the design, monitoring, and evaluation of state Health Opportunity Account demonstrations at an estimated total cost of less than \$500.

APPENDIX

Comparison of Health Savings Accounts and Medicaid Health Opportunity Accounts

	HSAs	HOAs
Eligibility	Anyone not in Medicare and with qualified high-deductible coverage	Low-income (gen. healthy) Medicaid children & adults in demonstration states
Components	Savings account + High-deductible insurance plan Some positive incentives for healthy behaviors not prohibited	Savings account + High-deductible coverage States may incorporate rewards for healthy behaviors
Health Plan Coverage General	Must have a qualified high-deductible health plan (HDHP) and not have duplicative coverage.	State's standard Medicaid benefits (per DRA), provided through state or contracted private plan.
Preventive Care	Waiver of deductible permitted but not required. At insurer discretion.	Deductible waived for ESPDT. State may waive deductible for other preventive services.
Accounts		
Ownership	Individual	State
Portability	Yes	75% of balance, up to 3 years after leaving Medicaid
Funding Source	Employer &/or employee/individual	State Medicaid program
Annual Contribution Limit	Lesser of 100% of deductible or \$2,650 for individual policies \$5,250 for family policies	Up to \$2,500 per adult and \$1,000 per child. Can vary by beneficiary income
Tax Treatment	Tax-free contributions, interest, and expenditures. Non-qualified expenditures taxed, plus 15% penalty if under age 65.	Not applicable
Carryover of Unused Funds	May be carried over indefinitely	May be carried over while enrolled in Medicaid HOA; state may limit carryovers
Qualifying Expenses	Medical expenses defined by §213(d) of IRS Code, including non-covered benefits. Premiums payments generally not allowed.	State may allow non-covered benefits. Upon leaving Medicaid, state may allow premiums and some non-medical expenses, e.g., tuition, job training.
Cost-Sharing & Benefit Limits		
Annual Deductibles	\$1,000 to \$5,100 for individuals \$2,000 to \$ 10,200 for families	100% to 110% of account contribution
Coinsurance or Copayments	Permitted before OOP limit	Same as standard Medicaid
Annual Out-of-Pocket	\$5,100 for individuals \$10,200 for families	Standard Medicaid limit of 5% of family income
Annual Benefit Limit	None, but lifetime limit may apply	None

Note: HSA dollar figures refer to 2005. Sources: The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; U.S. Treasury Department; and Deficit Reduction Act (DRA) of 2005.