Strategy	Health Savings Accounts and Health Opportunity Accounts
Background:	**Health Savings Accounts** Health Savings Accounts are increasingly being adopted by employers and individuals in the private insurance market who are looking to limit health care costs. Health Savings Accounts (HSAs) or Health Reimbursement Accounts (HRAs) are combined with high-deductible health plans. Together, they are known as Consumer Directed Health Plans (CDHP). Of the approximately 70 million American workers who receive health benefits through their employers, about 1.3 million are enrolled in an HRA and about 1.4 million are enrolled in an HSA.[i] The underlying premise of CDHPs is that health care costs can be better controlled if employees take more responsibility for decision-making about their health care. CDHPs generally provide internet decision-support tools to help enrollees make decisions; however, the challenge for these health plans is to obtain and present complex quality and cost data in a meaningful and useable way to enrollees.[ii] HRAs are employer-established accounts that reimburse employees for medical costs that occur before the employee meets the deductible. Only employers can contribute to the HRA accounts. Account balances are allowed to accrue from one year to the next, but the employees do not own the accounts and cannot retain unspent funds when they change jobs. HSAs, authorized by the 2003 Medicare Modernization Act, have received considerable attention because of the increased flexibility offered through these accounts. HSAs differ from HRAs in that both employers and employees can contribute to HSAs. HSA accounts are owned by the enrollee, can accrue without limit, and may also be taken by the enrollee to a new employer. Annual contributions to an HSA can total up to $2,700 for an individual and $5,450 for a family. Individuals are eligible to open an HSA when they have a high-deductible health plan that requires a minimum deductible amount of $1,050 for single coverage and $2,100 for family coverage in 2006, and a maximum limit on out-of-pocket spending of $5,250 for single coverage and $10,500 for family coverage in 2006. HSA funds may be used to pay for health care-related expenses not always covered by traditional health insurance, such as prescription and non-prescription drugs, eye care, dental care, COBRA premiums, acupuncture, Braille books, midwife services, seeing-eye dogs, and qualified long-term care services. [iii] Under HSAs, contributions by individuals are tax-deductible, grow tax-free, and are withdrawn tax-free from the accounts as long as the funds are used to pay for out-of-pocket medical expenses. Critics warn of the possibility that these accounts could be used as tax shelters by high-income individuals.[iv] CDHPs offer consumers a lower premium for their health plan but with higher up-front costs than traditional insurance. CDHPs have raised concerns about their

Strategy	Health Savings Accounts and Health Opportunity Accounts
	possible effects on the insurance market if healthy people leave traditional insurance for CDHPs, resulting in a less healthy pool of enrollees in traditional insurance plans. This effect is called adverse selection and may cause the cost of traditional health insurance to increase.[v] **Health Opportunity Accounts** The Deficit Reduction Act of 2005 (DRA) allows for 10 states to develop demonstration programs that replace traditional Medicaid coverage with Health Opportunity Accounts (HOAs). HOAs are similar to the private health insurance market's Health Savings Accounts (HSAs). Beginning January 1, 2007, up to 10 states may apply to create an HOA pilot program. The demonstration program will last five years. The state and federal governments fund HOA accounts, for a maximum of $2,500 all funds per adult and $1,000 all funds per child. States may set the deductible at up to 110 percent of the amount in the HOA. In other words, in the case of adults, if the account is funded at $2,500, states could require the enrollee to pay up to $250 in annual deductibles out of pocket. Private donations and other sources may contribute to the accounts, but the federal government will only provide a match for the state's contribution. The federal government will also not provide matching funds once the account reaches the annual maximum amounts described above. There has been no federal guidance regarding when enrollees must pay the deductible. Therefore, states may require enrollees to pay the full deductible, either periodically or in lump sums, before spending funds in the account, or before accessing traditional Medicaid benefits if funds in the account have been exhausted. The account may pay for some medical expenses not covered under the state Medicaid plan. If the account is not exhausted, an individual may use 75 percent of the leftover funds for up to three years to pay for tuition, workforce training, or private health insurance coverage after losing Medicaid coverage. The DRA mandates that the HOA demonstration program must use an electronic system for payments made from the account and may not allow cash withdrawals. HOA enrollees may obtain medical services from any participating Medicaid provider at the state's current Medicaid provider rates or any other provider at payment rates up to 125 percent of the state's Medicaid rates. CMS released direction regarding program application on January 10, 2007. States may submit an application for an HOA demonstration program through a special application process. Texas could develop an HOA program for inclusion in a more comprehensive reform waiver to CMS, which could potentially allow for some flexibility from DRA requirements. Even so, the benefits of an HOA developed under a waiver would need to be carefully evaluated against the costs of implementing the program.

Strategy	Health Savings Accounts and Health Opportunity Accounts
Other States:	• Health Savings Accounts are available through the private insurance market in Texas and throughout the country to employers and individuals. • No other states have implemented Health Opportunity Accounts. • **Indiana's** proposed Medicaid reform initiative includes a POWER account, which is like an HSA except that control of the fund is held at the state. o The state and participant (up to 5 percent of family income) contribute a combined total of $1,100 per adult. The state may fund the POWER account at a higher rate if the individual is screened as high-risk. o Employers may elect to contribute. o POWER accounts do not include the tax advantage of a traditional HSA. o Annually, up to $500 of unspent funds in excess of $500, may be returned to participants if preventive services are completed. o The individual controls account spending with a debit card. o The account covers only approved plan benefits provided by health plan providers.
Application to Texas – Advantages & Disadvantages:	**Advantages**: **HSAs** • HSAs are designed to encourage consumers to become more aware of health care costs and more responsible for their health care decisions. This may lead to reduced health care costs. • HSAs may be a good option for employers that want to contribute to their employees' health care but are not able to cover the full cost of traditional health insurance. • HSAs may be a good option for healthy individuals who do not anticipate using many health care services. • HOAs allow for some portion of unutilized funds in the account to be used by the enrollee for other purposes. **HOAs** • HOAs may promote personal responsibility and consumer-driven decision-making processes regarding health care. • Enrollees may be more prudent in accessing health care services, particularly if states require out-of-pocket deductibles by beneficiaries. • HOAs may be a good option for healthy individuals who do not anticipate using many health care services. • Enrollees can use HOA funds to pay for non-Medicaid health services. • Enrollees can use non-Medicaid providers, who may be reimbursed at up to 125 percent of the Medicaid rate. • Enrollees can use up to 75 percent of funds in the account for up to three years

Strategy	Health Savings Accounts and Health Opportunity Accounts
	after they lose Medicaid eligibility for certain expenses, including non-health related costs such as workforce training and tuition. • If enrollees are required to pay deductibles out-of-pocket to use the account, savings may accrue to the state (although savings may be offset by additional expenditures required to implement HSAs). **Disadvantages**: **HSAs** • To avoid paying deductibles, enrollees in HSAs may delay or avoid necessary health care, thereby potentially leading to increased costs for later interventions and poor health outcomes. • A survey by the Employee Benefit Research Institute and Commonwealth Fund found that enrollees in HSAs tend to be less satisfied with their health plan overall than enrollees in more comprehensive health plans and are less likely to recommend the health plan to a friend or colleague.[vi] • HSAs, combined with high-deductible health plans would result in higher out-of-pocket payments than traditional insurance options for people with chronic health conditions. • HSAs, combined with high-deductible health plans may encourage adverse selection, which may lead to increased insurance costs as healthier individuals leave the traditional insurance market.[vii] **HOAs** • If enrollees are required to pay deductibles, they may be less likely to participate. The DRA requires participation in HOAs to be voluntary. • HOA-funded deductibles or deductibles required above the state funded amounts may result in enrollees avoiding or delaying preventive care or necessary medical care. This may result in poor health outcomes, and higher medical costs in the traditional Medicaid program once enrollees have expended their HOAs. (However, the DRA does allow states to implement incentives for enrollees to use preventive services, such as additional account contributions for individuals demonstrating healthy prevention practices.) • The Congressional Budget Office estimates that over the five-year period Fiscal Year 2007-2011, HOA demonstrations will result in a $56 million increase in federal Medicaid spending. Cost increases might result from several factors including 1) benefits that enrollees can access once Medicaid eligibility expires, 2) higher reimbursement rates allowed for non-Medicaid providers, 3) non-Medicaid services that could be used by enrollees, and 4) state administrative expenses to establish and maintain HOA programs. • Implementation of HOAs will require significant systems and administrative changes and related costs to implement and maintain the accounts and establish an additional model of care in Medicaid.

<table>
<tr><td>Strategy</td><td colspan="8">Health Savings Accounts
and Health Opportunity Accounts</td></tr>
<tr><td></td><td colspan="8">• A primary goal of HOAs is to influence consumer health care choices by encouraging consumers to become more aware of health care costs. However, because health cost information is often difficult for consumers to access, this goal may go largely unrealized.
• Because beneficiaries can access traditional Medicaid if they expend the funds in the HOA, there may be a diminished incentive to manage HOA accounts compared to private sector HRA or HSA accounts.</td></tr>
<tr><td rowspan="3">Meets Medicaid Reform Goal(s):</td><td>Cost Reduction or Avoidance</td><td></td><td>Maximizes federal funds</td><td></td><td>Improves Program Sustainability</td><td></td><td>Consumer Choice/ Responsibility</td><td>X</td></tr>
<tr><td>Reduces Number of Uninsured</td><td>X</td><td>Supports Private Market Coverage</td><td>X</td><td>Improves Quality</td><td></td><td>Improves Access</td><td></td></tr>
<tr><td>Benefit Options</td><td>X</td><td colspan="6"></td></tr>
<tr><td>Populations Affected:</td><td colspan="8">HSAs
According to a survey conducted by the Kaiser Family Foundation and the Health Research and Educational Trust Employer Health Benefits Survey released September 26, 2006, about 4 percent of insured workers are enrolled in a CDHP, compared to 60 percent in a preferred provider organization and 20 percent in a health maintenance organization.

Fifty-three percent of employees enrolled in an HSA-eligible plan and 24 percent of employees enrolled in an HRA plan were not offered a choice of plans by their employer. When workers do have a choice of a CDHP and at least one other health plan, 19 percent of the 8.9 million employees chose a CDHP in 2006.

HOAs
Most children, pregnant women and healthy adults would be eligible to participate in an HOA program.

<u>Limitations and Exclusions:</u>
According to the DRA, the number of individuals with an HOA also enrolled in a managed care organization (MCO) may not exceed 5 percent of the total number of individuals enrolled in the MCO. Additional parameters on eligibility and participation in HOAs include the fact that participation is voluntary and re-enrollment into an HOA is disallowed for one year if the enrollee loses eligibility to participate in the HOA for any reason.

The DRA specifies that the following groups are not eligible to participate in a HOA program:
o Individuals who are 65 years or older.
o Individuals who are blind or disabled.
o Individuals who are eligible for medical assistance only because they are (or were within the last 60 days) pregnant.
o Individuals who have been eligible for medical assistance for a continuous period of less than three months.</td></tr>
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Strategy	Health Savings Accounts and Health Opportunity Accounts
	o Individuals who are dual eligibles. o Individuals who are institutionalized. o Individuals who are terminally ill. o Individuals who are medically frail and have special needs. o Beneficiaries qualifying for long-term care services. o Children in foster care and children receiving adoption assistance. o Women in a breast and cervical cancer program. o Limited services beneficiaries.

General Revenue Impact:	HHSC anticipates a cost to General Revenue for implementation of an HOA pilot in the Texas Medicaid Program. Costs are anticipated in the following areas:
	• Administrative:
	  • Systems and program changes in eligibility processes to outreach to potential HOA enrollees and track eligibility, including changes in the event enrollees expend all funds in their HOAs and become eligible for traditional Medicaid programs and changes to recognize continued eligibility for the HOA even if the enrollee loses Medicaid eligibility.
	  • Systems and program changes to establish and monitor accounts, including account balances should enrollees lose Medicaid eligibility.
	  • Systems and program changes in billing and payment processes to providers, including payment to non-Medicaid providers and for non-Medicaid services.
	  • Systems and program changes to account for differing capitation payments and program requirements for HOA enrollees also participating in a health maintenance organization.
	• Medical:
	  • Reimbursement for non-Medicaid providers up to 125 percent of Medicaid costs.
	  • Reimbursement for allowable non-Medicaid services.
	  • Payment for tuition, workforce training, or private health insurance coverage after enrollees lose Medicaid coverage.
	Some savings to General Revenue could result if the state chose to implement deductibles of up to 10 percent that enrollees would be required to pay out-of-pocket. However that would require implementation of a state policy that adults would pay $250 before accessing regular Medicaid benefits, and children's families would have to pay $100 per child before being able to access regular Medicaid benefits.
	
	Note: A cursory review of all claims data (including drugs and dental) for fee for

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<tr><td></td><td colspan="6">service, Primary Care Case Management and managed care shows that FY2005 average cost per client per month was approximately $440 ($5,280/yr) for adults and $168 ($2016/yr) for children.[1]</td></tr>
<tr><td rowspan="2">Other Considerations</td><td colspan="2">Stand Alone Option</td><td>X</td><td colspan="2">This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
<tr><td colspan="6">Although HSAs and HRAs are products for private insurance enrollees, they could be considered as a component of a premium assistance program should the state decide to pursue waiver initiatives to reduce the rate of uninsurance.</td></tr>
<tr><td rowspan="4">State and Federal Approval(s) Required:</td><td rowspan="3">Federal</td><td>1115 Waiver (CFHPs could be an option for employer-sponsored coverage if a premium assistance program is included in Medicaid reform efforts)</td><td>X</td><td rowspan="3">State</td><td>Rules</td><td></td></tr>
<tr><td>Other Waiver(s), [LIST]</td><td></td><td>Legislation</td><td></td></tr>
<tr><td>State Plan Amendment</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="6"><u>Affected Stakeholders</u>
HSAs
• Uninsured individuals
• Employers
HOAs
• Medicaid eligibles
• Medicaid consumer groups and consumers will likely oppose any HOA demonstration that includes out-of-pocket deductibles for enrollees.
<u>Systems and Resource Considerations</u>
• If a premium assistance program were pursued, there would be systems and administrative changes required to implement and maintain the program. Although the state would rely on employers or individuals to enroll in CDHPs, state eligibility staff would need to be trained about these options.</td></tr>
</table>

[i]. Kaiser Family Foundation, "*2006 Employer Health Benefits Survey,"* September 26, 2006.
[ii] United States Government Accountability Office (GAO), *Consumer-Directed Health Plans; Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, April 2006.
[iii] National Conference of State Legislatures, "*2004 – 2006 State Legislation on Health Savings Accounts and Consumer-Directed Health Plans*," November 13, 2006, p. 2.
[iv] Center on Budget and Policy Priorities, *"Last Minute Addition to Tax Package Would Make Health Savings Accounts More Attractive as Tax Shelters for High-Income Individuals,"* December 7, 2006.
[v] Kaiser Family Foundation, *"Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models."*

[1] Information provided by David Wilkes, Rudd & Wisdom, December 20, 2006.

[vi] Employee Benefit Research Institute and Commonwealth Fund, *"Consumerism in Health Care Survey, 2006: Early Experience with High-Deductible and Consumer-Driven Health Plans," December 2006.*
[vii] Kaiser Family Foundation, *"Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models."*