Report to the Health and Human Services Appropriations Subcommittee

Consumer-Driven Health Care in Medicaid

Prepared by the Division of Medicaid and Health Financing

September 2009

UTAH DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed by the 2009 Legislature:

"The Legislature intends that the Department of Health make a report to the Health and Human Services Appropriations Subcommittee that recommends ways to significantly expand consumer-driven health care in Medicaid including any necessary waivers. The Department of Health shall report to the Health and Human Services Appropriations Subcommittee by October 1, 2009."

Current Delivery System

Utah's Medicaid service delivery system currently utilizes three different methods: fee-for-service, managed care and premium assistance. The majority of Utah's Medicaid clients are enrolled in the managed care delivery system.

Health Opportunity Accounts

The Deficit Reduction Act of 2005 allows up to ten states to operate a consumer-driven health care plan. The program uses a Health Opportunity Account (HOA) for the payment of routine care services and traditional Medicaid coverage for catastrophic care.

Even though state Medicaid programs can offer these plans, there are several restrictions on how they can administer the program. The most limiting restriction is that currently enrolled Medicaid clients must volunteer to forgo further traditional Medicaid coverage to enroll in the HOA program.

Implementation Options

Medicaid can implement an HOA by either a State Plan Amendment or by an 1115 Demonstration Waiver. Each option has its advantages and disadvantages. South Carolina implemented a State Plan Amendment for currently eligible populations and has 3 enrollees. Indiana implemented an 1115 Demonstration Waiver, expanded eligibility and has 47,000 enrollees.

Recommendation

Given the intent language objective to recommend ways to "…significantly expand consumer-driven health care in Medicaid…", Medicaid recommends that the 1115 Demonstration Waiver option be considered because of its success in Indiana and the comparative lack of success in South Carolina with the State Plan Amendment option.

Introduction

Consumer-driven health care (CDHC) is a relatively new approach to paying for health care services. While traditional health insurance covers a defined list of benefits and requires the insured individual to pay specified copayment and coinsurance amounts out of pocket, consumer-driven health care has the consumer pay for routine health care expenditures out of a Health Savings Account (HSA) and have coverage for catastrophic events through a high-deductible health plan (HDHP).

In the CDHC model, the consumer is the primary decision maker. As a result, the consumer is more likely to compare the cost of services and to seek less expensive treatments.

The federal government has authorized up to ten states to offer consumer-driven health plans for limited Medicaid populations. Currently two (Indiana and South Carolina) are offering such a plan.

Terminology

It is useful to explain a few terms at this point, for clarity:

- *Consumer-driven Health Care* — a method of paying for health care services with routine services paid for from a Health Savings Account and catastrophic services paid for through a high-deductible health plan.
- *Health Opportunity Account (HOA)* — the Medicaid version of a health savings account.
- *Health Savings Account (HSA)* — an account into which an individual or employer can deposit money for use in obtaining routine medical services.
- *High-deductible health plan (HDHP)* — catastrophic health insurance coverage that includes a large-dollar deductible amount—usually higher than a couple thousand dollars.

Current Medicaid Delivery System

Utah's Medicaid service delivery system currently utilizes three different methods: fee-for-service, managed care and premium assistance.

Fee-for-Service

Fee-for-service is a reimbursement system in which Medicaid reimburses providers a predetermined fee for each covered service a Medicaid client uses. Providers who are willing to accept the Medicaid fee schedule and who meet other provider qualifications are authorized to deliver the services.

Many Medicaid clients are liable for a limited copayment at the time of service. The federal government determines the Medicaid populations who can be charged a copayment and what the maximum amount of the copayment can be.

This system is used primarily in the rural counties in Utah.

Managed Care

Managed care is a reimbursement system in which Medicaid contracts with a qualified managed care organization (MCO) to arrange for the care and payment of services for a specific group of Medicaid clients. The contract can be either a risk-based contract or variation of the fee-for-service model.

The copayment requirements in fee-for-service are also applicable in managed care.

This system is used primarily along the four Wasatch Front counties and includes the majority of Medicaid enrollees.

Premium Assistance

Premium assistance is a reimbursement system in which Medicaid pays a subsidy to an individual to purchase private, employer-sponsored health insurance. The amount of the monthly subsidy is capped at the lower of the employee's share of the premium or a state-established maximum dollar amount.

The copayment requirements depend on the plan offered through the employer.

This system is available statewide, but contingent upon the enrollee's having employer-sponsored health insurance and the enrollee's not being eligible for traditional Medicaid coverage.

Medicaid Health Opportunity Accounts (HOA)

The Deficit Reduction Act (DRA) of 2005 Section 6082 added a new section (1938) to the Social Security Act allowing up to ten states to operate a five-year demonstration program in consumer-driven health care. The program utilizes what is known as a Health Opportunity Account (HOA) for the payment of routine care services and wrap-around traditional Medicaid coverage for catastrophic care. There are several limitations on how states can implement the demonstration program.

Eligibility Criteria

The federal government has three criteria that an individual Medicaid client must meet before enrolling into the HOA program:

- Must be a "healthy" adult or child and
- Must have been on Medicaid for three months and
- Must volunteer to enroll in the HOA program

The term "healthy" means that the person is not over age 65, is not pregnant, does not have a disability, is not blind, is not terminally ill, is not living in an institution and is not in the foster care system.

The requirement that a client volunteer to enroll in the program means that the State cannot mandatorily enroll anyone in the program. The client would have to choose to forgo traditional Medicaid coverage to enroll in the HOA plan.

Duration of Coverage

Once an individual enrolls in the HOA program, then the person receives coverage for a period of twelve continuous months, even if the individual would have lost Medicaid coverage under the traditional Medicaid program at an earlier date.

Benefit Design

The Health Opportunity Account (HOA) receives monthly contributions from the Medicaid program within specified limits of what is eligible for federal match. Once the resources in the HOA are exhausted, then Medicaid must cover additional expenditures with traditional Medicaid coverage, with the option for a client deductible higher than the amount of the HOA account contribution. The HOA would be operated like a bank account with an electronic access card, akin to a debit card.

Account Contributions

Medicaid can place a maximum of $2,500 per year for each adult and of $1,000 per year for each child into the HOA and receive the standard federal matching payment. Any contributions above that amount must be made with all state funds. Medicaid can allow contributions from individuals or from charitable organizations into the account, but those contributions are not eligible for a federal match.

Annual Deductibles

Medicaid has the option of setting the plan's annual deductible at either the amount of the HOA contribution or up to 110 percent of that amount. The deductible can be based on the income of the family as long as it does not favor higher income families over lower income families.

If Medicaid set the annual deductible as the amount of the HOA contribution, then as soon as the account was exhausted the client would receive immediate traditional Medicaid coverage for any health care service expenditures in excess of the HOA. However, if Medicaid chose to set the deductible at the maximum amount allowable, then an adult would have to pay $250 out of pocket before the traditional Medicaid coverage would be in effect.

Account Use

The HOA account can be used only for Medicaid-specified health care expenditures, but the client is not limited to the current provider panel available in the Medicaid program. The client has the option to pay up to 125 percent of the Medicaid fee schedule to non-Medicaid providers for covered health care expenditures.

Implementation Alternative One: State Plan Amendment

If the State wants to offer the HOA plan to those eligible from within its current enrollment, then it can submit a State Plan Amendment (SPA) to the federal government. The State would need to select from available program design options, such as the deductible amount and the contribution amount, and then submit a standardized approval package. The federal government would have 90 days from the receipt of the SPA to make a decision on whether to approve or deny the plan.

The State would also need to adopt a new electronic payment system that clients could use to access the funds in their HOA.

South Carolina Experience

South Carolina is the only state to date that has implemented the State Plan Amendment option. The program began in May 2008 in Richland County (contains the capital city of Columbia). South Carolina designed its program by allowing the maximum contribution amount to be put into the HOA and requiring the 110 percent deductible. This means that adults would have an out-of-pocket expense of $250 and children would have an out-of-pocket expense of $100 once the HOA amounts of $2,500 and $1,000 were exhausted, respectively.

South Carolina currently has three people on the program. The highest enrollment the program has seen was five people. This enrollment is from a pool of over 60,000 Medicaid enrollees in Richland County.

Implementation Alternative Two: 1115 Demonstration Waiver

If the State wants to offer the HOA plan to populations not currently eligible for Medicaid, then it can submit an 1115 Demonstration Waiver to the federal government. The State would need to specify its program design options, such as the deductible amount and the contribution amount. It would also need to show a budget neutrality calculation. This would account for expansion coverage of populations not currently covered by Medicaid but eligible for coverage under federal regulations. It would also account for coverage of populations not eligible for Medicaid under federal regulations without a waiver.

The federal government has no required response time on an 1115 waiver to make a decision on whether to approve or deny the plan.

As with the State Plan option, Medicaid would also need to adopt a new electronic payment system that clients could use to access the funds in their HOA.

Indiana Experience

Indiana is the only state to date that has implemented the 1115 waiver option. The program began in January 2008 as a statewide program offered to individuals not previously eligible for Indiana's Medicaid program. In addition to the Indiana Medicaid contributions, the program requires the clients to contribute to the HOA account on a sliding scale based on income. Enrollees can have incomes up to 200 percent of the federal poverty level and still qualify for the program. They just have a higher contribution requirement to the account than do lower income enrollees.

Indiana decided not to have a higher deductible amount than the amount of the HOA because the clients are already contributing to the HOA balance.

The new expenditures for the program are funded from a new cigarette tax. Unused disproportionate share hospital allotments (DSH) were used to satisfy the federal government of the budget neutrality of the program. Indiana currently has 47,000 people enrolled in the program.

Advantages and Disadvantages of Each Option

Advantages of a State Plan Amendment

- Offers a time-specified approval time line from the federal government
- Provides an alternative delivery system to current enrollees

Disadvantages of a State Plan Amendment

- Allows less flexibility in program design
- Has mandatory volunteer enrollment provision and covers only currently eligible populations

Advantages of the 1115 Demonstration Waiver

- Allows more flexibility in program design
- Allows for the expansion of individuals eligible for the program and specifies the HOA as the only option for Medicaid coverage

Disadvantages of the 1115 Demonstration Waiver

- Carries an uncertain approval time line
- Requires a budget neutrality justification to the federal government to authorize the program. Indiana has a large unused DSH allotment from the federal government. Utah has a small allotment and uses all of it.

Recommendation

Given the intent language objective to recommend ways to "…significantly expand consumer-driven health care in Medicaid…", Medicaid recommends that the 1115 Demonstration Waiver option be considered because of its success in Indiana and the comparative lack of success in South Carolina with the State Plan Amendment option.