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## HEALTH OPPORTUNITY ACCOUNTS FOR LOW-INCOME MEDICAID BENEFICIARIES: A Risky Approach

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On October 27, the House Energy and Commerce Committee marked up reconciliation legislation that includes about \$10 billion in cuts to the Medicaid program.<sup>1</sup> In addition to other Medicaid proposals that would adversely affect low-income beneficiaries by increasing cost sharing and reducing benefits, the package approved by the House Energy and Commerce Committee includes a provision to establish “Health Opportunity Accounts” for Medicaid beneficiaries in up to ten states.<sup>2</sup> These accounts would be somewhat similar to tax-favored Health Savings Accounts (HSAs) attached to high-deductible health insurance plans, which were established under the 2003 Medicare drug legislation.<sup>3</sup>

Like HSAs, Health Opportunity Accounts pose significant risks.<sup>4</sup> They also would add to federal Medicaid costs.

These accounts raise concerns because they would require low-income Medicaid beneficiaries to meet a substantial deductible before they could access their standard Medicaid benefits. (Once beneficiaries reached the deductible, Medicaid coverage would kick in, and beneficiaries would be

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<sup>1</sup> Subtitle A of the House Energy and Commerce Committee package reduces Medicaid spending by \$11.9 billion over five years. Subtitle B, however, includes a \$2.5 billion provision that provides 100 percent federal funding on a temporary basis for Medicaid coverage furnished to certain survivors of Hurricane Katrina, producing an overall reduction to the Medicaid program of \$9.4 billion over the next five years.

<sup>2</sup> The provision is identical to “The Medicaid Health Opportunity Act of 2005,” introduced in the House (H.R. 3757) by Representative Rogers (R-MI) and in the Senate (S. 1833) by Senator Coburn (R-OK).

<sup>3</sup> Under the 2003 Medicare drug legislation, any individual who enrolls in a high-deductible health plan with a deductible of at least \$1,000 for individual and \$2,000 for family coverage may establish a tax-favored savings account known as a Health Savings Account. Any individual with a HSA may take a tax deduction for contributions he or she makes to the account (up to the amount of the deductible in his or her insurance policy) as long as the contributions do not exceed an annual limit, set at \$2,650 for individuals and \$5,250 for family coverage in 2005. Earnings on funds held in these account accrue tax-free and withdrawals from the account also are exempt from tax as long as they are used to pay for out-of-pocket medical costs such as deductibles, copayments and other uncovered medical expenses.

<sup>4</sup> For a discussion of HSAs and the risks they pose of “adverse selection” and that they will be used extensively as tax shelters by high-income individuals, see, for example, Edwin Park and Robert Greenstein, “Latest Enrollment Data Still Fail to Dispel Concerns About Health Savings Accounts,” Center on Budget and Policy Priorities, October 26, 2005.

required to make the standard copayments and other cost-sharing charges associated with Medicaid.) States would make contributions to the accounts to help beneficiaries pay for the costs they would incur before Medicaid coverage kicked in, but states would *not* be required to fully offset those costs. As a result, some beneficiaries, particularly those in poorer health who exhaust the funds in their accounts but still have not met their deductible, could face a substantial increase in cost-sharing obligations (i.e., in out-of-pocket costs), which would discourage their use of medically necessary services.

As discussed below, an established body of research shows that even modest cost-sharing significantly increases the likelihood that low-income children and adults will not receive effective medical care and that making low-income Medicaid beneficiaries incur increased cost-sharing can endanger their health. Allowing states to experiment with Health Opportunity Accounts for Medicaid beneficiaries thus is likely to be harmful to beneficiaries, particularly those in poorer health who need the most health care services.

In addition, Health Opportunity Accounts are likely to end up increasing federal Medicaid costs. That is because Medicaid beneficiaries participating in these Health Opportunity Accounts can keep 75 percent of any funds remaining in their accounts if they become ineligible for Medicaid. The federal government currently pays only for medically necessary services covered under Medicaid provided to an individual during his or her period of eligibility. By helping finance a portion of the state contribution to these accounts and permitting beneficiaries to keep most of these funds, the federal government is essentially continuing to pay for individuals even though they no longer qualify for Medicaid.

Furthermore, the demonstration project permits beneficiaries to use funds held in these accounts to reimburse certain health care providers *at a higher rate* than under the state's Medicaid program. It also permits states at their option, to allow beneficiaries to use their accounts to pay for medical services not otherwise covered under Medicaid and even to pay for non-medical services such as job training and tuition expenses. The Congressional Budget Office (CBO) estimates that this provision will actually increase federal Medicaid spending by \$60 million over the next five years.

Despite these dubious features, the Health Opportunity Accounts provision would permit the Secretary of Health and Human Services to extend the demonstration project *nationwide* after the initial five-year period. Congress would have no role in this decision. Unless the Secretary determined that each of the individual state demonstrations were "unsuccessful," the provision could become permanent on a national basis. At that time, *all* states could establish Health Opportunity Accounts. As a result, CBO expects the use of Health Opportunity Accounts to become more widespread. CBO estimates that the provision would cost \$205 million in the second five years (2011-2015), more than triple the cost of the provision over the first five years. The demonstration project would thus increase Medicaid spending by a total of \$265 million over a ten-year period.

## **The Health Opportunity Accounts Demonstration Project**

The House Energy and Commerce Committee provision would establish a five-year demonstration project to allow up to 10 states to establish Health Opportunity Accounts. Under

such accounts, beneficiaries would have to meet a deductible before obtaining their standard Medicaid benefits.

The deductible would be set at not more than 110 percent of the state's contribution to the individual's or family's Health Opportunity Account (and at not less than 100 percent of that contribution).<sup>5</sup> State contributions to the accounts would be limited to \$2,500 per adult and \$1,000 per child.<sup>6</sup>

Beneficiaries could use the funds in the Health Opportunity Account to pay providers for services otherwise covered under Medicaid. Providers participating in the Medicaid program would be paid at their standard payment rate; non-participating providers would be paid at no more than 125 percent of the Medicaid payment rate. States could also elect to allow beneficiaries to use Health Opportunity Account funds to pay for additional services not covered by an individual state's Medicaid plan as well as health care services not otherwise permitted under Medicaid. In addition, states would have the option of exempting certain preventive services from application of the deductible but would not be required to do so.

The demonstration project does not have to be statewide, and participation in the demonstration project must be voluntary on the part of beneficiaries. The elderly, people with disabilities, pregnant women, and beneficiaries who had been on Medicaid for less than three months would not be permitted to participate. In addition, participation by Medicaid beneficiaries enrolled in managed care plans would be limited to no more than five percent of any individual plan's total Medicaid enrollment.<sup>7</sup>

If a Medicaid beneficiary with a Health Opportunity Account became ineligible for Medicaid due to a change in income or resources, the beneficiary could keep the account, with the balance in the account being reduced by 25 percent. The state would be required to continue to administer the account on behalf of the former beneficiary. The state would also have the option of allowing the former beneficiary to use remaining account funds to pay for non-medical services such as job training and tuition expenses.

The demonstration project could become *permanent* after the initial five-year period unless the Secretary of Health and Human Services determined that each of the individual state demonstration projects were "unsuccessful," using evaluation criteria to be specified by the Secretary. At that time, at the discretion of the Secretary, *all* states could establish Health Opportunity Accounts and *all* beneficiaries, including the exempt populations, could participate. In other words, the Executive Branch would decide at the end of five years whether to extend the project nationwide.

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<sup>5</sup> States would be permitted to vary the deductible and contribution levels by a beneficiary's income.

<sup>6</sup> These contributions would constitute Medicaid expenditures eligible for federal Medicaid matching payments. State contributions in excess of these limits would not qualify for any federal match.

<sup>7</sup> States must also ensure that participation in Health Opportunity Accounts do not disproportionately come from individuals enrolled in a particular managed care plan.

## **Health Opportunity Accounts Could Significantly Increase Cost-Sharing for Some Beneficiaries**

Under this proposal, low-income individuals and families participating in the demonstration project could face a large increase in the out-of-pocket costs they now incur under Medicaid. Consider, for example, a family of three consisting of a single parent and two children, all of whom are enrolled in Medicaid. A state electing to provide the maximum contribution could contribute up to \$4,500 (\$2,500 for the parent and \$1,000 for each of the children) to the family's Health Opportunity Account. The state could then set the deductible at the maximum level permitted under the proposal: \$4,950 (110 percent of the state's contribution).

Now assume one of the family's children becomes seriously ill and the family incurs health costs in excess of the state's contribution of \$4,500. This means that the family of three would now face a "doughnut hole" of \$450 (\$4,950 minus \$4,500), which the family would have to incur on an out-of-pocket basis after its account was exhausted.<sup>8</sup> Standard Medicaid coverage would kick in only after the family reached the \$4,950 expenditure point.

This \$450 in cost-sharing would be in addition to any standard copayments or other cost-sharing required under the state's Medicaid program once the deductible was met. In other words, after meeting the deductible, the family would have to make normal Medicaid copayments for the prescription drugs and physician visits needed by the sick child. Those copayments, however, would likely be significantly higher than they are today, because the House Energy and Commerce reconciliation package significantly increases the copayments that low-income Medicaid beneficiaries can be required to pay.

## **This Increase in Cost-Sharing Would Likely Cause Some Low-Income Medicaid Beneficiaries to Forgo Needed Health Care Services**

Numerous studies have been conducted on the effects of cost-sharing charges on the use of health care services. The studies show that for people with low incomes, increased cost-sharing results in significantly reduced access to care and often in a deterioration of their health.

- The RAND Health Insurance Experiment, considered the definitive study of this issue, found that while copayments did not adversely affect the health of middle- and high-income people, they did lead to poorer health for those with low incomes. The Rand study found that copayments led to a marked reduction in "episodes of effective care" among low-income adults and children. As a consequence, health status was considerably poorer among those low-income adults and children who had to make copayments to obtain care than among comparable low-income adults and children who were not subject to copayments. As one example, copayments were found in the RAND experiment to increase the risk of death by

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<sup>8</sup> For an individual child, the doughnut hole could be as high as \$100 (\$1,100 deductible attached to a maximum state contribution of \$1,000) and for an individual adult, the doughnut could be as high as \$250 (\$2,750 deductible attached to a maximum contribution of \$2,500).

about 10 percent for low-income adults who were at risk of heart disease.<sup>9</sup>

- A recent small survey in Minneapolis' main public hospital that examined the effects of modest copayments for prescription drugs that were instituted in that state's Medicaid program produced similar findings. Slightly more than half of those surveyed reported being unable to obtain their prescriptions at least once in the last six months because of the copayment charges. Those who failed to obtain their prescriptions at least once experienced an increase in subsequent emergency room visits and hospital admissions, including admissions for strokes and asthma attacks.<sup>10</sup>
- Still another such piece of research, published in the *Journal of the American Medical Association*, found that after Quebec imposed copayments for prescription drugs on adults who were receiving welfare, these individuals filled fewer prescriptions for essential medications, and emergency room use subsequently climbed by 88 percent among these individuals. In addition, the number of "adverse events," such as death and hospitalization, rose by 78 percent.<sup>11</sup>
- Finally, Medicaid beneficiaries already bear substantial financial responsibility for their health care, taking into account their limited income and resources. Recent studies show that, on average, adults on Medicaid pay a *larger* percentage of their income in out-of-pocket medical expenses than do *non*-low-income individuals with private insurance. Studies also demonstrate that in recent years, the share of Medicaid beneficiaries' income that is consumed by out-of-pocket medical expenses has been rising twice as fast as their incomes. Medicaid beneficiaries who have disabilities bear especially high out-of-pocket costs.<sup>12</sup>

Increasing the cost-sharing faced by Medicaid beneficiaries through Health Opportunity Accounts would heighten the risk that beneficiaries, particularly those in poorer health, would go without needed care. Once beneficiaries exhausted their accounts, they would have to pay the full cost of health care services in the "doughnut hole" between the state's contribution and the level of the deductible. The use of these Health Opportunity Accounts in Medicaid consequently would be likely to result in decreased use of necessary and effective care (and ultimately, in increased costs for beneficiaries who became sicker).

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<sup>9</sup> Joseph Newhouse, *Free for All? Lessons from the Rand Health Insurance Experiment*, Harvard University Press, 1996.

<sup>10</sup> Melody Mendiola, Kevin Larsen, et al., "Medicaid Patients Perceive Copays as a Barrier to Medication Compliance," Hennepin County Medical Center, Minneapolis, MN, at <http://www.hcmc.org/depts/medicine/medresearch.htm>.

<sup>11</sup> Robyn Tamblyn, et al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," *Journal of the American Medical Association*, 285(4): 421-429, January 2001. In this study, the low-income people were adults who were on welfare.

<sup>12</sup> Leighton Ku and Matthew Broaddus, "Out-Of-Pocket Medical Expenses For Medicaid Beneficiaries Are Substantial And Growing," Center on Budget and Policy Priorities, May 31, 2005.

## Research Does Not Support the Notion That Medicaid Beneficiaries Make Excessive Use of Health Care Services

Those supporting the use of the Health Opportunity Accounts in Medicaid may claim that the accounts will reduce the use of unnecessary health care services and increase the likelihood that low-income beneficiaries will use less costly services. Yet any evidence that Medicaid beneficiaries are using too much care, or care that is too expensive, is anecdotal and inconsistent with the research in the field. Moreover, states already have a number of methods they can use to ensure appropriate utilization of health care services without resorting to Health Opportunity Accounts.

A recent 13-state study refutes the notion that Medicaid beneficiaries use more health care than they need, finding that adult Medicaid beneficiaries use about the same level of health care services as adults with private insurance.<sup>13</sup> A study of mothers in low-income families found similar results.<sup>14</sup> Among children, Medicaid has been found to provide better access to preventive services for children than private health insurance does; this is a desirable outcome that likely reflects the success of Medicaid in facilitating preventive services for children.<sup>15</sup>

Most states are already using a number of tools to avoid over-utilization and to encourage the use of less costly services. For example, most Medicaid programs already require beneficiaries to use generic drugs when they are available. In fact, the majority of drugs used by Medicaid beneficiaries are generic drugs, and Medicaid beneficiaries are 28 percent more likely than patients with private insurance to be prescribed generic drugs.<sup>16</sup> Most states can and do require prior authorization for certain brand-name drugs as well as for other services.<sup>17</sup> Many Medicaid managed care programs use strategies such as telephone advice lines to limit unnecessary and costly visits to the emergency room. Unlike Health Opportunity Accounts, these approaches can reduce costs without endangering the ability of beneficiaries to get necessary health care services.

## Health Opportunity Accounts Would Increase Federal Medicaid Costs

Health Opportunity Accounts may reduce some Medicaid costs by discouraging utilization of medically necessary and cost-effective medical services by low-income Medicaid beneficiaries. At

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<sup>13</sup> Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs*, 24(4):1073-1083, July/August 2005.

<sup>14</sup> Sharon K. Long, Teresa Coughlin and Jennifer King, "How Well Does Medicaid Work in Improving Access to Care?" *Health Services Research*, 40(1): 39-58, February 2005.

<sup>15</sup> Lisa Dubay and Genevieve M. Kenney, "Health Care Access and Use Among Low-income Children: Who Fares Best?" *Health Affairs* 20(1): 112-21, January/February 2001.

<sup>16</sup> Congressional Budget Office, "Medicaid's Reimbursements to Pharmacies for Prescription Drugs," December 2004. G.E. Miller & J.F. Moeller, "Outpatient prescription drug prices and insurance coverage," in *Investing in Health: The Social and Economic Benefits of Health Care Innovation*, pp 23-57, 2001.

<sup>17</sup> Vernon Smith, et al., "Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results from a 50-State Survey," Kaiser Commission on Medicaid and the Uninsured, October 2005; Jeffrey S. Crowley, et al., "State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update," Kaiser Commission on Medicaid and the Uninsured, October 2005.

the same time, however, Health Opportunity Accounts would likely add to federal Medicaid costs on several other fronts.

Because beneficiaries get to keep any remaining balances in their accounts if they become ineligible for Medicaid, such accounts may end up being *more costly* than existing Medicaid coverage, since Medicaid currently incurs costs only for Medicaid services provided to current enrollees, not for costs that former participants incur. These costs will mount if the healthiest Medicaid beneficiaries elect to participate in the demonstration project while sicker beneficiaries decline to participate because of the large deductible and the “doughnut hole.” Because the healthiest individuals may need little health care, they often would have large balances remaining in their accounts when they left the program. And because the federal government would pay for a portion of the state contributions to Health Opportunity Accounts that had funded these balances, the federal government would bear greater Medicaid costs for these beneficiaries than it would otherwise have incurred.

Moreover, under Health Opportunity Accounts, beneficiaries are permitted to pay providers for health care costs below the deductible at rates *higher* than those that Medicaid generally pays. If a beneficiary saw a provider who does not participate in the Medicaid program, the beneficiary could use Health Opportunity Account funds to pay the provider at a rate 25 percent higher than the standard Medicaid reimbursement rate. This means that some of the funds contributed to the accounts that the federal government helped finance may be spent in a less cost-effective manner than they would spend if the funds were used to pay for Medicaid benefits directly.

Furthermore, states, at their option, may elect to allow beneficiaries to use funds in their Health Opportunity Accounts to pay for services not covered under their Medicaid state plan and medical services that federal law does not permit Medicaid to cover. States could also allow former beneficiaries to use funds remaining in their accounts to even pay for non-medical services specified by the state, including job training and beneficiaries’ tuition expenses. These are all services that are not otherwise eligible for federal matching payments under the Medicaid program but for which the federal government would now be financially responsible.

Finally, under federal law, the federal government generally pays for 50 percent of states’ Medicaid administrative costs. As a result, the federal government would have to finance half of states’ Medicaid costs related to setting up new administrative structures to establish and monitor the accounts, ensuring the accounts are conducted electronically, and administering these accounts even after beneficiaries became ineligible for Medicaid.

As a result of these higher costs, the Congressional Budget Office expects that the demonstration project will actually increase federal Medicaid spending by \$60 million over the next five years. In addition, CBO assumes that the use of Health Opportunity Accounts will become more widespread after the first five years, at which point the Secretary can make the demonstration project permanent and expand it nationwide. As a result, CBO estimates that the costs of the provision would more than triple over the second five years (2011-2015), for a total increase in Medicaid spending of \$265 million over 10 years.

## Conclusion

While the scope of the Health Opportunity Accounts demonstration project is limited for the first five years, the use of such accounts for low-income Medicaid beneficiaries poses a significant risk of reducing beneficiary access to medically necessary services. The Health Opportunity Accounts could leave some beneficiaries, particularly those in poorer health, responsible for out-of-pocket costs related to health services they need when they have exhausted their accounts but not yet met the deductible. These costs would be on top of the standard copayments that beneficiaries would have to pay once the deductible was exhausted, which themselves would be increased by other Medicaid provisions of the Energy and Commerce reconciliation package. Research indicates that increased cost-sharing particularly affects the ability of low-income individuals to access health care.

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

Despite these substantial risks, after five years, the demonstration project would become permanent, and the Secretary of Health and Human Services could extend it nationwide to all states and all beneficiaries, without review and further action by Congress. All of this leads to a conclusion that the demonstration project in the Energy and Commerce Committee's reconciliation package is seriously flawed in a number of respects and that its enactment would represent neither sound health care policy nor sound fiscal policy.