Health Care: Current Reviews

Randall et al., Health Care Current Reviews 2015, 3:1
http://dx.doi.org/10.4172/2375-4273.1000134

Research Article Open Access

Medicaid Expansion and the use of Account-based Health Plans

David Randall[1]*, Stephen T Parente[2] and Ramzi Abujamra[3]

[1]American Research and Policy Institute, Suite 200, 1250 Connecticut Ave, NW, Washington, DC., USA
[2]Carlson School, University of Minnesota, Minneapolis, MN, USA
[3]American Research and Policy Institute, Washington, DC., USA

Abstract

Objectives: U.S. Medicaid expansion has added over 11 Million new enrollees since 2010 and U.S. states are attempting to integrate the increased population as well as addressing fiscal constraints. Account based plans (such as Health Savings Accounts) have been successfully used to control utilization while providing enrollee flexibility. We suggest that a portion of the 55 million Medicaid beneficiary population can be enrolled in account based plans and assist state and federal Health Insurance Exchanges with the 'churn' that occurs between the two systems while controlling costs.

Methods: We use publicly available per capita Medicaid spending in each state to estimate the population that could be enrolled in an account based plan and apply factors from previous private market research in estimating the reduction in utilization trend and spend for the selected population.

Results: We find that using conservative enrollment and utilization trend assumptions that states could collectively see a reduction in spend of over $800 million to over $1 billion in a fiscal year.

Conclusions: States can enroll select Medicaid populations that could benefit from having a potentially seamless product that would allow individuals to transition between Medicaid plans and state and federal Health Insurance Exchange products while reducing utilization and spend.

Keywords: U.S. Medicaid; Cost containment; U.S. Health care reform; Health savings accounts

Introduction

As U.S. states contemplate policy options to expand Medicaid to select populations, they confront the challenges of also controlling costs associated with existing and new enrollees. This fact is complicated by the policy challenges associated with serving a poor population and thus new tools and methods should be explored. Importantly, the private health insurance market has developed tools in recent years to control costs and reduce utilization trend with diverse enrollee populations. We suggest that examining private market solutions can be useful to state Medicaid systems in controlling costs and utilization trend [1,2].

The private sector has a long history of deploying a variety of cost control mechanisms to reduce utilization trend and make certain that there are not adverse health outcomes. Account-based plans allow individuals to control the spending of basic health care needs such as routine care and thus encourage prudent spending and accompanying reduced utilization of health care services. The theory of account-based health accounts assumes that individuals will control and contribute to the account and thus have a vested interest in what they spend on routine health spending. Health Savings Accounts (H.S.A.s) and other account-based plans have had rapid expansion in the U.S. since 2003 and accompanying reduction in utilization trend [1]. Utilizing past research associated with account-based plans and previous research associated with select Medicaid populations, there are numerous policy scenarios that can assist in predicting how Medicaid beneficiaries can use account-based plan tools.

Utilization trend reductions associated with cost-sharing schemes are varied based upon several demographic and health care service type variables. The RAND experiment that examined a large health plan population demonstrated that income played a significant role in determining how private insurance beneficiaries utilized health care services with variations in cost sharing. An important finding and applicable to the Medicaid population specifically was that patients who received 'free' care (i.e. no cost sharing) consumed over 60% more services than individuals with some form of cost sharing [1,3-5].

Other research conducted after the RAND Health Insurance Experiment (RAND HIE) study, including recent research associated with H.S.A.s and high deductible health plans (HDHP) show that there is variation in utilization of services based upon service type. The types of service include outpatient services, ancillary services, primary care services, pharmacy and inpatient hospital [5,6]. Utilization trend shows a decrease of 16-22% for populations surveyed and generally utilization trend is 20% less for lower income strata [1,2]. These factors can be reasonably applied to the Medicaid population based upon income characteristics, with noted caution.

Several states have attempted (or are attempting) to experiment with having select Medicaid populations using account-based tools to not only reduce utilization but also use the accounts as a means of transitioning to HDHP plan on a state or federal Health Insurance Exchange (HIX) [7]. A policy concern that has been expressed is that a significant portion of the Medicaid population in states that have expanded to 133% of the Federal Poverty Limit (FPL) will see their populations 'churn' between Medicaid and the state or federal Health Insurance Exchange (HIX) [8,9]. Account-based plans have

***Corresponding author:** David Randall, Executive Director and Resident Scholar, American Research and Policy Institute, Suite 200, 1250 Connecticut Ave, NW, Washington, DC. USA, Tel: (202) 558-6364; E-mail: info@arapi.org

Received June 25, 2014; **Accepted** July 13, 2015; **Published** July 20, 2015

Citation: Randall D, Parente ST, Abujamra R (2015) Medicaid Expansion and the use of Account-based Health Plans. Health Care Current Reviews 3: 134. doi: 10.4172/2375-4273.1000134

the potential to address not only policy and budgetary concerns about utilization trends but also assure a mechanism to transition between the differing delivery systems.

Medicaid expansion under the 2010 Patient Protection and Affordable Care Act (ACA) provides states a variety of options to serve new populations previously under-insured and uninsured. States have a variety of policy tools at their disposal to expand product offerings to the new populations but introduce private sector options that have been proven to reduce utilization and the cost of health care services. Under Section 1115 of the U.S. Social Security Act waiver provisions and previously enacted statutes, many states are experimenting with select Medicaid populations to utilize account-based plan options as a means to expand private sector insurance products that will potentially allow enrollees to use Medicaid plans and then transition to Health Insurance Exchange products with similar benefit and use characteristics. This includes the use of account plans designed similar to H.S.A.s.

Enthusiasm for consumer-driven health plans (CDHPs) and HSAs has led Congress to consider the potential for implementation of public-sector CDHP-style plans, in Medicaid and Medicare. The Deficit Reduction Omnibus Reconciliation Act of 2005 (S. 1932) and signed by the President on February 8, 2006 calls for the establishment of Medicaid demonstration projects in as many as 10 states that will take the form of "Health Opportunity Accounts" (HOAs) for non-elderly, non-disabled Medicaid beneficiaries, modeled after CDHPs with health savings accounts. In the demonstration plans beginning on January 1, 2007, participating Medicaid beneficiaries will face a deductible ($1000 for each child, $2500 for an adult) but will be able to pay for health care expenses subject to the deductible from their HOA, to which the states will contribute.

Three central provisions of the HOA legislation are:

- Demonstration participants may seek care from Medicaid-participating providers as well as non-Medicaid-participating providers, while seeking health care and paying within their deductible. Payment rates for non-participating providers may be as much as 125 percent of participating provider rates.
- Medicaid beneficiaries enrolled in Medicaid managed care organizations may participate, provided their participation rates do not exceed 5 percent of the total number of enrollees in each organization and that the state adjusts per capita payments to the managed care organizations to take into account differences in the likely use of health services by those who participate versus those who do not.
- Payment for care rendered under the deductible and paid for with HOA funds must be transacted electronically, as it will not be allowable to withdraw cash from such accounts.

These three provisions all pertain to physicians and managed care organizations who serve as the front-line sources and coordinators of care for Medicaid beneficiaries, but their responses to these provisions are unknown. Moreover, the provision for electronic transactions brings to the forefront the opportunities and challenges of new tools and methods of payment inherent in CDHPs – so-called "consumer solutions" that the private sector is innovating but the public sector has not yet widely adopted.

There are several key policy issues related to state adoption of a HOA to serve targeted segments of a state Medicaid population. Since few states have adopted HOAs since 2006, there is limited evidence beyond the Indiana HOA program [10]. However, we can examine private market experience with account-based plans and make statistical and market inferences about how the Medicaid population in a state may react and utilize a new plan design. The key items to consider in analyzing the impact of account-based plans include: 1) utilization trend experience; 2) plan design; 3) program implementation and role of existing Medicaid insurers.

Utilization Trend

Account-based plans now account for over 20 million insured lives and the research shows the effectiveness of these plans in reducing utilization trend without having adverse health consequences for beneficiaries. The impact of health savings accounts (H.S.A.s), health reimbursement accounts (H.R.A.s) and flexible spending accounts (F.S.A.s) is well documented with numerous studies showing that utilization trend decreases from 18-22% after adoption. In addition, research also shows that there are not any tangible negative health outcomes with populations who switched from a traditional fee-for-service insurance product to a H.S.A. In addition, sicker populations also benefit from using account-based plans that allow for greater flexibility of provider choice to meet complex health needs [1].

Plan Design

Under the 2006 statute, plan design and the use of specific populations are mandated by states that wish to use the HOA with Medicaid. One key research finding related to plan design with private sector employers is that employee satisfaction and reduced utilization trend is directly correlated to employer contribution to the H.S.A, H.R.A, and F.S.A. [11]. In short, the greater the employer contribution to the account, the greater the employee satisfaction and the greater decrease in utilization trend (up to 10%). This fact is especially important for any plan design with a targeted Medicaid population. Detailed actuarial analysis of a targeted population can assist a state in designing a plan that achieves plan satisfaction and assists the state Medicaid system in reducing utilization. Private employer data analysis can be used in the analysis to make statistically significant inference to the Medicaid population.

Program Implementation

A Medicaid HOA can be administered by a variety of state-licensed entities, but there a several considerations given the nature of the population. Medicaid populations have been historically transient with a great deal of 'churn' or dropping off the rolls due to marginal increase in income [1]. This fact will be important implementation criteria since various research suggests that there will likely be a 25-30% 'churn' rate between individuals moving between Medicaid and state or federal Health Insurance Exchanges [8]. The use of account-based plans has the potential to ease the burden associated with the Medicaid population transferring between two very different health care systems. Medicaid enrollees will (with great probability) choose the cheapest option (Bronze) on the Health Insurance Exchange (federal or state), which offer a High Deductible Health Plan (HDHP) and accompanying H.S.A. The 2006 HOA law allows for a state waiver (under Section 1115) to use HOA funds with the H.S.A. thus allowing for a smooth coverage transition between the two systems.

Recent Medicaid Expansion Trend and 1115 Waivers

Many states have made efforts to utilize the Section 1115 waiver provisions in conjunction with ACA expansion to introduce account based plans. Recent Government Accountability Office (GAO) reports suggest that a variety of premium assistance schemes can be used by

states with exchange-based products, including Bronze plans that have H.S.A.s as part of the plan design [12]. As an example, both Iowa and Arkansas have applied for 1115 waivers to allow segments of the population to directly purchase exchange plans. However, questions do remain about potential federal and state budget revenue impact and budget neutrality as outlined by the GAO.

As states continue to expand Medicaid, there is potential to experiment with a wide variety of alternatives beyond traditional fee-for service provider reimbursement and existing managed care arrangements. Given the wide policy variation and choices that states have made in the past, the use of alternative delivery mechanisms is a natural extension of federalism as evidenced by the evolution of Medicaid managed care [13]. States that experiment with differing delivery schemes under the Section 1115 waiver now account for over $70 Billion of the $265 Billion of Medicaid spending according to the GAO report. This fact alone shows the potential for states to achieve significant savings and potential efficiencies associated with alternative delivery systems.

Methods and Data

The application of account based plans and the potential assessment of how select Medicaid populations could be enrolled in these plans can be assessed in a variety of methods. In order to gauge the potential use of the policy tool, we suggest that an examination of per capita Medicaid spending by state is an important initial metric and thus use this measure. The use of per capita spending measures is a better gauge of policy impact since there is a great deal of variation in state Medicaid program policy choices and aggregate spending [1].

We use the per capita Medicaid spending data from Kaiser Family Foundation (2015) and apply specific factors associated with private market account-based plans (H.S.A.s) and accompanying reductions in utilization trend with specific population cohorts. The application of past utilization trend experience to the Medicaid population has several noted caveats. Most importantly, not all the population can (or agreeably should) be enrolled in plans due previously cited scholarship and the 2006 HOA statute and rules. We suggest that only very select segment of a state's population be enrolled in these account plans with an emphasis on the segment of the population that would likely 'churn' between Medicaid and Health Insurance Exchange eligibility and enrollment. This will potentially alleviate issues commonly confronting individual enrollment and continuity of care and coverage.

Given the potential policy limitations, we suggest that 5% of a state Medicaid population be enrolled in an account-based plan. This estimate is a conservative assumption since many states are contemplating a greater share of the population that meets both potential Section 1115 waiver stipulations and the 2006 HOA statutory requirements. We also suggest that the potential reduction in utilization trend will be less than previously published research with H.S.A.s. Utilization trend reductions associated with H.S.A.s has shown to be over 20% with a range of 15-22% on a sustained basis [1,2]. Again, we apply a conservative metric and suggest that utilization trend associated with the potential demographic cohort should be less than previously surveyed populations with greater incomes and thus apply a reduction factor of 5-7%.

Based upon the noted research, what follows are estimated utilization trend reductions that could be associated with specific demographic and health care service factors.

1. Federal Poverty Limits: Less than 100% to 75% of FPL, Greater than 100%

   Estimated reduction in utilization trend will be greater with beneficiaries over 100% FPL.

   Reduction in spend: 5-7% for FPL<100%, 7-10% for FPL>100%

2. Outpatient Healthcare Services: Copayments or cost sharing not more than $100 total for all services. If greater than $100, utilization trend will increase by 5% or more based upon RAND HIE.

3. Ancillary Services: Copayments or cost sharing not more than $100 total for all services. If greater than $100, utilization trend will increase by 5% or more based upon RAND HIE.

4. Primary Care Visits: Copayments or cost sharing not more than $100 total for all services. If greater than $100, utilization trend will increase by 5% or more based upon RAND HIE.

5. Pharmacy Spend: Copayments or cost sharing not more than $100 total for all services. If greater than $100, utilization trend will increase by 5% or more based upon RAND HIE.

All of the above factors suggest that a 7% to 10% reduction in utilization trend is likely to occur if cost sharing mechanisms are used with a Medicaid population, including CHIP. As noted, if cost sharing amounts become a burden (greater than $100 per month), past research suggests that the effect of cost sharing on overall spend will be negated. Again, we suggest a more conservative utilization trend reduction of 5%.

Results and Discussion

Table 1 shows how each state could potentially benefit by enrolling a select population in an account based plan and applying a conservative utilization trend reduction factor. The results are displayed on a per capita spend per beneficiary based upon the most recent available data from the Kaiser Family Foundation and the Centers for Medicare and Medicaid Services (CMS).

The results suggest that states could collectively see a potential $1 Billion in savings per year as a conservative estimate of the population enrolled. Obviously given the variation in state programs and benefit configuration, there would be additional variation in the data presented. As an example, states with higher FPL eligibility limits and state specific cost sharing requirements could observe greater utilization trend reductions versus states with lower FPL limits and limited cost sharing mechanisms. The results, while aggregate in nature, do suggest that programmatic savings could be achieved in each state regardless of the state policy variation.

The savings associated with enrolling a small percentage of a state Medicaid population should not be dismissed a mere incremental policy tool. The potential impact of having individual enrollees utilize account based plans not only could encourage prudent purchasing decisions, but also allow for a much easier transition to federal HIX plans and private market health plan options. We suggest the potential impact of incremental policy changes could significantly impact state Medicaid spending for decades to come as evidenced by the private market experience of Health Savings Accounts.

The conservative enrollment and utilization trend factors associated with our analysis should also be noted since the impact of even greater Medicaid enrollment by states could have significant fiscal implications. State specific factors, including a significant portion of the enrolled Medicaid population at or near the higher Federal Poverty Limit (133%), could allow for a greater portion of the population to

STATE	Medicaid Enrollment (in Thousands)	Spend per enrollee	Population HOA Eligible (in 000's)	Per Enrollee Savings	Total Savings
Alabama	856.5	$4,111	42.83	$205.55	$8,802,678.75
Alaska	107.1	$9,474	5.36	$473.70	$2,536,663.50
Arizona	1,245.30	$7,022	62.27	$351.10	$21,861,241.50
Arkansas	553.9	$5,264	27.70	$263.20	$7,289,324.00
California	8,337.00	$4,468	416.85	$223.40	$93,124,290.00
Colorado	773	$5,679	38.65	$283.95	$10,974,667.50
Connecticut	618.7	$7,465	30.94	$373.25	$11,546,488.75
Delaware	211.1	$5,949	10.56	$297.45	$3,139,584.75
District of Columbia	213.8	$8,875	10.69	$443.75	$4,743,687.50
Florida	3,340.60	$4,434	167.03	$221.70	$37,030,551.00
Georgia	1,509.00	$3,992	75.45	$199.60	$15,059,820.00
Hawaii	277.7	$5,438	13.89	$271.90	$3,775,331.50
Idaho	234.6	$5,700	11.73	$285.00	$3,343,050.00
Illinois	2,690.00	$4,477	134.50	$223.85	$30,107,825.00
Indiana	990.8	$5,256	49.54	$262.80	$13,019,112.00
Iowa	461.8	$5,491	23.09	$274.55	$6,339,359.50
Kansas	350.3	$5,996	17.52	$299.80	$5,250,997.00
Kentucky	782.8	$5,937	39.14	$296.85	$11,618,709.00
Louisiana	1,055.10	$4,869	52.76	$243.45	$12,843,204.75
Maine	266.9	$5,968	13.35	$298.40	$3,982,148.00
Maryland	966.3	$7,046	48.32	$352.30	$17,021,374.50
Massachusetts	1,276.30	$8,717	63.82	$435.85	$27,813,767.75
Michigan	1,892.60	$5,067	94.63	$253.35	$23,974,510.50
Minnesota	873	$7,506	43.65	$375.30	$16,381,845.00
Mississippi	625.4	$5,335	31.27	$266.75	$8,341,272.50
Missouri	775.7	$6,488	38.79	$324.40	$12,581,854.00
Montana	116.3	$7,140	5.82	$357.00	$2,075,955.00
Nebraska	201.2	$5,763	10.06	$288.15	$2,898,789.00
Nevada	331.3	$3,728	16.57	$186.40	$3,087,716.00
New Hampshire	135.3	$7,254	6.77	$362.70	$2,453,665.50
New Jersey	959.7	$8,309	47.99	$415.45	$19,935,368.25
New Mexico	501.1	$5,803	25.06	$290.15	$7,269,708.25
New York	5,161.40	$8,901	258.07	$445.05	$114,854,053.50
North Carolina	1,501.30	$5,226	75.07	$261.30	$19,614,484.50
North Dakota	64.4	$8,338	3.22	$416.90	$1,342,418.00
Ohio	2,076.60	$6,855	103.83	$342.75	$35,587,732.50
Oklahoma	679.7	$4,782	33.99	$239.10	$8,125,813.50
Oregon	558.4	$5,908	27.92	$295.40	$8,247,568.00
Pennsylvania	2,138.40	$7,811	106.92	$390.55	$41,757,606.00
Rhode Island	174.8	$9,247	8.74	$462.35	$4,040,939.00
South Carolina	777.2	$4,805	38.86	$240.25	$9,336,115.00
South Dakota	100.3	$5,485	5.02	$274.25	$1,375,363.75
Tennessee	1,273.40	$5,155	63.67	$257.75	$16,410,942.50
Texas	3,614.50	$5,278	180.73	$263.90	$47,693,327.50
Utah	283.4	$4,890	14.17	$244.50	$3,464,565.00
Vermont	141.3	$6,291	7.07	$314.55	$2,222,295.75
Virginia	843	$6,224	42.15	$311.20	$13,117,080.00
Washington	1,132.30	$4,993	56.62	$249.65	$14,133,934.75
West Virginia	350.4	$6,315	17.52	$315.75	$5,531,940.00
Wisconsin	945.4	$5,414	47.27	$270.70	$12,795,989.00
Wyoming	66	$6,110	3.30	$305.50	$1,008,150.00
TOTALS	55412.4	$ 6,118.61	2770.62	$ 305.93	$ 810,884,878.50
		(Average)		(Average)	

Table 1: *(Source: Kaiser Family Foundation and CMS, 2015. Assumes 5% of eligible population enrolled in Medicaid account based plans and accompanying 5% utilization trend reduction associated with enrolled population)*

enroll in account based plans than our assumptions. Importantly, the issue of market churn between state Medicaid systems and the state and federal Health Insurance Exchanges is likely to be an increasingly relevant policy concern. We argue that account based plans provide a proven option for select Medicaid populations to smoothly transition between the two systems.

As states and private market participants contemplate how to manage the expansion of Medicaid, we suggest that existing account-based plans long utilized by private insurance markets should be used as a program management tool. In addition, an added policy benefit is to have Medicaid plans structured with account-based plans as a means to easily transition the segment of the population that 'churns' between the state or federal Health Insurance Exchange and Medicaid.

Further research should focus on not only the potential savings, but also health outcomes. In addition, the wide array of state specific factors could also be analyzed to examine how select population groups could be impacted by account based plans as well as specific spending categories within a state program. Based upon past private market research with account-based health plans, select segments of every state's Medicaid population could be enrolled in these plans and potentially save a state millions in spending while allowing a transition between Medicaid and Health Insurance Exchange health plan offerings.

References

1. Parente ST, Randall D (2012) Impact of High Deductible Health Plans: Point-Counterpoint. In:Debates on U.S. Health Care Reform, Kronefeld JJ, Parmet W, Zezza M (ed.,) Sage Publishing, Thousand Oaks, CA.
2. Kronefeld JJ, Parmet W, Zezza M (2012) Debates on U.S. Health Care Reform. Sage Publishing Point-Counterpoint.
3. Davis K (2004) Consumer Directed Plans Will it Improve Health System Performance? Health Services Research 39: 1219-1233.
4. Newhouse JP (1981) Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance. N Eng J Med 305: 1501–1507.
5. Newhouse JP Cambridge The Health Insurance Group Free For All? Lessons from the RAND Health Insurance Experiment .
6. RAND Corporation (2011) Largest Study of High-Deductible Health Plans Finds Substantial Cost Savings, but Less Preventive Care.
7. Kaiser Family Foundation (2015) State Health Facts Medicaid and CHIP.
8. Sommers, Benjamin D, John A Graves, Katherine Swartz, Sara Rosenbaum, et al. (2014) Medicaid and Marketplace Eligibility Changes Will Occur Often In All StatesPolicy Options Can Ease Impact. Health Affairs 33: 700-707.
9. Milligan C (2015) From Coverage to Care Addressing the issue of Churn. J of Health Policy Politics and Law 40: 227-232.
10. Mathematica Policy Research. Healthy Indiana The First Two Years.
11. Consumer Driven Health Care Institute.
12. Government Accountability Office (2014) Medicaid Demonstrations HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns GAO 14-689R. Gov Prntg Off: Washington DC.
13. Randall D, Parente ST (2012) U.S. Medicaid Managed Care Markets Explaining State Policy Choice Variation. Insurance Markets and Companies Analyses and Actuarial Computations 3: 2078-2454

Citation: Randall D, Parente ST, Abujamra R (2015) Medicaid Expansion and the use of Account-based Health Plans. Health Care Current Reviews 3: 134. doi: 10.4172/2375-4273.1000134