Health Savings Account Pilot Report: Cost-Effectiveness and Feasibility Analysis

Prepared by the Texas Health and Human Services Commission

May 2008

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Executive Summary

S.B. 10, 80th Legislature, Regular Session, 2007, requires the Texas Health and Human Services Commission (HHSC) to develop and implement a Medicaid Health Savings Account (HSA) pilot program if it is determined to be feasible and cost effective. HSAs have received considerable attention as a tool for increasing recipients' "ownership" of their health care. The key goal of HSA–like strategies is typically to reduce utilization of unnecessary services by providing consumers with a financial stake in their health care. As states pursue health-care reform, some have developed, or are considering, HSA-like options as a means of spreading responsibility for health-care decisions to Medicaid enrollees and traditional payers, as well as to help public sector enrollees become more prudent users of health-care services.

Per S.B. 10, HHSC contracted with Health Management Associates (HMA) to evaluate the cost effectiveness and feasibility of implementing an HSA pilot for the state Medicaid population using either the authority granted by the federal Deficit Reduction Act of 2005 (DRA), or through a waiver under Section 1115 of the Social Security Act.[1]

The goal of the analysis was to determine if an HSA pilot could be cost effective, by comparing the necessary administrative and medical costs to develop and sustain the pilot against the savings (e.g., lower utilization of unnecessary services), that could result from an HSA model. The analysis also took into account the feasibility of an HSA pilot, given the requirements under federal and state law, as well as the structure and demographics of Texas' Medicaid program.

State and Federal Requirements

In order to establish an HSA (or a Health Opportunity Account (HOA), if using DRA authority), HHSC must comply with certain state and federal requirements that include specific guidelines. Section 4 of S.B. 10 amends Chapter 531.0941 of the Government Code to require HHSC to develop and implement a Medicaid HSA pilot program consistent with federal law if it is determined that the program would be cost effective and feasible. S.B. 10 lays out certain parameters regarding establishing an HSA pilot, including:

- Excluding children from participation.
- Requiring voluntary participation in the program.
- Requiring that a recipient who participates in the pilot program may, at the recipient's option, discontinue participation in the program and resume receiving benefits and services under the traditional Medicaid program.

[1] The DRA allows states to establish HOAs, which function similarly to HSAs. Where this report refers to HSAs under DRA authority, it is referencing these HOAs.

After taking into account federal and state requirements for implementing a Medicaid HSA pilot, the eligible population becomes somewhat limited. With limits on the eligible population, there is an increased difficulty of having pilot participation large enough to achieve the savings necessary to offset the required administrative expenses.

If HHSC were to implement an HSA pilot for Medicaid enrollees, there are two options that can be used to secure federal approval to obtain federal financial participation for the costs of the pilot. Texas could apply for a Medicaid State Plan Amendment (SPA) using new authority granted under the DRA, or seek a Section 1115 waiver.

Of the two options, developing an HSA pilot program under DRA authority is more prescriptive, in that the DRA contains numerous limitations and requirements regarding the structure of the program, which serve to limit the size of the eligible population and increase the cost of the pilot due to certain administrative requirements. The DRA excludes the following categories of participants:

- pregnant women,
- people with disabilities or who are medically frail,
- people aged 65 or older, and
- people who have been on Medicaid less than three months.

The DRA also requires states to utilize certain technological resources, such as electronic withdrawals, that Texas currently does not employ.

HHSC could also develop an HSA using waiver authority, which is significantly less prescriptive than DRA authority, particularly in regards to the eligible population. A key benefit of waiver authority would be the ability to include newly eligible Medicaid enrollees in the HSA pilot and to be able to avoid some of the administrative requirements of the DRA. If a pilot were developed under waiver authority, the model would still adhere to state requirements in ensuring that participation is voluntary and that children are excluded.

How Would an HSA Work?

The cost-effectiveness analysis was based on various assumptions about how a Texas HSA pilot would be designed for Medicaid enrollees. The analysis assumed a set of design features that are believed to be sound from the standpoint of managing an enrollee's health care and which are consistent with state law and likely to achieve federal approval.

The HSA pilot would be voluntary and limited to healthy adults who are current Medicaid enrollees. The state would contribute an amount (the model assumes a state contribution of $2,000) to an enrollee's account to be used for approved health-care expenses. Enrollees would be required to pay a deductible, based on a percentage of the state's contribution, and set to be approximately $50 per year. Unused account balances would carry forward to following years,

and the state would contribute the funds necessary to bring the account up to $2,000, but the account balance would never exceed $2,000.[2]

When participants use the full amount of the state's contribution and have met their deductible, they would return to traditional Medicaid. In order to prevent the situation of an enrollee electing to participate in the HSA pilot, but then not having the funds to pay the deductible that would allow them to return to Medicaid, enrollees would be required to pay the deductible up front to participate. Thus, a participant is not enrolled in the HSA until the deductible is paid. Once the participant pays the required deductible, they can use the HSA for allowable medical expenses. State contractors would manage the HSAs and conduct other administrative activities, such as outreach and enrollment.

In order to model the cost effectiveness of an HSA, a hypothetical benefits package was assumed. This hypothetical package was selected to emphasize primary and preventative care. Under the assumed benefits package, allowable medical expenses that could be paid from the participant's HSA would include all of those services currently reimbursable by Texas Medicaid for the adult population, as well as some additional "enhanced" services (e.g., dental), which would serve both as an incentive for enrollees to participate in the pilot and which may delay their return to traditional Medicaid. The benefit package would consist of all the benefits in the traditional Medicaid package (including any existing limitations or prior authorization requirements), as well as the following:

- Dental benefits – preventive and therapeutic services, up to $500 per 12-month period.
- Tobacco cessation programs – up to $300 per 12-month period.
- Weight loss programs – up to $300 per 12-month period.
- Marriage counseling/parenting "workshops" – up to $300 per 12-month period.

Additionally, in order to help ensure that participants seek necessary preventive care, the following services would be considered "first dollar" coverage and would not be paid from a participant's HSA:

- one well visit/annual exam per 12-month period and
- three prescriptions per month.

Other than the "first dollar" coverage listed above, any covered medical service used would be paid from a participant's HSA. Once the participant exhausts their HSA, they revert back to traditional Medicaid.

[2] Under DRA authority, states are only eligible for federal financial participation for HSA contributions for adults for up to $2,500 per year. For the purposes of developing this cost-effectiveness model, a state contribution of $2,000 was assumed. Texas could choose to increase this contribution up to $2,500 if using DRA authority to implement an HSA; under waiver authority, the maximum amount eligible for federal match would be determined as part of the waiver negotiations.

Findings

Feasibility

The DRA requires states to include various parameters if they establish an HOA.[3] These include the DRA's lock-in provision, which requires that enrollees be "locked in" to an HOA for 12 months, except in cases of hardship. This requirement conflicts with the provision in S.B. 10 that allows enrollees to revert to Medicaid at their discretion. The DRA also requires states use electronic withdrawals, a function that Texas does not currently utilize in its Medicaid program and which would add significantly to the administrative expenses necessary to develop the program. Finally, the DRA also requires states retain any unused funds in an enrollee's HOA for three years to pay for, at a minimum, health insurance premiums. This requirement, like the requirement for electronic withdrawals, would add to the administrative expenses associated to establish an HOA pilot using DRA authority.

Additionally, HOAs established under the DRA include constraints (e.g. excludes individuals who are pregnant, disabled, or who have been enrolled in Medicaid for fewer than 3 months) on which individuals are eligible to participate. When children are excluded from the population as well, the statewide eligible population becomes small – approximately less than 56,000. Since both the DRA and S.B. 10 require that participation be voluntary, only a subset of these individuals could be expected to elect to enroll.

Under Section 1115 waiver authority, fewer constraints would apply to eligible populations. However, federal approval of certain populations for an HSA pilot using 1115 authority might be difficult to obtain. In particular, it would likely be challenging to secure federal approval for inclusion of people with disabilities or pregnant women. However, including individuals new to Medicaid (a population prohibited by the DRA), would expand the eligible population and make the enrollment of individuals more efficient. Additionally, waiver authority would allow the state to avoid some of the administrative expenses, such as electronic withdrawal capabilities, that must be present under the DRA. The process of applying for a waiver is more cumbersome and likely to take longer than the Medicaid SPA process, which is the vehicle for implementation of HOAs under the DRA; however, waiver authority would more than likely provide the state with more flexibility.

Cost effectiveness

As a result of the feasibility challenges associated with the DRA, the cost-effectiveness analysis assumed that the HSA pilot would be developed using waiver authority. This allowed for a larger eligible population (by including individuals new to Medicaid) and avoided administrative expenses required by the DRA (e.g. electronic withdrawal capability). The analysis also assumed that the pilot would be located in an area with approximately 800 individuals eligible to participate in the pilot. This figure is based on a review of various regions where there was the highest concentration of Medicaid enrollees who fit the eligibility criteria for a Texas HSA pilot.

In strictly monetary terms, the state would pay substantially more to develop and operate an HSA pilot than it would pay for the same individuals under traditional Medicaid. To highlight why

[3] As noted previously, HOAs established under DRA authority are essentially Medicaid HSAs.

developing and operating an HSA pilot is not cost effective compared to traditional Medicaid, the analysis evaluated cost effectiveness from three vantage points:

- The total cost of implementing and operating an HSA pilot over the entire five-year period compared to traditional Medicaid.
- The average per member per month (PMPM) cost of an HSA pilot compared to traditional Medicaid.
- The cost of the state's contribution to an enrollee's HSA account, compared to PMPM costs for similar enrollees in traditional Medicaid.

Both total costs and PMPM costs for implementing and administering an HSA are greater than what the state would pay under traditional Medicaid, largely due to the significant start-up and operating costs associated with developing an HSA pilot. However, another way to evaluate the cost effectiveness of an HSA would be to put aside the issue of start-up and operating costs, in order to evaluate the program's effects independent of the costs associated with developing a new program and running an additional administrative structure on top of the existing Medicaid program. This analysis considered only the state's contribution to an enrollee's HSA in comparison to the PMPM costs the state would pay for that individual in the traditional Medicaid program. Under this type of an analysis, an HSA would be more cost effective than traditional Medicaid, *but only if* the associated start-up and administrative costs are not taken into consideration.

The total costs of the HSA pilot, for the five years included in the model, ranged from $8.2 million in all funds ($3.5 million in general revenue) to $8.3 million in all funds ($3.6 million in general revenue), depending on the degree of declines in unnecessary utilization of services. In either case, the total costs of the pilot exceeds the costs of providing traditional Medicaid services to the same group of individuals, which is estimated to cost $2.3 million in all funds ($937,070 in general revenue) for the five-year period.

HSA Pilot Costs, All Funds

	Start-Up Costs	2009	2010	2011	2012	2013	Total
Number of Pilot Participants	N/A	56	72	88	104	120	
Administrative Costs	$6,507,005	$59,120	$66,098	$73,075	$80,052	$87,030	$6,872,380
Medical Costs	$0	$174,384	$231,048	$291,482	$354,319	$420,463	$1,471,697
Total Administrative and Medical Costs	$6,507,005	$233,504	$297,146	$364,557	$434,371	$507,493	$8,344,077
Total Savings	N/A	$5,600	$14,400	$17,600	$31,200	$48,000	$116,800
Net Costs	**$6,507,005**	**$227,904**	**$282,746**	**$346,957**	**$403,171**	**$459,493**	**$8,227,277**

Notes:

- Assumes a five-year pilot, from 2009-2013.

- Pool of eligible pilot participants of approximately 800 eligible individuals, with participation rates increasing from 7 percent in 2009 to 15 percent in 2013.
- Medical expenses include annual state contribution of $2,000 and first dollar coverage of annual physical and three prescriptions per month.
- Administrative costs include outreach and enrollment, account maintenance, and necessary system and technology changes.
- Savings shown above is the maximum savings scenario, which assumes declines in utilization starting in year one and by year five achieving a 15 percent decline in need for state contribution to fund enrollee's account.

HSA Pilot Costs, General Revenue

	Start-Up Costs	2009	2010	2011	2012	2013	Total
Number of Pilot Participants	N/A	56	72	88	104	120	
Administrative Costs	$2,842,253	$29,560	$33,049	$36,538	$40,026	$43,515	$3,024,940
Medical Costs	$0	$70,573	$93,505	$117,963	$143,393	$170,161	$595,596
Total Administrative and Medical Costs	$2,842,253	$100,133	$126,554	$154,501	$183,419	$213,676	$3,620,536
Total Savings	N/A	$2,266	$5,828	$7,123	$12,627	$19,426	$47,269
Net Costs	**$2,842,253**	**$97,867**	**$120,726**	**$147,378**	**$170,792**	**$194,250**	**$3,573,267**

Notes:

- FMAP for medical costs assumes 2009 FMAP of 40.47 percent.
- Administrative costs are matched at 50 percent, except for hardware costs, which are eligible for 75 percent match.

Traditional Medicaid Costs

	2009	2010	2011	2012	2013	Total
Number of Enrollees	56	72	88	104	120	
Weighted PMPM	$386.69	$406.48	$428.58	$452.19	$477.43	
Total Member Months	672	864	1,056	1,248	1,440	5,280
Total Cost, All Funds	**$259,856**	**$351,199**	**$452,580**	**$564,333**	**$687,499**	**$2,315,467**
Total Cost, General Revenue	**$105,164**	**$142,130**	**$183,159**	**$228,386**	**$278,231**	**$937,070**

Notes:

- PMPM is based on the anticipated PMPMs for 2009-2013 for the eligibility groups able to participate in the pilot, weighted according to size of the group.

- FMAP for medical costs assumes 2009 FMAP of 59.53 percent.

Looked at another way, the average PMPM during the five-year period is $439 (all funds) for traditional Medicaid, compared to $1,558 (all funds) in the HSA pilot. These findings are summarized in the table below:

Summary of Health Savings Account Pilot Costs Compared to Traditional Medicaid SFY 2009-2013, All Funds

	Total Cost	Total Member Months	Cost Per Member Month
Traditional Medicaid (Business as Usual)	$2,315,467	5,280	$439
HSA Pilot, Aggressive Utilization Declines	$8,227,801	5,280	$1,558

Discussion

The first and most logical question that should be asked of the analysis is "Why does the HSA cost so much more than traditional Medicaid, for essentially the same people?" The main contributor to the cost of the HSA is the administrative costs. The bulk of these costs are "fixed" costs to pay for necessary technology and system changes. These costs would be the same whether the program had enrollment of one or one million participants. Since the number of anticipated program participants is relatively small, the administrative costs cannot be spread across a large population and thus account for a significant portion of the pilot's per person costs.

The medical costs also contribute to the overall cost of the pilot. Unlike administrative costs, which have to be incurred in order to develop and maintain the pilot, some portion of the medical costs could be avoided if the state chose to do so. Specifically, these are the costs associated with providing HSA participants "first dollar" coverage for an annual physician visit and three prescriptions per month, benefits offered to traditional Medicaid clients and intended to ensure enrollees did not delay or avoid necessary care. It would be possible for the state to either eliminate these optional medical costs or to scale them back. However, even if all of these "optional" medical costs are eliminated, the HSA pilot still would cost considerably more than traditional Medicaid, given the start up administrative costs.

PMPM Costs vs. HSA Contribution

Another way to consider the cost effectiveness of the HSA pilot is to look solely at the state's contribution to the enrollees' HSAs in comparison to what the state pays for traditional Medicaid members in terms of PMPM costs. For example, the weighted PMPM for the Medicaid populations eligible to participate in the HSA pilot in 2009 is $386.69, or $4,640.28 per year (all funds). While this is more than the $2,000 contribution the state would make to a pilot participant's HSA, the difference is quickly overshadowed by the required administrative costs of the pilot.

Intangible Benefits

While the analysis did not show an HSA pilot to be cost effective in strict monetary terms, there are other intangible benefits that might occur as a result of an HSA pilot that should be considered. These possible benefits are:

- Improved health status for enrollees. Since the HSA would include certain enhanced benefits, such as dental care, enrollees' access to these benefits, as well as any health promotion and education that they might get as a result of participating in the pilot, could be expected to improve their overall health status. That improvement in health status would clearly benefit the individual and their family. However, the small size of the pilot makes it highly unlikely that any reduction in costs that accompanied their improved health status once (and if) they returned to traditional Medicaid would translate into lower Medicaid PMPM costs in the future.
- Greater awareness of costs and ability to navigate private sector coverage. HSA pilot participants would be expected to take a greater interest in understanding the costs of health care and seeking to manage their care to retain their account balances. This increased cost awareness could help better prepare recipients to navigate commercial insurance if and when they left the Medicaid program and were able to secure private health insurance. The degree to which participants would actually have control over their health-care costs depends to a large degree on the program's design. In a model where Medicaid continued to pay for services at established rates, participants would not have the ability to select a service based on cost. However, enrollees would be expected to gain an awareness of cost by virtue of monitoring their account balances.
- Increased knowledge of the low-income population's needs and patterns of health-care utilization. The HSA pilot could provide HHSC with information about recipients' needs and interests in certain types of benefits, specifically those "enhanced" benefits (e.g., dental care, smoking cessation, marriage counseling). This information could inform various reform efforts Texas is considering or future decisions on changes to the Medicaid benefit.

Conclusion

This analysis evaluated the cost effectiveness of a small, regional, HSA pilot. The analysis found that implementing an HSA pilot for the currently eligible Medicaid population, regardless of the type of federal authority used, would not be cost effective. The lack of cost effectiveness rests largely with the significant start-up and administrative costs associated with implementing a new program, and with the fact that the pilot size is small, minimizing the ability to offset costs with savings. Additionally, the analysis found that the constraints of the DRA make waiver authority a more feasible option for pursuit of an HSA.

However, it should be noted that the findings of this analysis are limited to the establishment of a small HSA pilot for the currently eligible Medicaid population. If Texas were to develop an HSA for a much larger population, perhaps including a Medicaid expansion population, it is more likely cost effectiveness could be achieved, since the fixed costs would be spread across a larger group of individuals. Thus, while a small, regional, HSA pilot would not be cost effective, an HSA-type model may have benefit for Texas if applied to a much larger population, where

costs can be more broadly distributed and where the population is large enough to generate savings sufficient to off-set costs.

Introduction

Under an approach commonly referred to as "consumer driven" health care, health savings accounts (HSAs) have received considerable attention as a tool for increasing recipients' "ownership" of their health care. The driving force behind developing HSA–like strategies is typically to reduce utilization of unnecessary services by providing consumers with a financial stake in their health care. As states pursue health-care reform, some have developed, or are considering developing, HSA-like options as a means of spreading responsibility for health-care decisions to enrollees and traditional payers, as well as to prepare public sector enrollees to become more prudent users of health-care services.

Like many states, Texas is exploring options for Medicaid reform. As a part of this process, the Texas Health and Human Services Commission (HHSC) contracted with Health Management Associates (HMA) in September of 2007, to evaluate the cost effectiveness and feasibility of implementing an HSA pilot for current Medicaid recipients. HHSC sought this analysis as a result of Section 4, S.B. 10, 80th Legislature, Regular Session, 2007, which requires HHSC to implement an HSA pilot for Medicaid recipients if it is determined to be both cost effective and feasible.

HMA was charged with the task of determining the cost effectiveness and feasibility of implementing an HSA using either the authority granted by the federal Deficit Reduction Act of 2005 (DRA), or through a waiver under Section 1115 of the Social Security Act.[4] The goal of the analysis was to determine if an HSA pilot could be cost effective, by comparing the necessary administrative and medical costs to develop and sustain the pilot against the savings that could result from an HSA model. The analysis also took into account the feasibility of an HSA pilot, given the requirements under federal and state law, as well as the structure and demographics of Texas' Medicaid program. Finally, the analysis considered some of the less tangible effects of an HSA pilot that, in addition to the direct costs and benefits, may also influence Texas' decision about whether and how to pursue an HSA pilot.

Health Savings Accounts and High Deductible Health Plans in the Private Market

Overview

Health Savings Accounts (HSAs) have been promoted as a fundamental part of the Bush Administration's plan for health-care reform within the private market. The general premise

[4] The DRA created a demonstration program to allow ten states to deliver Medicaid benefits through a Health Opportunity Account (HOA) combined with a high deductible health plan (HDHP). The financial structures of these accounts have several parallels to the private market HSAs. States may also use waiver authority to implement an HSA. While a waiver requires the program be budget neutral and typically involves lengthy discussions with the Centers for Medicare and Medicaid Services (CMS), pursuing a waiver rather than an HOA demonstration could provide a state with greater flexibility with the requirements of the DRA statute, which significantly limit the eligible population, require that the program be voluntary, and set specific caps on the account balances.

behind HSAs is that individuals with greater control over expenditures will pay closer attention to the cost of services, reduce unnecessary utilization of services, and compare prices of services, all of which would be expected to lead to lower overall health-care costs and therefore lower premiums.

The Medicare Modernization Act of 2003 provided a tax advantage to enrollees using an HSA paired with a high deductible health insurance plan (HDHP). All contributions and withdrawals from an HSA are tax exempt, as long as they are spent on approved health-care expenses, while withdrawals spent on non-health related costs are subject to higher taxes. In order to be eligible for tax exemption, HSAs must be accompanied by an HDHP. In 2007, the minimum deductible was $1,100 for individuals and $2,200 for families. (These minimum deductibles apply regardless of the individual's or family's income. Thus, those with high incomes take on less risk than those with lower incomes.) Maximum out-of-pocket expenses are capped at $5,500 for individuals and $11,000 for families.

Both employees and employers can contribute to an HSA and money deposited is usually invested, with the expectation that funds will increase over time. Interest that accrues on an HSA is not taxed. Annual contributions to HSAs are limited – in 2007, deposits were limited to $2,850 for individuals and $5,650 for families.

Rate of Adoption

The degree to which HSAs can be expected to yield any meaningful savings to health-care costs overall is fundamentally tied to the rate at which eligible individuals elect to participate. A survey in 2006, by the Kaiser Family Foundation, found that 19 percent of workers chose an HDHP with an HSA (or HSA-like option) when offered a choice of different types of plans.[5] Additionally, information from the Government Accounting Office found similar rates of adoption in the private insurance market. Data from three large, multi-state insurance carriers that offered employees a plan with HSA-like options along with other more traditional insurance options showed that 17 percent chose the HSA-type plan.[6]

Effect on Premium Cost

HSAs have been shown to have lower premium costs compared to more traditional types of insurance coverage, but there is evidence that these lower costs are achieved in part because the population participating in HSAs is healthier and the lower premiums entail enrollees assuming greater risk for potentially paying out large amounts for uncovered expenses. The Kaiser Family Foundation survey found that in 2006, the average HSA-eligible plan premium was about $1,100 less for an individual and $3,000 less for a family than the average premium of a traditional health plan.[7] While employees paid slightly less in premiums (employers typically accrued more

[5] Health Employer Benefits, 2006 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust, 2006.
[6] General Accounting Office, as cited in "Health Savings Accounts and High-Deductible Health Plans" Bell Policy Center, Issue Brief No. 8, August 29, 2007.
[7] "Health Savings Accounts and High-Deductible Health Plans" Bell Policy Center, Issue Brief No. 8, August 29, 2007.

of the savings when HSA-type arrangements were used), they took on significantly greater risk. Individuals with HSA-eligible health plans reported spending more on health care than people with traditional insurance and were more than twice as likely to spend 10 percent or more of their income on premiums and out-of-pocket insurance.[8] Several surveys have shown that people choosing HSAs are healthier than the population enrolled in traditional insurance.[9] Thus, lower premiums may be driven not just by the structure of HSAs but also by the fact that healthier enrollees tend to use less care and are therefore less expensive to insure.[10]

Effect on the Insurance Market

Given the likelihood of having to meet deductible requirements if significant health-care needs occur, it makes sense that generally healthy people would be more attracted to an HSA plan. If this attraction to HSAs continues for the healthier individuals, there are clear implications for the cost of other types of health insurance coverage. Because health insurance is based on the concept of pooled risk, any situation that removes healthy (i.e., less costly) individuals from the risk pool will eventually lead to higher costs for those individuals left in the pool. Thus, if HSAs attract a disproportionate number of healthier individuals, premiums for traditional insurance coverage would become more expensive as the pool of covered individuals has fewer healthier people across which to spread risk.

Appropriateness for Low-Income Population

The general structure of HSAs often puts them out of reach of many low-income individuals (having incomes less than 200 percent of the federal poverty level, or FPL). Since the required minimum deductible for an individual with an HDHP is $1,100, regardless of income, low-income individuals must take on relatively greater risk to enroll in an HDHP than high income families. Additionally, the tax advantage of HSAs is generally absent for most low-income families. According to data from the U.S. Department of the Treasury, a family of four with an income of $20,000 would not receive any benefit from contributing to an HSA.[11] (If an HSA were applied to current Medicaid beneficiaries in Texas, 94 percent of whom have incomes of less than 100 percent FPL, very few, if any, individuals would realize any tax advantage from participation in an HSA.)

Low-income populations are also more likely than higher-income populations to experience adverse effects on their health status due to increased cost sharing requirements. The seminal research on this issue was conducted by the RAND Corporation in 1974. The RAND studies found that, overall, when people were required to spend more of their own money on their health

[8] "Early Experience with High Deductible and Consumer Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006" Paul Fronstin of EBRI and Sara Collins of the Commonwealth Fund, December 2005.
[9] "Health Savings Accounts and High-Deductible Health Plans" Bell Policy Center, Issue Brief No. 8, August 29, 2007.
[10] "Early Experience with High Deductible and Consumer Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006" Paul Fronstin of EBRI and Sara Collins of the Commonwealth Fund, December 2005.
[11] "Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?" Catherine Hoffman and Jennifer Tolbert, Kaiser Commission on Medicaid the Uninsured, October 2006.

care, they received less care and spent less money, but they had the same health outcomes as people with less cost sharing. However, low-income individuals with high levels of cost-sharing had higher mortality rates than those with free care, suggesting that this segment of the population may be particularly vulnerable to delaying or altogether failing to receive recommended care due to increases in the cost of care. Researchers since have noted that this negative effect of cost-sharing on low-income populations could be minimized by exempting key services, such as annual screenings, from cost sharing requirements.[12]

Policy Considerations

HSAs and HDHPs are a growing, although still small, segment of the insurance market, and have generated significant interest as a tool to reduce health-care costs and possibly expand access to health insurance. While these plans have been shown to lower premiums, two policy issues need to be carefully weighed prior to promoting HSAs and HDHPs as a key component to health-care reform efforts. First, the health status of low-income individuals may be adversely affected if certain design features (such as first dollar coverage for preventive care) are not part of the plan structure. Second, if HSAs continue to attract an overall healthier population, this segmenting of the insurance market could lead to higher premiums in other types of coverage options.

State policy makers are looking at ways to customize the underlying principles behind an HSA (e.g., incentivizing cost-consciousness and individual control over health-care decisions) into public sector solutions. These concepts are still very new, but bear consideration as a possible mechanism by states to address the problem of the uninsured. Structuring HSAs and HDHPs in a way that does not deter low income individuals from seeking necessary preventive and therapeutic services will be a key issue in the effectiveness of these public models.

Federal and State Laws and Regulations Affecting Health Savings Accounts

The two principal authorities states may use to pursue HSA-like models for the public sector (e.g., Medicaid or the uninsured population) are either the DRA or an 1115 waiver. While an 1115 waiver can be used for redesigning the Medicaid plan for current Medicaid recipients or to expand the Medicaid plan to those who are uninsured, the option to develop an HSA-type model under the DRA via a State Plan Amendment (SPA) is limited to only those clients who have been on Medicaid for at least three months. A comparison chart of the specific elements of the DRA and an 1115 waiver, as they relate to establishing an HSA, can be found on page 17.

Deficit Reduction Act of 2005

The federal DRA of 2005 created a demonstration to test alternative systems to deliver Medicaid benefits through an HOA in combination with an HDHP.[13] The HOA under the DRA uses similar concepts of an HSA in the private market, such as providing incentives for enrollees to pay attention to the cost of care and reducing inappropriate utilization of services. The demonstration program became effective on January 1, 2007.

[12] "Health Savings Accounts and High-Deductible Health Plans" Bell Policy Center, Issue Brief No. 8, August 29, 2007.
[13] This authority exists in section 6082 of the DRA, which adds a new section 1938 to the Social Security Act.

Eligibility/Approval Criteria/Submission Process

Up to ten states will be approved to operate an HOA demonstration during the initial five years of the program (January 1, 2007, through December 31, 2011). Federal approval will be based on a first come, first served model (i.e., will not be competitive). At the end of the five-year period, the Medicaid SPAs approved under the initial demonstration may continue unless the Secretary of Health and Human Services (HHS) finds the program was unsuccessful based on cost effectiveness, quality of care, or other criteria established by the Secretary. All states, including those operating an 1115 statewide demonstration, are eligible to submit proposals. HOA proposals do not have to be statewide. Proposals must meet the following criteria:

- Create patient awareness of the high cost of medical care.
- Provide incentives to patients who seek preventive care services.
- Reduce inappropriate use of health-care services.
- Enable patients to take responsibility for health outcomes.
- Provide enrollment counselors and ongoing education activities.
- Provide transactions to be conducted electronically.
- Provide access to negotiated provider payment rates.

Eligible Populations for HOA Demonstrations

The primary population for HOAs is healthy adults and children. The DRA specifically excludes the following populations from participation in the HOA demonstration during the first 5 years:

- Aged - Individuals who are 65 years of age or older.
- Disabled - Individuals who are disabled, regardless of whether or not their eligibility for medical assistance is based on such disability.
- Pregnant - Individuals who are eligible for medical assistance only because they are (or were within the previous 60 days) pregnant.
- New to Medicaid - Individuals who have been eligible for medical assistance less than 3 months.

Additionally, individuals covered under Section 1937(a)(2)(b) of the Social Security Act (mandatory eligibles) are excluded from participating in an HOA demonstration at any time. Thus, the following individuals are also excluded from HOA demonstrations:

- Those mandatorily eligible for Medicaid, including pregnant women.
- Those who are blind or disabled.
- Those who have dual eligibility for Medicaid and Medicare.
- Those eligible for Medicaid based on institutionalization.
- Those who are medically frail.
- Those qualified for long-term care services.
- Those in foster care and receiving welfare or adoption assistance.
- Those in the breast and cervical cancer program.
- Those with limited service beneficiary.

States can further limit participation in their demonstration programs. Once an individual elects to participate in an HOA, he or she is locked in for 12 months, except in cases of hardship.[14]

Benefit Packages

States may determine the benefit package for HOA participants, within certain limitations. Benefit packages must include services covered under federal Medicaid law; however, states can develop benefit packages that vary from the state's traditional Medicaid program by adding certain optional Medicaid services as an incentive to increase participation. For example, services such a dental care for adults could be added and would likely be of interest to some potential enrollees.

Costs of Health Opportunity Accounts under the DRA

The Congressional Budget Office estimates that over the five-year period of federal fiscal years 2007-2011, HOA demonstrations will result in a $56 million increase in federal Medicaid spending. The predicted cost increases are expected to come 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.[15]

Potential Prohibition on New Health Opportunity Account Demonstration Programs

There have been a number of recent attempts in Congress to prevent states from implementing a demonstration program that includes an HSA/HDHP. Federal legislation reauthorizing the State Children's Health Insurance Program (SCHIP) included a provision prohibiting the initiation of any new health opportunity account demonstration programs as of the date of enactment of the legislation. Both the initial reauthorization bill (H.R. 976), which was vetoed by President Bush, and a subsequent bill (H.R. 3963), which was vetoed December 12, 2007, included the prohibition.

In addition, H.R. 3936 sought to further limit states' ability to expand health coverage through HSAs and/or HDHPs. While the legislation's main intent was to reduce barriers to using SCHIP funds for premium assistance programs, it specifically excluded HSAs and HDHPs from eligibility for premium assistance subsidies.

A summary of additional HOA requirements can be found in Appendix A.

Section 1115 Waiver Authority

[14] State Medicaid Directors' Letter, January 10, 2007, http://www.cms.hhs.gov/smdl/downloads/SMD011007.pdf.
[15] Families USA, *Health Opportunity Accounts, What Are They and Why Should State Advocates Care?* http://www.familiesusa.org/assets/pdfs/dra-hoas.PDF.

Section 1115 of the Social Security Act allows the Secretary of HHS to waive certain aspects of the Medicaid and SCHIP programs to allow states to test innovative approaches to service delivery. Programs approved by the Secretary under Section 1115 authority are referred to as "demonstrations" or "waivers."

Section 1115 waivers provide significant flexibility to allow states to test new policy approaches for delivering Medicaid services. These projects are intended to demonstrate and evaluate a policy or approach before it is implemented on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. Section 1115 waivers can be very limited in scope, such as waivers that provide family planning services to low-income women who would not otherwise qualify for Medicaid, or those that allow certain people with disabilities to manage their health care purchasing. Some Section 1115 waivers are statewide, comprehensive demonstrations that affect the majority of people who receive Medicaid in that state. When Section 1115 came into widespread usage in the early 1990s, many of these waivers required people to enroll in a managed care plan and redirected the resultant savings toward expanding coverage to all state residents with incomes below a certain level. However, the Balanced Budget Act of 1997 enabled states to enact mandatory Medicaid managed care through the State Plan (waivers are only needed in very limited circumstances). As a result, the focus of Section 1115 waivers changed somewhat to be less of a vehicle for managed care.

Section 1115 waivers are generally approved for a five-year period and states may submit renewal requests to continue the project for additional three-year terms. Demonstrations must be "budget neutral" over the life of the project. The budget neutrality requirement means the waiver program cannot cost the federal government more than the state would have spent on Medicaid for people covered by the waiver if the waiver did not exist.

States can use 1115 waiver authority to implement an HSA. (Indiana recently negotiated an 1115 waiver that includes an HSA-type program.) However, the 1115 waiver approval process can be lengthy and usually takes considerable investment of state time to work with CMS and the Office of Management and Budget on both the policy issues and budget neutrality requirements. As a result, states tend not to pursue 1115 authority for program changes when there is a SPA approach that would achieve similar goals.

While states can pursue an HSA-type program under the DRA's HOA provision, the SPA approach under the DRA includes fairly narrow parameters, specifically around eligible populations and the requirement that program participation is voluntary, which may conflict with a state's goal in how they wish to construct their HSA program. In such cases, an 1115 waiver approach could potentially provide more flexibility than what exists under the DRA. However, although there are not specific prohibitions under 1115 waiver authority from including certain populations of current Medicaid recipients, such as people with disabilities or pregnant women, in an HSA-type program, the fact these populations are permanently excluded under the DRA indicates that states would likely encounter federal resistance in including them in an HSA-program under an 1115 waiver.

State Requirements

S.B. 10

Section 4, S.B. 10, 80th Legislature, Regular Session, 2007, amends Government Code 531.0941, to require HHSC to develop and implement a Medicaid HSA pilot program consistent with federal law if HHSC determines the program would be cost effective and feasible. This section of the bill became effective September 1, 2007.

S.B. 10 references the following goals associated with an HSA pilot program: (1) encourage health care cost awareness and sensitivity and (2) promote appropriate utilization of Medicaid services.

S.B. 10 requires HHSC to follow certain requirements in terms of developing an HSA pilot program. These include:

- Allowing only adult recipients in the program (e.g., children are excluded).
- Ensuring participation in the program is voluntary.
- Ensuring that a recipient who participates in the pilot program may, at the recipient's option, discontinue participation in the program and resume receiving benefits and services under the traditional Medicaid program. Individuals choosing to discontinue participation in the pilot program and resume participation under the traditional Medicaid program forfeit any funds remaining in their HSA.

Excluding children from participation and requiring the pilot be voluntary, particularly if paired with the limitations that exist under the DRA, significantly shrinks the eligible population for an HSA. This raises challenges in achieving a large enough eligible population in any particular geographic area in the state that would justify the expenses associated with developing a pilot worthwhile and which would be large enough to draw conclusions that can be generated statewide.

S.B. 10 is silent on whether the participant must have first met his or her deductible before reverting back to traditional Medicaid. This ambiguity can be addressed by implementing a pilot that requires the deductible be paid up front. This strategy would also minimize any false economies that would occur if eligible Medicaid recipients were barred from participating in the Medicaid program due to unpaid deductibles.

Summary of Federal and State Requirements for HSA/HOA

The following chart compares the requirements associated with establishing an HOA under DRA authority and an HSA under 1115 waiver authority. Where relevant, S.B. 10 requirements are also noted, since these requirements would exist in either a DRA or waiver pilot. The chart helps to clarify why the DRA, particularly when combined with state law, is a much less feasible option than using waiver authority if an HSA pilot were to be established.

	Federal Requirements		State Requirements
	DRA	**1115 Waiver**	**SB 10**
Budget Neutrality Requirement?	No	Yes	Cost effectiveness must be met
Available for Non-Medicaid/Uninsured Populations?	No, limited to current Medicaid beneficiaries	Yes (See Indiana example)	Not applicable (N/A)
Conditions for Federal Match	Federal match only available for state contributions	Must be budget neutral	N/A
Deductible Limits	Annual limits of: $2,500 per adult; $1,000 per child	Depends on waiver design, suggested $2,000 per adult	N/A
Can HSA Enrollment be Mandatory?	No	Yes, if approved	No
Can Statewide Requirement be Waived?	Yes	Yes	N/A
What Populations are Excluded?	Excluded populations: • Aged • Disabled • Pregnant • Clients new to Medicaid (< 3 months)	Depends on waiver design	Excludes children
Electronic System for Payments Required?	Yes	No	No
Transfer Back to Medicaid?	Yes, after deductible is met	Depends on waiver design	Yes
MCO Limit?	Yes	No	No
Enrollment Counselors Required?	Yes	No	No

State Examples

There is limited state experience in developing HSA-like options under either DRA or 1115 waiver authority. Two states, Indiana and South Carolina, have each developed programs using an HSA structure. Indiana is using an 1115 waiver to develop a program that combines an HSA and an HDHP for the low-income, uninsured population, while South Carolina is using the DRA to establish HOAs for current Medicaid beneficiaries.

Indiana

Indiana is the first state to have received approval for a large-scale eligibility expansion that uses an HSA coupled with an HDHP as the coverage vehicle. The plan was approved by CMS in December 2007. The Healthy Indiana Plan (HIP), authorized by H.B. 1678 and funded by a tobacco tax, will cover uninsured parents and childless adults with incomes up to 200 percent of FPL. Coverage will be provided through contracted health plans that will provide a state-specified comprehensive benefit package. The plans will also be responsible for administering the HSA-like account, which Indiana refers to as a Personal Wellness and Responsibility (POWER) account. Indiana implemented HIP on January 1, 2008 and expects to cover approximately 130,000 uninsured individuals.

The Indiana program was designed to respond to the major concerns that have historically been raised in conjunction with HSAs for a low-income population – the high cost to consumers and the fact that there may be a disincentive to seek preventive care. The amount of money in each POWER account, which will be used to pay the deductible portion of the cost of health care, will be $1,100. Each enrollee will be responsible for providing a share of the $1,100 on a sliding scale according to income and the state will subsidize the remainder to assure the account is fully funded. In addition, the state will provide $500 in first dollar coverage for preventive care, meaning the deductible does not apply unless the enrollee needs more than $500 in preventive care. This element is designed to eliminate any incentive for the enrollee to attempt to preserve the balance in the POWER account by foregoing preventive services.

The portion of the $1,100 POWER account enrollees will be required to contribute is based on a percentage of family income and will range from two percent to five percent of income. The combined enrollee contribution to the POWER account and emergency room (ER) co-payments will not exceed five percent of family income for parents. Childless adults will pay five percent of their income into the POWER account and may be liable for additional costs to cover ER copayments (which are waived if the individual is admitted).

HIP offers coverage to uninsured individuals using three "layers" of coverage:

- Preventive Care – A minimum of $500 for prevention services such as smoking cessation programs or annual doctor visits.
- POWER Accounts –$1,100 per year for each individual to be used like an HSA to cover health-care costs and to contribute to the health plan deductible.
- HDHP – coverage of a minimum of $300,000 per individual per year with a $1 million lifetime limit.

HIP is authorized under a Section 1115 waiver, rather than through the DRA. There are two key aspects of HIP that support the use of a Section 1115 waiver over a DRA SPA: the eligibility expansion and mandatory use of the POWER account model. Since the DRA requires that HOAs can only be offered to current Medicaid beneficiaries, and only on a voluntary enrollment basis, an 1115 waiver offered a vehicle more in line with the state's goals than the DRA.

Eligible Population

The eligible population for HIP consists of two groups. Both groups are required to be uninsured for at least six months prior to enrollment and may not be eligible for employer-sponsored health insurance. The first eligibility group is composed of parents and other caretaker relatives of dependent children with incomes up to 200 percent FPL. The second eligibility group consists of uninsured childless adults whose income is below 200 percent FPL. Non-disabled adults without dependent children can only be covered under a waiver.

HIP is not an entitlement. Indiana may limit enrollment if funds are not sufficient to cover all the eligible participants. Enrollment will be on a first come, first serve basis. For childless adults, since they are only covered by virtue of the waiver, the state can impose an outright cap on enrollment. Because state plan populations cannot be capped, Indiana will have to amend its state plan if it becomes necessary to cap enrollment of caretaker relatives. Should it become necessary to do so, the state will submit a Medicaid SPA that will disregard less earned income for new applicants than for recipients. This will have the effect of allowing previously enrolled individuals to remain covered under the program, while eliminating new enrollments of individuals who do not meet the pre-HIP Medicaid eligibility requirements.

Once an individual enrolls in a HIP plan, they will be "locked in" for the entire 12-month eligibility period. The state will allow disenrollment for poor quality care, but unlike the Medicaid managed care program, there will be no "without cause" disenrollment. The purpose of this provision is to minimize the administrative disruption associated with disenrollment, since the plans will be charged with administering the POWER accounts and would need to make account transfers to other plans in the event of a disenrollment.

Chronic Care Management

The other unique enrollment aspect of HIP is the treatment of individuals who have a chronic health-care condition that necessitates enhanced disease management services. All HIP enrollees will be screened for such a condition. If the screening indicates an enrollee would be better served in an enhanced services model, they will be served by the Indiana Comprehensive Health Insurance Association (ICHIA) plan, which is the state's existing high-risk pool. This aspect of HIP is referred to as the Enhanced Services Program (ESP). The ESP is not meant for common chronic diseases such as diabetes and heart disease, but rather serious and costly conditions such as metastasized cancer, hemophilia, and AIDS. ESP participants are not a part of the high-risk pool but can take advantage of the risk pool's specialized networks and disease management programs.

One important element of the program is the treatment of preventive health services. As mentioned above, a key concern related to HSAs for a low-income population is the potential for creating a disincentive to use preventive health-care services. To address this concern, HIP provides for $500 in first-dollar coverage for preventive care. After an enrollee meets the $500 threshold, preventive services are covered but the deductible applies. In addition, the state intends to provide an incentive for enrollees to obtain the recommended preventive health-care services. In cases where enrollees have unspent funds remaining in their POWER account at the end of a year, they will be allowed to "roll over" the funds to the following year as long as they have obtained all recommended preventive health services. This provision is intended to

eliminate any possibility that enrollees would forego needed health-care services. Any funds remaining in the account could be used to reduce the enrollee's contribution in the next year.

South Carolina

Program Overview

South Carolina is the first state to have applied for and received approval of their SPA to operate an HOA under the DRA. The program is limited to one county and enrollment is capped at a maximum of 1,000 participants. The pilot will be located in Richland County (Columbia), one of the most populous counties in South Carolina. The program will provide medical benefits using an HDHP in conjunction with an account from which beneficiaries direct their own care. Enrollment is voluntary and is generally limited to Medicaid children and parents. South Carolina expects to begin enrollment in May 2008.[16]

HOA participants will receive coverage of preventive care without regard to an annual deductible and will also receive incentives to obtain appropriate preventive care including periodic health evaluations (including annual physicals), routine prenatal and well-child care and immunizations. Individuals who lose Medicaid eligibility while enrolled are allowed to use any remaining account balances (minus 25 percent) for three years to purchase health insurance or for tuition expenses and job training.

The state will contribute the maximum amount allowed under federal law into the enrollee's account - $2,500 per eligible adult and $1,000 per eligible child. Assuming the individual remains eligible, balances will carry forward from previous years. HOA participants are subject to 10 percent cost-sharing once the HOA account has been exhausted. All the services offered will be traditional Medicaid benefits and will be provided as fee-for-service. While in the HOA, enrollees will not have any cost-sharing (aside from the deductible).

South Carolina's stated purpose in pursing the HOA pilot is to assess the behavior of the Medicaid population in a private plan environment to study how members deal with the opportunity of flexibility and self-management and to determine if the concept works better for certain ages or coverage groups. The state anticipates the pilot will help Medicaid recipients be better prepared for the commercial health care delivery system when they leave the Medicaid program. If the initial pilot is successful, the state may expand the HOA statewide.

Enrollment will be on a first come, first serve basis. If enrollment exceeds 1,000, a waiting list will be established. Enrollment will be effective for 12 months and may be extended for an additional 12 months at the individual's consent.

[16] South Carolina has delayed implementation of their HOA, originally scheduled for February 2008, pending discussions with CMS about the use of an electronic claims payment system, which is a DRA requirement for HOAs. South Carolina is seeking CMS permission to delay procuring a vendor to operate the electronic claims payment component of the program until the state has initiated enrollment and determined there is sufficient interest in the program to justify the expense of contracting with a vendor. At the time of this writing, South Carolina is still awaiting formal approval from CMS for this strategy, but expects to have the approval in time to allow for enrollment by May 2008.

South Carolina's structure for paying claims under the HOA will require strong provider and participant education. First dollar expenses will be paid from the account made by the state's contribution. If and when the participant's expenses exceed the state contribution, he or she has the responsibility of meeting a 10 percent out-of-pocket deductible. As the beneficiary continues to receive services, the provider bills the state, but claims are maintained as encounter data only until the deductible is satisfied. Once the deductible has been met, the state will resume paying providers' claims at the normal Medicaid reimbursement rates. Use of the ER for non-emergent care will result in a deduction from the HOA. Expenses for routine preventative care are covered outside of the HOA expense (e.g., are paid by Medicaid without any deduction of the enrollee's HOA balance.)

HOA participants will receive a card similar to the regular Medicaid card that will allow electronic debits by providers from the enrollee's HOA. All reimbursements will be processed according to the covered services of the Medicaid program.

The program is being designed to provide members with regular updates on their account balances and information helpful to seeking appropriate health care. On a monthly basis, participants will receive an update on the HOA balance, detailed feedback on the care they received and suggestions for further reducing their medical expenses (e.g., "you are irregularly filling your maintenance drug" or "you visited the ER for an earache during your physician's regular office hours").

Overview of Texas HSA Pilot Concept

Design Considerations

This cost-effectiveness analysis is based on a hypothetical HSA pilot. In order to assign costs and predict savings that would be associated with an HSA pilot, a number of decisions were made regarding how the pilot would operate. These design considerations include factors such as whether the pilot would be voluntary or mandatory, how much of a deductible would be required of individuals, and the structure and content of the benefits package. The design considerations selected also impact the assumptions used to model cost effectiveness. For example, making the pilot voluntary as opposed to mandatory influences assumptions about how many people will participate. A detailed description of the assumptions used in this analysis can be found in Appendix B.

Outlined below are key design considerations used to develop the hypothetical HSA pilot structure that served as the basis for the cost-effectiveness and feasibility analysis. The various design considerations were chosen based on what HHSC believes are the most feasible to implement and which would support the overall goal of giving enrollees control over their health care while also attempting to address concerns that HSAs might prompt enrollees, particularly low-income enrollees, from securing necessary preventative care.

The HSA pilot would be voluntary and limited to healthy adults who are current Medicaid enrollees. The state would annually contribute a set amount ($2,000) to an enrollee's account and enrollees would be required to pay a deductible in order to participate in the HSA pilot. Unused funds would carry forward to following years and the state would make annual

contributions so that an individual's account was funded at, but not in excess of $2,000 at the start of each year.

The eligible enrollee would be responsible for meeting a deductible set at approximately 2.5 percent of the state's contribution ($50). Once the participant pays the required deductible, they can use the HSA for allowable medical expenses. Many of the administrative activities associated with implementing and managing an HSA (e.g. enrollment, outreach, and account management) would be conducted by a state contractor. The model assumes that the enrollee's required deductible would be paid prior to enrollment in the HSA and that payment of the deductible would be a condition of enrollment.

Allowable medical expenses that can be paid from the participant's HSA include all of those services currently reimbursable by Texas Medicaid for the adult population, as well as some additional "enhanced" services (e.g., dental), which would serve both as an incentive for enrollees to participate in the pilot and which may delay their reversion back to traditional Medicaid. The model benefit package consists of all the benefits in the traditional Medicaid package (including any existing limitations or prior authorization requirements), as well as the following:

- Dental benefits – preventive and therapeutic services, up to $500 per 12-month period.
- Tobacco cessation programs – up to $300 per 12-month period.
- Weight loss programs – up to $300 per 12-month period.
- Marriage counseling/parenting "workshops" – up to $300 per 12-month period.

Additionally, in order to help ensure participants seek necessary preventive care, the following services would be considered "first dollar" coverage and would not count against an enrollee's deductible:

- One well visit/annual exam per 12-month period.
- Three prescriptions per month.

Other than the "first dollar" coverage listed above, any covered medical service used would count against a participant's deductible. Once the participant exhausts their HSA, they revert back to traditional Medicaid.

The decision to cover three prescriptions per month on a first dollar basis highlights the trade-offs inherent in many of the design considerations associated with developing an HSA model. Enrollees' use of medications is generally assumed to be price sensitive. Thus, how medications are paid will affect whether an enrollee adheres to their physician's recommendations regarding medications. By covering medications on a first dollar basis, there is greater likelihood enrollees will fill and take their medications as directed. Alternatively, removing medications from first dollar coverage creates the possibility that enrollees will forgo recommended medications as a means to preserve their account balance. In designing this hypothetical model, the desire to develop a benefits plan that emphasized prevention and primary care influenced the decision to include medications as first dollar coverage. However, had the primary goal been to encourage

enrollee cost consciousness, it would have been more appropriate to have medications paid for from the enrollee's HSA account, as opposed to first dollar coverage.

The intent behind an HSA-type pilot is to encourage participants to think differently about how they utilize services. The premise on which HSA models are frequently based is that because individuals do not "pay" for services in usual health insurance, they do not have an incentive to avoid unnecessary care. By putting enrollees in the position of managing how available funds are used, and providing incentives to "save" dollars for necessary care, HSA models have been of interest to purchasers wishing to encourage health-care consumers to become more cost-conscious and prudent users of health-care services.

Profile of HSA Enrollee

Given the requirements that exist in S.B. 10, and expectations about populations not likely to be included by CMS under a waiver (e.g. people with disabilities and pregnant women), an individual eligible for a Texas HSA would have the following characteristics:

- female
- on Medicaid, with an average length of time on Medicaid of less than six months
- relatively young (the largest proportion of eligible adults are between 21-34 years old)
- a parent or caretaker
- very low income (e.g., many at approximately 14 percent of FPL)
- enrolled in the Primary Care Case Management (PCCM) program[17]
- Hispanic

The table below describes the income limits and average length of Medicaid eligibility associated with the categories of eligible individuals.

Summary of Statewide Population Eligible to Participate in an HSA, State Fiscal Year 2007

Medicaid Category	Income Limits	Average Time on Medicaid in FY 2007	Approximate Number of Clients
TANF Cash Grant (TP 1, 61)	$188 per month	4.2 months	27,926
TANF – Non Cash Grant (TP 55)	$188 per month	5.3 months	40,959
Transitional Medicaid (TP 7,20,29,37)	Varies	5.4 months	16,049
TOTAL			**84,934**

Notes:

- Number of clients is based on HHSC's eight month eligibility file for FY 2007.

[17] Enrollees in capitated managed care are excluded because these clients are already in a model that manages costs and including them would add to the administrative complexity of the program.

- Temporary Assistance for Needy Families (TANF) is the federal-state program of cash assistance for impoverished families. States set their own income eligibility guidelines for TANF. Texas' income cap for a mother with two children is $188 per month, with an asset limit of $1,000. The TANF monthly cap is based on a set dollar amount and is not determined by federal poverty levels.
- Transitional Medicaid is available to households for up to 12 months following denial of TANF benefits due to new or increased earnings or expiration of TANF time limits as long as an eligible child resides in the home.

The low income level and relative youth of individuals who would be eligible for an HSA pilot makes it likely they would not be familiar with the private insurance market and consequently, a significant amount of upfront outreach and education would need to occur to help participants understand and manage their benefits. The low income level of the eligible population also raises important issues about the amount of deductible this population can reasonably be expected to pay. Additionally, Hispanics comprise the greatest percentage of eligible enrollees (44 percent of the statewide eligible population) and outreach efforts would need to account for possible language barriers.

Finally, the fact that the eligible population tends to be on Medicaid for fairly short durations (all eligible categories of Medicaid for the purposes of the pilot have an average length of time on Medicaid of less than six months), means that connecting to these individuals will be challenging in that short duration of time. In terms of efficiency, it would make the most sense to try to develop a pilot that enrolled individuals in the HSA, assuming they elected to do so, at the time they became eligible for Medicaid. While simultaneously enrolling clients in Medicaid and in the HSA if they chose that option conflicts with the DRA requirements (and thus would require the use of an 1115 waiver), it would be the most efficient way to deal with the short Medicaid tenure experienced by most of the eligible individuals.

Methodology/Approach

Overview of Approach

This analysis measures the benefits of an HSA pilot program (e.g., lower utilization of unnecessary services) and the costs the state must incur to realize those benefits (e.g., new administrative activities like enrollment counseling and processing) under the constraints and assumptions outlined below. In order to be considered cost effective, the pilot must accrue benefits that, in economic terms, are greater than the costs necessary to implement and sustain the pilot. The typical challenge in an analysis like this one is that costs are often more clear cut and therefore easier to measure than benefits, which rest on a number of assumptions, and are therefore more elusive.

The analysis used the following steps:

- Establish assumptions and constraints: HMA worked in conjunction with HHSC to define the assumptions and constraints to be used in the model based on the state's objectives and program capabilities.
- Identify possible alternative approaches: In evaluating alternative approaches, the effects of implementing an HOA under the DRA or an HSA under waiver authority were considered. Given that the design features of an HOA or HSA will significantly influence their effects, in some instances, multiple scenarios were modeled (e.g., assumptions about declines in utilization of unnecessary services).
- Identify and assign costs to each alternative: An HSA pilot will entail multiple administrative costs (e.g., program changes related to eligibility and account management) and medical costs (e.g., payments to non-Medicaid providers under DRA authority). The factors associated with each alternative were identified and assigned costs.
- Identify potential benefits and consequences associated with each alternative. Whether using waiver or DRA authority, there will be numerous benefits and consequences that cannot easily be assigned costs, but which must be weighed regardless. The analysis identifies and describes these qualitative costs and benefits.
- Develop conclusions and recommendations. Based on the cost-effectiveness analysis, recommendations on options to both minimize costs and/or enhance savings are discussed.

Costs Associated with an HSA

While there are numerous administrative and medical costs that need to be considered, this aspect of the analysis is fairly straight forward. Administrative needs and services associated with the program are identified and then assigned costs by the state or its vendors. These costs are eligible for federal financial participation (FFP) at different rates, depending on the type of service. For the administrative costs, Medicaid administrative claiming, at either the 50 or 75 percent match rate, is available. Medical costs would be eligible for FFP at the Federal Medical Assistance Percentage (FMAP) rate in effect in the year in which the costs were incurred.

Administrative Costs

- Financial Administration (e.g. claims payments, account maintenance): This high level cost estimate was developed by the state's contracted claims administrator and includes both the fixed costs to establish the program and variable costs, based on a per member per month fee, that would be paid to a third party contractor to operate the program.
- Outreach and Enrollment: These high level cost estimates were provided by the state's enrollment broker and include both start-up and initial costs and ongoing maintenance costs.
- Eligibility Systems Programming Changes: These costs were provided by HHSC's Enterprise Applications division, which is responsible for the Texas Integrated Eligibility Redesign System (TIERS) and the System of Application, Verification, Eligibility, Referral and Reporting (SAVERR). All the costs associated with programming changes are start-up/fixed costs. No maintenance costs are required.

Administrative Costs, All Funds

	Start-Up Costs	2009	2010	2011	2012	2013	Federal Match
Financial Admin - Technology and Hardware	$1,645,000	$0	$0	$0	$0	$0	75%
Financial Admin - Account Maintenance	$2,510,000	$24,420	$31,398	$38,375	$45,352	$52,330	50%
Outreach and Enrollment	$684,000	$34,700	$34,700	$34,700	$34,700	$34,700	50%
Eligibility System Changes – TIERS	$103,845	$0	$0	$0	$0	$0	50%
Eligibility System Changes – SAVERR	$1,564,160	$0	$0	$0	$0	$0	50%
TOTAL	**$6,507,005**	**$59,120**	**$66,098**	**$73,075**	**$80,052**	**$87,030**	**$6,872,380**

Notes:

- Pilot of approximately 800 eligible individuals, with participation rates of increasing from 7 percent in 2009 to 15 percent in 2013.
- Ongoing costs associated with financial administration would be performed by a TPA for $36.34 PMPM.
- These costs assume that both the TIERS and SAVERR systems will require programming changes; however, if the TIERS system is operational statewide at the time of the pilot, these estimated costs would be reduced.
- The federal match rate applied is contingent upon CMS approval.

Administrative Costs, General Revenue

	Start-up Costs	2009	2010	2011	2012	2013	Federal Match
Financial Admin - Technology and Hardware	$411,250	$0	$0	$0	$0	$0	75%
Financial Admin - Account Maintenance	$1,255,000	$12,210	$15,699	$19,188	$22,676	$26,165	25%
Outreach and Enrollment	$342,000	$17,350	$17,350	$17,350	$17,350	$17,350	50%
Eligibility System Changes – TIERS	$51,923	$0	$0	$0	$0	$0	50%
Eligibility System Changes – SAVERR	$782,080	$0	$0	$0	$0	$0	50%
TOTAL	**$2,842,253**	**$29,560**	**$33,049**	**$36,538**	**$40,026**	**$43,515**	**$3,024,940**

Notes:

See all funds assumptions.

Medical Costs

- State contribution to the HSA/HOA: This cost was modeled at an annual contribution by the state of $2,000 per enrollee, per year. Unused funds would carry forward. Enrollees' account balances would not exceed $2,000. No inflationary factor was included in this amount.
- Reimbursement for allowable services that are "first dollar" coverage and do not count against an enrollee's HSA: Such services include one annual adult well checkup and three prescriptions per month. The amount of these costs was based on the average cost for services and an inflationary factor was considered for each cost.

Annual Medical Costs, All Funds, Per Person

	2009	2010	2011	2012	2013
Annual Contribution to HSA	$2,000	$2,000	$2,000	$2,000	$2,000
Medications	$994	$1,083	$1,180	$1,286	$1,358
Annual Well Visit	$120	$126	$132	$139	$146
TOTAL	**$3,114**	**$3,209**	**$3,312**	**$3,407**	**$3,504**

Notes:

- Medication costs provided by HHSC, based on average medication costs expected for target population.
- Well visit assumes five percent annual inflation factor.

Annual Medical Costs, General Revenue, Per Person

	2009	2010	2011	2012	2013
Annual Contribution to HSA	$809	$809	$809	$809	$809
Medications	$402	$438	$478	$513	$550
Annual Well Visit	$49	$51	$54	$56	$59
TOTAL	**$1,260**	**$1,299**	**$1,340**	**$1,379**	**$1,418**

Notes:

- Medication costs provided by HHSC, based on average medication costs expected for target population.
- Well visit assumes five percent annual inflation factor.
- State match is based on the 2009 FMAP rate of 59.53 percent.

Benefits Associated with an HSA

HSAs are based on the premise that if individuals have control over their accounts, they will become more prudent users of health-care services. Specifically, the analysis assumes HSA participants will use fewer unnecessary health-care services out of the desire to conserve their funds in order to pay for "enhanced" services, such as dental care. As enrollees use fewer health

services, the amount the state would need to contribute each year to keep an initial $2,000 account balance would decline.

The degree to which utilization of services declines as a result of participation in an HSA-type model is difficult to predict and will likely be sensitive to a number of factors, including the structure of the benefit package, the health status of the enrollees who participate, and how well enrollees understand the benefits of an HSA. As a result, two scenarios of participants' service utilization were modeled, both of which assume a reduction in utilization, but which vary according to how long it takes to achieve utilization declines and the extent of those declines.

Scenario A assumes it will be three years before HSA participants experience lower utilization than what would have occurred under traditional Medicaid. This "lag" in achieving decreased utilization is based on the assumption that, because the program is required to be voluntary, only those clients with a significant interest in the "enhanced" services provided under the HSA option would enroll. This scenario assumes that pent up demand would eventually be met and at that point, utilization would decline.

Scenario B assumes a much faster rate of utilization decline, with utilization declines occurring starting in year one and ultimately declining by 15 percent.

The reductions in medical utilization associated with both scenarios are summarized in the table and graphs below. These reductions would lessen the amount the state would need to contribute to an HSA participant's account on an annual basis.

Decreased Utilization Assumptions

	2009	2010	2011	2012	2013
Scenario A	0%	0%	10%	10%	10%
Scenario B	5%	10%	10%	15%	15%

A description of other constraints and assumptions used in the analysis can be found in Appendix B.

Feasibility and Cost-effectiveness Findings

Feasibility Analysis

The feasibility analysis found that the DRA, given state requirements and the limitations associated with the short duration of Medicaid eligibility for the eligible clients, makes the DRA a largely infeasible option for establishing an HSA-type pilot.

As noted earlier, the DRA establishes fairly narrow criteria for who can participate in an HOA. In general, the DRA limits participation to adults and children who are healthy and who have been on Medicaid for at least three months. The DRA also limits participation of MCO enrollees so the number of individuals enrolled in the MCO who participate in the HOA program will not exceed 5 percent of the total number of individuals enrolled in the MCO.

Additionally, any HSA pilot established in Texas would need to align with S.B. 10 requirements. S.B. 10 requires the pilot be voluntary, and excludes children from participating in an HSA pilot. By excluding children from participation, the vast majority of individuals who would otherwise be eligible to participate in an HOA operated under DRA authority are eliminated.[18]

Combined, these requirements restrict the population eligible for an HSA in Texas to a relatively small number of individuals. Once children (e.g., birth to 20), managed care enrollees,[19] and disabled and pregnant adults are removed from the universe of eligible participants, the statewide eligible population (as of March 2007) is estimated to be 84,934.

The DRA's requirement that participation in an HOA be limited to individuals who have been eligible for medical assistance for at least three months would further limit the size of the population available for the pilot. In Texas, the average length of time on Medicaid is relatively short, making this DRA requirement a significant limiting factor.[20] In fiscal year 2007, the average length of time on Medicaid for the population groups eligible for an HSA was as follows:

[18] Approximately 70 percent of Texas Medicaid recipients are children.
[19] While a limited number of managed care enrollees can, under the DRA, be enrolled in an HOA, HHSC elected to exclude them from possible participation due the administrative complexity of accounting for their participation under the DRA requirements and because managed care enrollees are already in models designed to manage their care and control costs.
[20] A key factor in Texas' short Medicaid tenure is that current Medicaid eligibility policy only allows for six months of Medicaid enrollment before an individual must be recertified as eligible.

- TANF cash grant: 4.2 months
- Transitional Medicaid: 5.4 months
- Non-cash TANF: 5.3 months

Given these figures are an average, many of the 84,934 individuals across the state who would otherwise be eligible for the pilot would be excluded based on the fact they would not have been on Medicaid for the three months required by the DRA. At least one-third of the individuals would likely be excluded because they have not been on Medicaid the required three months. This means the statewide population eligible for a pilot using DRA authority would be reduced to approximately 56,000.

Both the DRA and S.B. 10 require that pilot participation be voluntary. Without the ability to mandatorily enroll eligible individuals, Texas would have to invest significant resources to educate and enroll the eligible population. It is important to note that expectations on what percentage of the eligible population would enroll should be conservative, particularly given the challenges of marketing an HSA to this population (e.g., the deductible requirement, complexity of the HSA arrangement, educational and language barriers that the target population may face, and lack of familiarity with HSA arrangements among the target population). Additionally, while a well-designed pilot that includes a benefit package attractive to the target population combined with an aggressive outreach campaign could increase participation, this increased participation will come at a cost to the state in terms of funding a comprehensive outreach campaign and offering additional (enhanced) benefits.

The only areas of the state where a significant number of these eligible individuals could expect to be grouped geographically are in the major urban areas (e.g., Austin, Dallas, San Antonio, and Houston). However, all of these areas enroll the eligible population into capitated managed care. In the remaining areas of the state, it would be extremely difficult to find a population large enough to justify the administrative expense of a pilot.

To illustrate the largest grouping of eligible individuals, not accounting for the DRA's three-month Medicaid eligibility requirement, is in the Laredo area, which, if adjacent counties are included, has approximately 800 eligible participants. Once the three-month Medicaid enrollment requirement is taken into account, the population will likely shrink to less than 500. Given even an optimistic participation rate of 20 percent, the pilot would then have only about 100 enrollees. The administrative hurdles and expenses necessary to administer a pilot far exceed any benefits likely to be achieved.

Additionally, the DRA requires states to include various options in their HOA pilots which can both lead to increased administrative expenses and which may conflict with the state's goals in establishing an HOA. These include the DRA's lock-in provision, which requires that enrollees be "locked in" to an HOA for 12 months, except in cases of hardship. This requirement conflicts with the provision in S.B. 10 that allows enrollees to revert to Medicaid at their discretion. The DRA also requires states use electronic withdrawals, a function Texas does not currently have in its' Medicaid program, and which would add significantly to its' administrative expenses necessary to develop the program. Finally, the DRA also requires states retain any unused funds

in an enrollee's HOA for three years to pay for, at a minimum, health insurance premiums. This requirement, like the requirement for electronic withdrawals, would add to the administrative expenses required by establishing an HSA pilot using DRA authority.

A pilot under DRA authority would have to operate under significant constraints regarding eligible participants. While many of the constraints on eligible participants would also apply under waiver authority (e.g. the exclusion of children), the DRA requirement regarding three-month continuous Medicaid eligibility, in particular, would make it difficult to develop a large enough population to justify the administrative expenses associated with a pilot, given the relatively short duration of Medicaid eligibility in Texas. This requirement would not exist if Texas were to pursue the pilot using waiver authority.

The process of applying for a waiver is more cumbersome and likely to take longer than the Medicaid SPA process which accompanies the HOAs under the DRA. However, the constraints of the DRA, combined with the requirements in S.B. 10, make pursuing an HSA-pilot infeasible using DRA authority. While an HSA pilot established under waiver authority would still have to adhere to S.B. 10 requirements, it provides the state with more flexibility to develop a program that can be made to meet the state's needs. Thus, if the state were to pursue an HSA pilot, waiver authority presents the most feasible option for Texas.

Cost-Effectiveness Analysis

Since the DRA is not a feasible option for establishing an HSA-type pilot, the cost-effectiveness analysis assumed the requirements associated with developing a pilot would be driven by what would be necessary under a waiver, rather than the DRA. For example, the DRA enrollment requirement limiting eligibility to only those individuals who had been on Medicaid at least three months and the administrative requirement around using electronic withdrawals were not considered in the analysis.

However, even if waiver authority is used, the analysis found costs are considerably in excess of savings for an HSA pilot. Because this pilot is relatively small, it is not surprising the costs for the pilot are much larger than the savings. Programs such as this one require a certain "critical mass" in order to spread fixed costs over a broad population.

The size of the HSA program has a direct effect on the program's cost effectiveness. While many of the administrative costs are fixed, and thus the same regardless of the number of individuals who participate, savings connected to the program are based on the declines in utilization and are therefore directly linked to the number of program participants. Thus, the smaller the number of participants, the more challenging it is to achieve cost effectiveness.

The analysis also assumed the pilot would be located in an area with approximately 800 individuals eligible to participate in the pilot. This figure was based on a review of various regions where there was the highest concentration of Medicaid enrollees who fit the profile of eligibility for the HSA pilot. Since participation must be voluntary, only a subset of this population will actually enroll in the HSA pilot. To estimate the cost effectiveness of this pilot project, both the start-up costs and the ongoing or "operating" costs the state would incur to run

the pilot were estimated. Next, an approximate estimate of the likely savings, based on reductions in the utilization of services, was developed.

This analysis assumes a steadily increasing, albeit relatively small proportion, of the 800 people would participate. Participation rates assume 7 percent of the eligible individuals would participate in the first year, 9 percent in the second, 11 percent in the third, 13 percent in the fourth, and 15 percent in the fifth year. For each year, the analysis projects the spending of the participants and then estimates the spending of the non-participants. Because so few individuals are assumed to participate (e.g., 56 in year one growing to 120 in year five), the savings associated with decreases in unnecessary care are quite small.

The components of the cost-effectiveness model and findings are summarized below:

Baseline Costs/Business as Usual

The business as usual scenario measures what the state would have paid for essentially the same individuals if an HSA pilot were not developed. This baseline cost was estimated using the projected PMPM costs HHSC anticipates paying for the groups eligible for an HSA pilot (e.g., TANF parents, adults on transitional Medical assistance) during the time period of the pilot. A weighted average of these PMPMs was then calculated. The annual costs associated with paying this weighted average PMPM, assuming the participation rates described above, represents the cost the state would incur for these enrollees had they not participated in the HSA.

It is important to note administrative costs associated with continuing the regular Medicaid program are not evaluated separately, because these administrative activities must continue regardless of whether an HSA pilot is developed.

The baseline cost for the five-year time period, assuming the participation rates discussed earlier, is $2,315,467, all funds ($937,070, general revenue). Thus, this is how much the state would have spent on the HSA enrollees under the traditional Medicaid program.

Traditional Medicaid Costs

	2009	2010	2011	2012	2013	Total
Number of Enrollees	56	72	88	104	120	
Weighted PMPM	$386.69	$406.48	$428.58	$452.19	$477.43	
Total Member Months	672	864	1,056	1,248	1,440	5,280
Total Cost, All Funds	**$259,856**	**$351,199**	**$452,580**	**$564,333**	**$687,499**	**$2,315,467**
Total Cost, General Revenue	**$105,164**	**$142,130**	**$183,159**	**$228,386**	**$278,231**	**$937,070**

Notes:

- PMPM is based on the anticipated PMPMs for 2009-2013 for the eligibility groups able to participate in the pilot, weighted according to size of the group.
- State funds only are calculated based on the assumptions of FMAP of 59.53 percent.

Savings

Savings, as measured in monetary terms, occurs when and if HSA participants' utilization of services declines. When utilization declines to the point the enrollee retains a portion of the state's annual $2,000 contribution, then, since these accounts carry forward to future years, the state is able to contribute less in the following year. Two scenarios were assumed with regard to declines in utilization to account for the fact this factor is challenging to predict. The first scenario (Scenario A) assumes there is "pent up" demand and utilization does not decline until year three, at which point medical expenses decrease by 10 percent and continue at that rate for the remainder of pilot. The second scenario (Scenario B) assumes utilization begins to decline immediately in year one and the associated medical expenses decline by 20 percent in year five. The table below describes the annual and total savings assumptions used in the analysis.

Savings Assumptions, All Funds
Scenario A

	2009	2010	2011	2012	2013	Total
State Annual Contribution	$2,000	$2,000	$2,000	$2,000	$2,000	
Number Pilot Participants	56	72	88	104	120	
Savings Assumption	0%	0%	10%	10%	10%	
Per Person Savings	$0	$0	$0	$200	$200	
Annual Savings	**$0**	**$0**	**$0**	**$20,800**	**$20,800**	**$41,600**

Savings Assumptions, All Funds
Scenario B

	2009	2010	2011	2012	2013	Total
State Annual Contribution	$2,000	$2,000	$2,000	$2,000	$2,000	
Number Pilot Participants	56	72	88	104	120	
Savings Assumption	5%	10%	10%	15%	15%	
Per Person Savings	$100	$200	$200	$300	$300	
Annual Savings	**$5,600**	**$14,400**	**$17,600**	**$31,200**	**$48,000**	**$116,800**

Costs

Administrative costs are a significant component of the cost-effectiveness analysis because the development of the program would require extensive enrollee outreach and education, as well as programming changes and account management, involving both state staff and multiple contractors. Administrative costs include both start up costs and costs for on-going program

maintenance. Based on high level estimates from the state and relevant contractors, it is estimated administrative costs for the pilot will be approximately $6.5 million, all funds ($2.8 million general revenue) in fixed or start up costs and total annual operating costs of $365,375 all funds ($182,687 general revenue).

Medical costs included in this analysis are the state's annual contribution of $2,000 and those services that are "first dollar" coverage, e.g., those that will not be paid from a participant's HSA. The use of "first dollar" coverage is intended to eliminate the incentive of participants to avoid or delay necessary care in order to preserve their account balance for enhanced care (such as dental work). This design feature is also intended to ensure enrollees maintain or improve their health status, so when and if they revert back to regular Medicaid, they are not in worse health. Based on estimated reimbursement for the first dollar medical coverage, as well as the state's expected contribution to the enrollee's HSA, per person annual medical costs in the final year of the pilot are $3,504 all funds ($1,418 general revenue).

Findings

In strictly monetary terms, the state would pay substantially more to develop and operate an HSA pilot than it would pay for the same individuals under traditional Medicaid. The total cost of the HSA pilot, for the five years included in the model is $8.2 million, all funds, if significant utilization declines are achieved, and $8.3 if only minimal utilization declines are achieved. In either case, the total costs of the pilot far exceed the costs of providing traditional Medicaid services to the same group of individuals, which is estimated to cost $2.3 million, all funds. These findings are summarized in the tables below.

HSA Pilot Costs, All Funds

	Start-Up Costs	2009	2010	2011	2012	2013	Total
Number of Pilot Participants	N/A	56	72	88	104	120	
Administrative Costs	$6,507,005	$59,120	$66,098	$73,075	$80,052	$87,030	$6,872,380
Medical Costs	$0	$174,384	$231,048	$291,482	$354,319	$420,463	$1,471,697
Total Administrative and Medical Costs	$6,507,005	$233,504	$297,146	$364,557	$434,371	$507,493	$8,344,077
Total Savings	N/A	($5,600)	($14,400)	($17,600)	($31,200)	($48,000)	($116,800)
Net costs	**$6,507,005**	**$227,904**	**$282,746**	**$346,957**	**$403,171**	**$459,493**	**$8,227,277**

Notes:

- Assumes a five-year pilot, from 2009-2013.
- Pilot of approximately 800 eligible individuals, with participation rates of increasing from 7 percent in 2009, to 15 percent in 2013.
- Medical expenses include annual state contribution of $2,000 and first dollar coverage of annual physical and three prescriptions per month.

- Administrative costs include outreach and enrollment, account maintenance, and necessary system and technology changes.
- Savings shown above are the maximum savings scenario, which assumes declines in utilization starting in year one and by year five achieving a 15 percent decline in need for state contribution to fund enrollee's account.

HSA Pilot Costs, General Revenue

	Start-Up Costs	2009	2010	2011	2012	2013	Total
Number of Pilot Participants	N/A	56	72	88	104	120	
Administrative Costs	$2,842,253	$29,560	$33,049	$36,538	$40,026	$43,515	$3,024,940
Medical Costs	$0	$70,573	$93,505	$117,963	$143,393	$170,161	$595,596
Total Administrative and Medical Costs	$2,842,253	$100,133	$126,554	$154,501	$183,419	$213,676	$3,620,536
Total Savings	N/A	($2,266)	($5,828)	($7,123)	($12,627)	($19,426)	($47,269)
Net Costs	**$2,842,253**	**$97,867**	**$120,726**	**$147,378**	**$170,792**	**$194,250**	**$3,573,267**

Notes:

- FMAP for medical costs assumes 2009 FMAP of 59.53 percent.
- Administrative costs are matched at 50 percent, except for technology and hardware costs, which are eligible for 75% match.

Another way to consider cost effectiveness of an HSA pilot is to compare the per member per month costs to what the state would have otherwise paid under traditional Medicaid. The average cost per member per month during the five-year period is $439, all funds, for traditional Medicaid, compared to at least $1,558 in the HSA pilot.

Summary of Health Savings Account Pilot Costs Compared to Traditional Medicaid SFY 2009-2013

	Total Cost, All Funds	Total Cost, General Revenue	Total Member Months	Cost Per Member Per Month, All Funds	Cost Per Member Per Month, General Revenue
Traditional Medicaid (Business as Usual)	$2,315,467	$937,070	5,280	$439	$177
HSA Pilot, Significant Utilization Declines	$8,227,801	$3,573,267	5,280	$1,558	$677
HSA Pilot, Minimal Utilization Declines	$8,281,677	$3,595,284	5,280	$1,568	$681

Discussion

The first and most logical question that should be asked of the analysis is "Why does the HSA cost so much more than traditional Medicaid, for essentially the same people?" The main contributor to the cost of the HSA is the administrative costs. The bulk of these costs are "fixed" costs to pay for system changes and necessary technology and hardware. These costs would be the same whether the program had enrollment of one or one million participants. Since the program is relatively small, the administrative costs cannot be spread across a large population and thus account for a significant portion of the pilot's per person costs.

The medical costs also contribute to the overall cost of the pilot. Unlike administrative costs, which have to be incurred in order to develop and maintain the pilot, some portion of the medical costs could be avoided if the state chose to do so. Specifically, these are the costs associated with providing HSA participants "first dollar" coverage for an annual physician visit and three prescriptions per month, a design feature intended to ensure enrollees do not delay or avoid necessary care. It would be possible for the state to either eliminate these medical costs or to scale them back, for example by not offering any prescription drug coverage as "first dollar" coverage. However, even if all of these "optional" medical costs are eliminated, the HSA pilot still would cost considerably more than traditional Medicaid, simply given the start up administrative costs. The table below indicates total cost of the pilot, under each scenario, without any optional medical costs included. Thus, the only medical cost included is the state's contribution to the enrollee's HSA, which has been discounted in each scenario to account for lower utilization.

Health Savings Account Pilot Costs, Eliminating First Dollar, All Funds SFY 2009-2013

	Total Cost	Total Member Months	Average Cost Per Member Per Month
Traditional Medicaid (Business as Usual)	$2,315,467	5,280	$439
HSA Pilot, Significant Utilization Declines	$7,689,980	5,280	$1,456
HSA Pilot, Minimal Utilization Declines	$7,635,580	5,280	$1,446

Note:
The average cost per member per month includes both medical and administrative costs for each HSA pilot scenario.

PMPM vs. HSA Contribution

Another way to consider the cost effectiveness of the HSA pilot is to look solely at the state's contribution to the enrollees' health savings account in comparison to what the state pays for traditional Medicaid members in terms of PMPM costs. For example, the PMPM for a TANF cash grant recipient in 2009 is projected by HHSC to be $326.26, or $3,915 per year. While this is more than the $2,000 contribution the state would make to a pilot participant's health savings account, the difference, or savings, is quickly overshadowed by the necessary administrative

costs of the pilot. This further demonstrates the administrative costs associated with implementing and maintaining the pilot is a key driver in the lack of cost effectiveness.

Intangible Benefits

While our analysis did not show an HSA pilot to be cost effective in strict monetary terms, there are other intangible benefits that might occur as a result of an HSA pilot that should be considered. These possible benefits include:

- Improved health status for enrollees: Since the HSA would include certain enhanced benefits, such as dental care, enrollees' access to these benefits, as well as any health promotion education they might receive as a result of participating in the pilot, could be expected to improve their overall health status. That improvement in health status would clearly benefit the individual and their family. However, the small size of the pilot makes it highly unlikely that any reduction in Medicaid costs that accompanied their improved health status once (and if) they returned to traditional Medicaid would translate into lower overall Medicaid PMPM costs.
- Greater awareness of costs and ability to navigate private sector coverage: HSA pilot participants would be expected to take a greater interest in understanding the costs of health care and seeking to manage their care to retain their account balances. This increased cost awareness would help better prepare recipients to navigate commercial insurance if and when they left the Medicaid program and were able to secure private health insurance.
- Increased knowledge of the low-income population's needs and patterns of health care utilization. The pilot could provide HHSC with information about recipients' need for and interest in certain types of benefits, specifically those "enhanced" benefits (e.g., dental care, smoking cessation, parenting classes). This information could inform various reform efforts that Texas is considering.

Other Observations

The largest limiting factor in achieving cost effectiveness is the small size of the pilot. However, even if the state were to expand the program to a larger pool of participants, there are two principle factors to consider around any expectation of "savings". One, the relatively short duration that most TANF or TANF-related adults remain eligible for Medicaid could undermine attempts to reduce unnecessary utilization over time. Since these enrollee's have an average duration of Medicaid eligibility of less than six months, many of them would become ineligible for the program prior to achieving a measurable reduction in savings. The state could address this fact by granting a longer eligibility period to HSA enrollees, but that in and of itself becomes an additional cost to the program.

Second, the ability of pilot participants to revert back to Medicaid when their account is exhausted largely removes any significant incentive for enrollees to appreciably change their behavior. While the model assumes some expectation of lowered utilization, only significant reductions in utilization would provide enough "savings" to overcome the administrative and medical costs associated with a pilot. This raises the question of whether an HSA-type model is likely to work for a population that, due to the legislative requirement in S.B. 10 allowing

participants to revert back to Medicaid, would have minimal risk attached to utilizing unnecessary services. In addition, an HSA enrollee could exhaust his or her HSA funds on benefits not covered by regular Medicaid, e.g. dental services or weight loss programs, and immediately return to the traditional Medicaid program and begin incurring covered medical costs such as specialty visits or lab services.

Conclusion

Feasibility

The analysis showed that given the constraints imposed by the DRA, using waiver authority would be the more feasible option if Texas were to pursue an HSA pilot. The extensive requirements in the DRA, specifically the restriction on enrolling new Medicaid clients into an HSA and the requirement that states must maintain an enrollee's unused HSA balance for three years upon the client's disenrollment, make the DRA a much less feasible option than establishing an HSA using waiver authority. While waivers typically involve lengthy negotiations before federal approval is granted, a waiver ultimately provides Texas the flexibility necessary to implement an HSA pilot. However, even with the flexibility offered under a waiver, the extensive administrative costs combined with the limits on the eligible population, will continue to pose challenges to achieving cost effectiveness.

Cost Effectiveness

The analysis, given existing state and federal requirements, showed that an HSA pilot would not be cost effective. Over the five-year period, the analysis estimated the pilot would cost an additional $8.2 million, all funds, compared to the regular Medicaid program. Two major factors contributed to the lack of cost effectiveness: (1) the extensive administrative costs necessary to implement and maintain the program and (2) the small size of the eligible population, which limits the amount of savings available to offset administrative costs. The administrative costs are necessary because the program would require detailed enrollee outreach and education efforts, enrollment activities, account maintenance and monitoring functions, as well as mechanisms to pay providers from a client's HSA. Excluding children from participation removes approximately 70 percent of the Medicaid population from participating in an HSA. The remaining individuals eligible to participate in an HSA are almost all very low income. Ninety-four percent of the Texas Medicaid population has income of less than 100 percent FPL (which equated to $10,210 per year in 2007) and most of the eligible participants are some of the lowest income recipients within the Medicaid program, with incomes of less than $188 per month for a mother and two children (which equates to about 14 percent FPL).

Thus, the adults eligible for participation in an HSA pilot are likely to have difficulty meeting the deductible requirements associated with an HSA. Since savings accrue on a per person basis, any factors that limit or discourage enrollment directly decrease the savings associated with lower utilization of services.

Design Considerations

The analysis also highlights the various design considerations available to a state in establishing an HSA model. These considerations are critical in that they can both have a direct impact on the costs and/or savings, and they may also indirectly affect cost effectiveness by how they influence participation rates, or contribute to an enrollee's use of recommended health-care services. Key design considerations in developing an HSA model include:

- Use of "first dollar" coverage: Offering key prevention services as first dollar coverage requires the state incur additional medical costs, but also allows the state to address concerns that a low-income population might otherwise delay or avoid necessary care. Since enrollees would revert back to Medicaid when their HSA is exhausted, there is a clear incentive on the state's part to ensure their health status does not deteriorate while they are enrolled in an HSA pilot.
- Amount and timing of enrollee's deductible: States have flexibility in both the amount and timing of the enrollee's deductible. Small deductibles and those that don't have to be paid up front as a condition of enrollment are more likely to increase participation rates. However, the smaller the deductible, the less likely enrollees are to have an incentive to avoid unnecessary care. Additionally, requiring the deductible be paid up front ensures enrollees will actually meet their deductible and prevents the situation of the state needing to delay or deny and enrollees return to the traditional Medicaid program based on failure to pay their deductible. However, participation rates are likely to be lower when enrollees have to pay the deductible up front. States can also adopt pay as you go strategies, where required deductibles are collected periodically, either monthly or quarterly, but this option increases the administrative complexity of the program.
- Benefit package: The type of benefits allowable for reimbursement under the HSA can influence enrollee's participation rates, with attractive and otherwise uncovered benefits, such as dental care, likely to increase participation rates. Additionally, certain benefits for prevention and screening services not covered under traditional Medicaid, such as weight loss programs, may improve an enrollee's overall health status, which would have implications for the cost of their care when they revert back to Medicaid, leave the Medicaid program, and are possibly covered in the private market.

This analysis evaluated the cost effectiveness of a small, regional, HSA pilot. The analysis found that implementing an HSA pilot for the currently eligible Medicaid population, regardless of the type of federal authority used, would not be cost effective. The lack of cost effectiveness rests largely with the significant start-up and operating costs associated with implementing a new program, and with the fact that the pilot size is small, minimizing the ability to offset costs with savings. Additionally, the analysis found the constraints of the DRA make waiver authority a more feasible option for pursuit of an HSA.

However, it should be noted that the findings of this analysis are limited to the establishment of a small HSA pilot for the currently eligible Medicaid population. If Texas were to develop an HSA for a much larger population, perhaps including a Medicaid expansion population, it is more likely cost effectiveness could be achieved, since the fixed costs would be spread across a larger group of individuals. Thus, while a small, regional, HSA pilot would not be cost effective, an HSA-type model may have benefit for Texas if applied to a much larger population, where

costs can be more broadly distributed and where the population is large enough to generate savings sufficient to off-set costs.

Appendix A: Health Opportunity Account Requirements per the Federal Deficit Reduction Act of 2005

In addition to setting requirements as to who is eligible to participate in the demonstrations, the DRA specifies specific requirements regarding the manner in which HOAs can be developed. These are summarized below:

- Voluntary Enrollment: An individual can only be enrolled in an HOA if he or she elects to enroll. Mandatory enrollment is not allowed. Except for hardship cases, enrollment lasts for a period of 12 months and can be extended for additional periods of 12 months with the individual's consent.
- Federal Financial Participation (FFP) for Account Contributions: States are not eligible to receive FFP for contributions to an HOA to the extent that the amount of the contribution exceeds, on an annual basis, $2,500 for an adult and $1,000 for child. While states can exceed these limits, no FFP will be provided for contributions in excess of these limits. These annual caps will be increased each year after 2006 by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index.
- Entities Eligible to Fund the HOA: Charitable organizations and other sources may contribute to the account (as permitted under current law), but FFP is only allowed for the state contribution.
- Deductibles: The amount of the annual deductible must be at least 100 percent, but not more than 110 percent of the state's contribution to the HOA. For example, in a state that contributes the maximum amount allowed and applies the maximum deductible allowed, adults with HOAs would have $2,500 deposited in their account and they would have to meet a deductible of $2,750 ($2,500+$250). Thus, after exhausting the $2,500 deposited into his or her account, an individual would have a gap of $250 that must be paid before he or she can receive coverage under traditional Medicaid. There is limited federal guidance on when enrollees must pay their deductible. CMS has not yet released guidance on when HOA participants must pay their deductibles and thus states appear to have the option of making deductibles payable either prior to using the HSA or prior to reverting back to Medicaid.
- Managed Care Organizations (MCOs): States can develop demonstrations that allow individuals enrolled in Medicaid MCOs to participate in the HOA, but the state must assure:
  - The number of individuals enrolled in the MCO who participate in the HOA program will not exceed 5 percent of the total number of individuals enrolled in the MCO.
  - The proportion of enrollees in the MCOs who participate in the HOA will not be significantly disproportionate to the proportion of such enrollees in other MCOs who participate in the HOA.
  - The state will provide an appropriate adjustment in the per capita payments to the MCO to account for participation in the HOA. This will take into account the difference in the likely use of health-care services between MCO enrollees who participate in the HOA and MCO enrollees who do not participate in the HOA.
- Rollover of Funds: If an HOA enrollee loses Medicaid eligibility during the course of the year, he or she is permitted to keep 75 percent of any funds left in the HOA account (the state

keeps 25 percent). Withdrawals from an HOA by an individual who is no longer eligible for Medicaid may be used to purchase health insurance coverage, and may be used, at the option of the state and if the individual has had an HOA for over one year, for additional expenses specified by the state, such as for tuition, workforce training, or private health insurance coverage. Individuals have three years from the date on which they become ineligible for Medicaid to use the balance in their account.

- Revert Back to Regular Medicaid: Once an individual uses his or her full HOA account balance and has met the deductible, he or she reverts back to the regular Medicaid program in force prior to HOA enrollment.

Appendix B: Constraints and Assumptions

Constraints and Assumptions

A critical component in the development of any cost-effectiveness model is the determination of the constraints and assumptions that will be built into the model. Changes in any of these factors can influence the results of the analysis. This analysis incorporates assumptions regarding an HSA pilot believed to be the most realistic and practical options available to the state. Additionally, the analysis seeks to include all relevant constraints that would affect the development and operation of an HSA pilot.

Constraints

State and federal regulations present the most significant constraints under which an HSA pilot may operate. The requirements associated with S.B. 10, the DRA and, where relevant, an 1115 waiver, served as constraints for the cost-effectiveness analysis. Additionally, aspects of the Texas Medicaid program such as the relatively small number of individuals who would be eligible under DRA requirements (due both to the stringent income limits Texas uses for eligibility and the related short amount of time TANF and TANF-related clients spend on the Medicaid program) also affected the analysis.

Assumptions

1. Participation Rate

Both the DRA and S.B. 10 require that participation in an HOA or HSA be voluntary. As a result, the percentage of individuals who elect to enroll cannot be known for certain. The design of the program will affect enrollment, as will state outreach and education efforts. The analysis assumes the HSA or HOA program would be designed to encourage enrollment via an attractive benefit package (by including dental and other services not currently covered by Medicaid) and would include enrollment outreach and counseling (the counseling component is required by the DRA).

To date, only South Carolina has implemented a Medicaid HSA-type arrangement under the DRA. The program is both too new and too small to draw conclusions regarding enrollee participation. HSAs available in the private market, however, offer some indication of expected participation, with a general range of approximately 17-19 percent participation.[21,22] Extending these projections to the eligible population for the HSA pilot program (which will essentially be non-disabled adults at very low levels of income) presents some challenges. This population is assumed to be generally less aware of HSAs and their associated benefits and more difficult to reach to explain the HSA option.

[21] Kaiser Family Foundation and HRET, 2006.

[22] General Accounting Office, as cited in "Health Savings Accounts and High-Deductible Health Plans" Bell Policy Center, Issue Brief No. 8, August 29, 2007.

There are a number of challenges in marketing HSAs to this population. These include the complexity of the HSA arrangement, educational and language barriers, and the assumed lack of familiarity with HSAs. As a result, even relatively modest participation rates may be somewhat optimistic. The model was developed to assume participation rates will eventually reach 15 percent of eligible enrollees. Participation rates are shown in the table below.

	2009	2010	2011	2012	2013
Participation Rate	7 %	9 %	11 %	13 %	15 %
Number of Participants	56	72	88	104	120

Notes:
Pilot is assumed to operate in an area with approximately 800 individuals eligible to participate.

2. Failure to Meet Deductible to Re-enroll in Medicaid
The DRA allows states to set a deductible enrollees are required to pay out-of-pocket before they re-enroll in traditional Medicaid. If Texas enacted this policy, some percentage of adults participating in the program either might not chose, or may not be able, to pay the required deductible. This would result in a direct savings to state general revenue, since individuals who would otherwise be eligible for Medicaid would no longer be covered. At the same time, the loss of Medicaid would also likely lead to higher costs to the hospital systems and local governments as a result of an increased burden on county indigent care programs and emergency departments. Federal Medicaid match for these clients would also be lost.

S.B. 10 requires that "a recipient who participates in the pilot program may, at their option and subject to forfeiting any remaining funds in their account, discontinue participation in the program and resume receiving benefits and services in the traditional Medicaid program." By establishing a requirement that the deductible is paid up front, the program could be designed to meet the legislative intent of S.B. 10 and realize the goal of securing enrollee financial participation.

In order to assure that individuals can revert back to traditional Medicaid, and that the concept of a deductible is retained in the model, the model assumes a "pay as you go" approach, whereby the participants must pay their deductible (or a portion of their deductible) up front before they can be enrolled in the pilot program. This arrangement eliminates the possibility of an individual being denied the ability to go back to traditional Medicaid due to a failure to meet their deductible. Additionally, this assumption eliminates the false economies that are associated with delaying or denying Medicaid benefits to otherwise eligible individuals.

3. Pilots Sites
The analysis would ideally model two regional pilot sites – one in an urban location and one in a rural location. However, the total number of individuals eligible to participate in an HSA pilot who also live in non-urban areas across the state is 14,745. In any one regional area, there would not be sufficient numbers of eligible participants, particularly given the voluntary nature of the program, to support a rural pilot. As a result, the model assumes the pilot would be limited to metropolitan areas.

Parameters

1. Time Period
In April 2007, HHSC submitted a comprehensive 1115 waiver to reform its current Medicaid program that will span fiscal years 2009 through 2013. This analysis mirrors that five-year time frame and includes data on eligible populations and trend factors associated with this time frame.

2. Eligible Population
The model assumes the following categories of participants would be excluded from participating in an HSA pilot:

- Children (aged birth to 20), per S.B. 10 requirements.
- Individuals in capitated managed care, since these arrangements already manage an enrollees' utilization of services and because there would be extensive administrative requirements associated with adjusting MCO rates when individuals transitioned to and from an HSA pilot.
- Individuals who are aged, disabled, or pregnant, since these populations are permanently excluded from participation under the DRA, which is seen as a signal that federal approval to include these populations, even under a waiver, would be difficult to secure.

Because the pilot would not be statewide, only a subset of the eligible population would participate. HHSC Strategic Decision Support analyzed the service areas that could accommodate an HSA/HOA pilot and found the largest service areas have between 700-1,000 eligible individuals. The model assumes a pilot area with 800 individuals who meet eligibility criteria for an HSA.

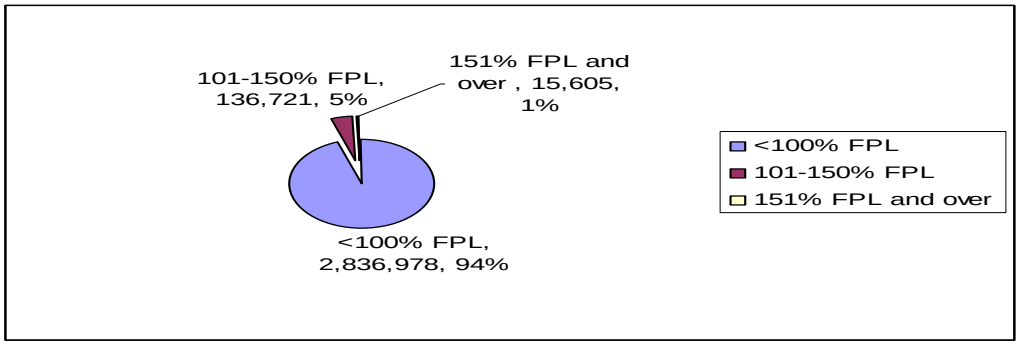
3. Amount of the State's Contribution
The model assumes the state contributes $2,000 per adult. The state could contribute up to $2,500 under the DRA and still receive federal match for that amount, and it is likely this amount would also be acceptable to CMS under a waiver. However, the inclusion of an annual physical and the current Medicaid benefit of three prescriptions per month that are provided as "first dollar coverage" is a relatively generous package and is assumed to lessen the need to more fully fund an enrollee's HSA.

4. Size of Deductible and Timing of Payment
The amount of the deductible would be based on the state's contribution to the HSA or HOA, which is assumed to be $2,000 per year. The model assumes the amount of the deductible would be similar to the present Children's Health Insurance Program (CHIP) enrollment fees, which, as of September 2007, were $0 for individuals at or below 150 percent FPL; $35 for individuals between 151 percent, up to and including 185 percent FPL, and $50 for individuals above 185 percent. In order to establish deductible amounts similar to the CHIP enrollment fees, the model assumes a 2.5 percent deductible, which would equate to an annual deductible of $50.

While deductibles could be much higher either under the DRA or conceivably under a waiver, this amount was chosen to account for the fact that the Medicaid population in Texas is almost entirely made up of very low income individuals. Approximately 94 percent of the Texas

Medicaid population has income of less than 100 percent FPL (which for a family of one in 2007 equated to $10,210).

Breakdown of Medicaid Population by Income



Source: HHSC Eligibility and Enrollment Data, April 2007

5. Benefit Package

The DRA allows states to provide coverage of preventive care within the alternative benefits without regard to the annual deductible. The analysis assumed a set of defined benefits HSAs would pay for under both DRA and 1115 scenarios. This hypothetical benefit package was based on the assumption that the addition of benefits not currently covered under traditional Medicaid would act as an incentive to enrollee participation and delay reversion to traditional Medicaid.

The benefit package would consist of all the benefits in the traditional Medicaid package (including any existing limitations or prior authorization requirements), as well as the following:

- Dental benefits – preventive and therapeutic services, up to $500 per 12 month period.
- Tobacco cessation programs – up to $300 per 12 month period.
- Weight loss programs – up to $300 per 12 month period.
- Marriage counseling/parenting "workshops" – up to $300 per 12 month period.

Additionally, in order to help ensure participants seek necessary preventive care, the following services would not count against an enrollee's deductible:

- One well visit/annual exam per 12 month period.
- Three prescriptions per month (this is a current Texas Medicaid benefit).

6. Enrollee Access to Account Balance When/If Become Ineligible for Program

Under the DRA, if an HOA enrollee loses Medicaid eligibility during the course of the year, they are permitted to keep 75 percent of any funds left in their HOA account, while the state keeps 25 percent. Withdrawals from an HOA by an individual who is no longer eligible for Medicaid may be used to purchase health insurance coverage, and may be used, at the option of the state and if the individual has had an HOA for over one year, for additional expenses specified by the state, such as for tuition, workforce training, or private health insurance coverage. Individuals have three years from the date on which they become ineligible to use the balance in their account. The DRA requires the enrollee have access to the balance for three years.

The administrative costs required to maintain these accounts were not included, largely because it is a DRA requirement and this and other elements of the DRA indicate it would not be a feasible option to use to implement an HSA pilot. Thus, the model assumes enrollees do not have access to any remaining account balance.

Appendix C: Alternate Scenarios

Cost Effectiveness with SAVVER Costs Omitted

HSA Pilot Costs, All Funds

	Start-Up Costs	2009	2010	2011	2012	2013	Total
Number of Pilot Participants	N/A	56	72	88	104	120	
Administrative Costs	$4,942,845	$34,700	$34,700	$34,700	$34,700	$34,700	$5,116,345
Medical Costs	$0	$174,384	$231,048	$291,482	$354,319	$420,463	$1,471,697
Total Administrative and Medical Costs	$4,942,845	$209,084	$265,748	$326,182	$389,019	$455,163	6,588,042
Total Savings	N/A	($5,600)	($14,400)	($17,600)	($31,200)	($48,000)	($116,800)
Net Costs	**$4,942,845**	**$203,484**	**$251,348**	**$308,582**	**$357,819**	**$407,163**	**$6,471,242**

Notes:
Assumes maximum savings scenario.