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Consumerism in Public Plans: Examining the Prospects for Health Opportunity Accounts

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Consumerism in Public Plans: Agenda

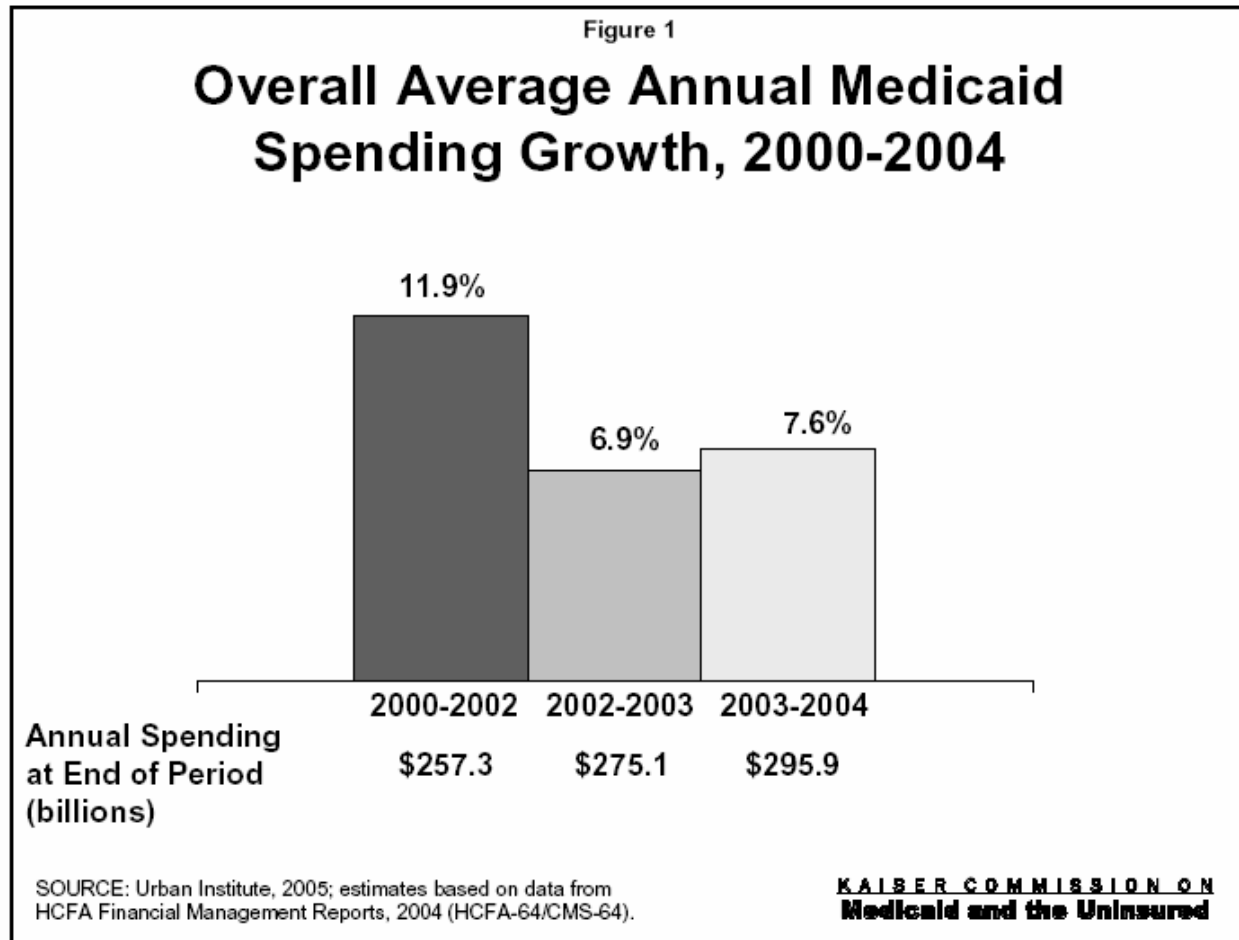
- Principles of health care consumerism
- Rationale for considering consumerism for Medicaid
- Analysis of options for implementing consumerism in Medicaid
- Implications for consumerism in public plans

Principles of Consumer-Driven Health Care

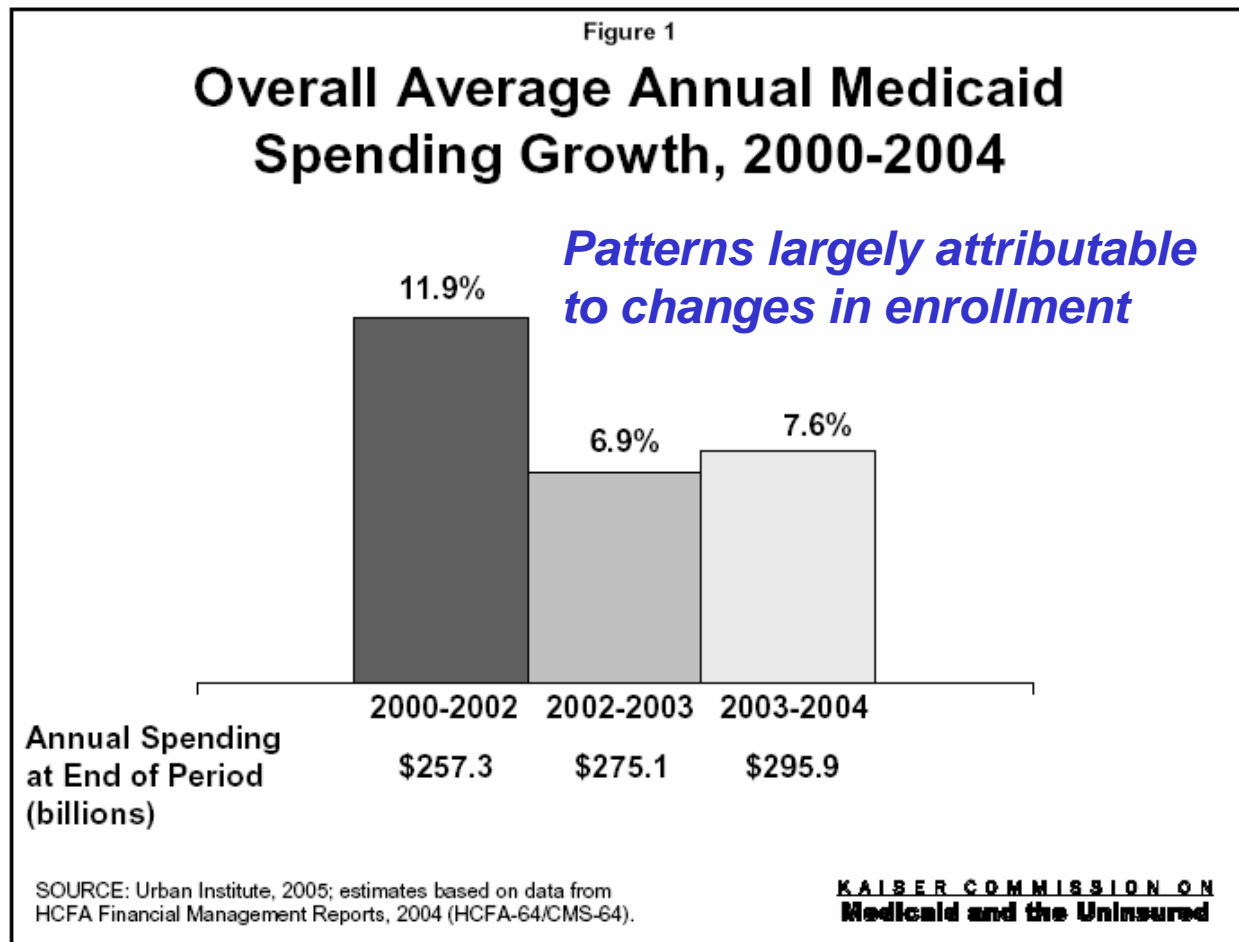
- Provide incentives to shop intelligently
- Provide real choice of plans
- Provide relevant information
- Provide equal subsidies for each plan
- Do not determine prices for providers
- Adjust payments for each enrollee to reflect enrollee needs

Herzlinger, *Consumer-Driven
Health Care*, 2004

Current Problem: Increasing Medicaid Expenditures

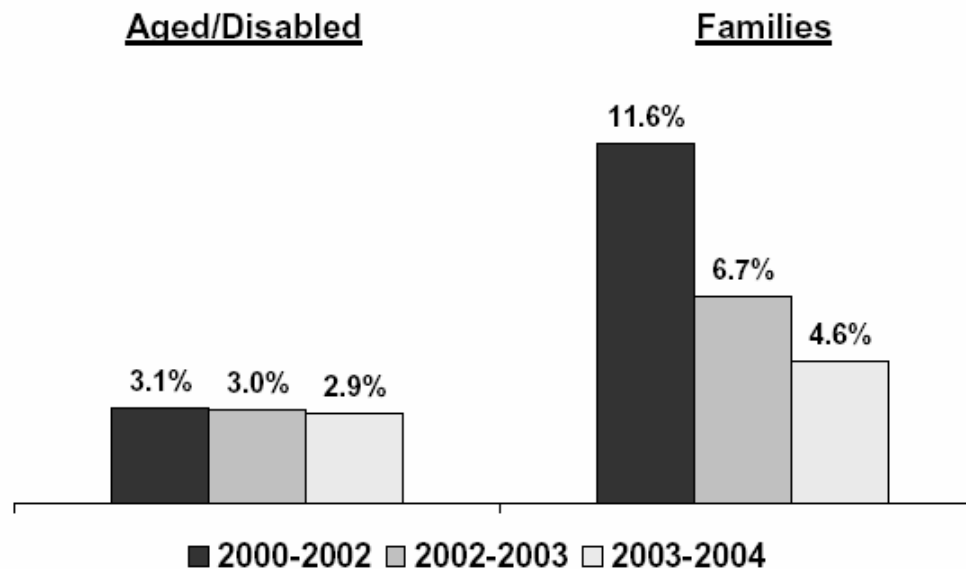


Current Problem: Increasing Medicaid Expenditures



Who has recently newly enrolled in Medicaid?

Figure 4
Medicaid Enrollment Growth
Average Annual Growth Rates, 2000-2004

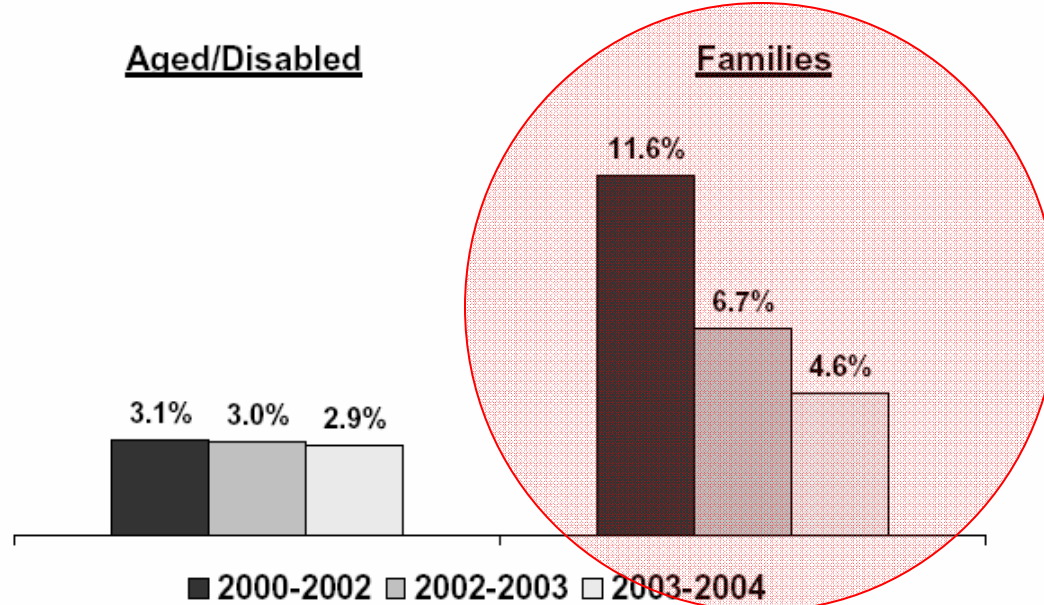


SOURCE: Urban Institute estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 44 states inflated proportionally to national totals, 2005.

**KAISER COMMISSION ON
Medicaid and the Uninsured**

Who has recently newly enrolled in Medicaid?

Figure 4
Medicaid Enrollment Growth
Average Annual Growth Rates, 2000-2004



SOURCE: Urban Institute estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 44 states inflated proportionally to national totals, 2005.

**KAISER COMMISSION ON
Medicaid and the Uninsured**

Growth in Medicaid Expenditures

	Average Annual Growth Rate for Expenditures		
	2000-2002	2002-2003	2003-2004
Total Medical Services	12.9%	8.3%	7.4%

Source: Kaiser Family Foundation

Growth in Medicaid Expenditures

	Average Annual Growth Rate for Expenditures		
	2000-2002	2002-2003	2003-2004
Total Medical Services	12.9%	8.3%	7.4%
Acute Care	14.6%	11.4%	8.5%
Long-Term Care	10.7%	3.6%	5.4%

Source: Kaiser Family Foundation

Challenge? – Yes

Opportunity? - Maybe

- **Growth in Medicaid expenditures**
 - **Growth in enrollment**
 - Chiefly among families
 - **Growth in expenditures**
 - Acute care > long-term care

Challenge? – Yes

Opportunity? - Maybe

- **Growth in Medicaid expenditures**
 - **Growth in enrollment**
 - Chiefly among families
 - **Growth in expenditures**
 - Acute care > long-term care

- *Could principles of consumerism be applied in Medicaid?*
 - *For whom?*

Consumerism in Medicaid: Potential Benefits and Risks

- **Potential Benefits**

- Encourage judicious use of medical services, perhaps reduce program costs?
- Educate potential future consumers in the private health care market?

- **Potential Risks**

- Medicaid as a vulnerable population – lessons from Rand Health Insurance Experiment re: worse health status?

Deficit Reduction Act of 2005

S. 1932

One Hundred Ninth Congress of the United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,
the third day of January, two thousand and six*

An Act

To provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95).

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE.

This Act may be cited as the “Deficit Reduction Act of 2005”.

SEC. 2. TABLE OF TITLES.

The table of titles is as follows:

TITLE I—AGRICULTURE PROVISIONS

TITLE II—HOUSING AND DEPOSIT INSURANCE PROVISIONS

TITLE III—DIGITAL TELEVISION TRANSITION AND PUBLIC SAFETY

TITLE IV—TRANSPORTATION PROVISIONS

TITLE V—MEDICARE

TITLE VI—MEDICAID AND SCHIP

TITLE VII—HUMAN RESOURCES AND OTHER PROVISIONS

TITLE VIII—EDUCATION AND PENSION BENEFIT PROVISIONS

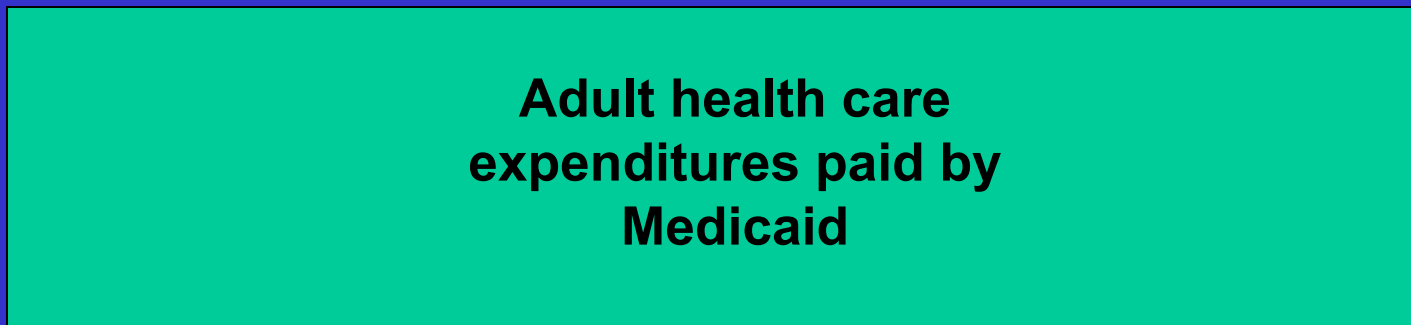
Health Opportunity Accounts

- **Medicaid demonstration projects**
 - As many as 10 states
 - 5-year demonstration timeline
- **Excluded beneficiaries**
 - ≥ 65 years old, disabled, pregnant
- **Enrollment**
 - Managed care plans - $\leq 5\%$ of enrollment
 - Fee-for-service

Health Opportunity Accounts: Fiscal Structure

**Adult health care
expenditures paid by
Medicaid**

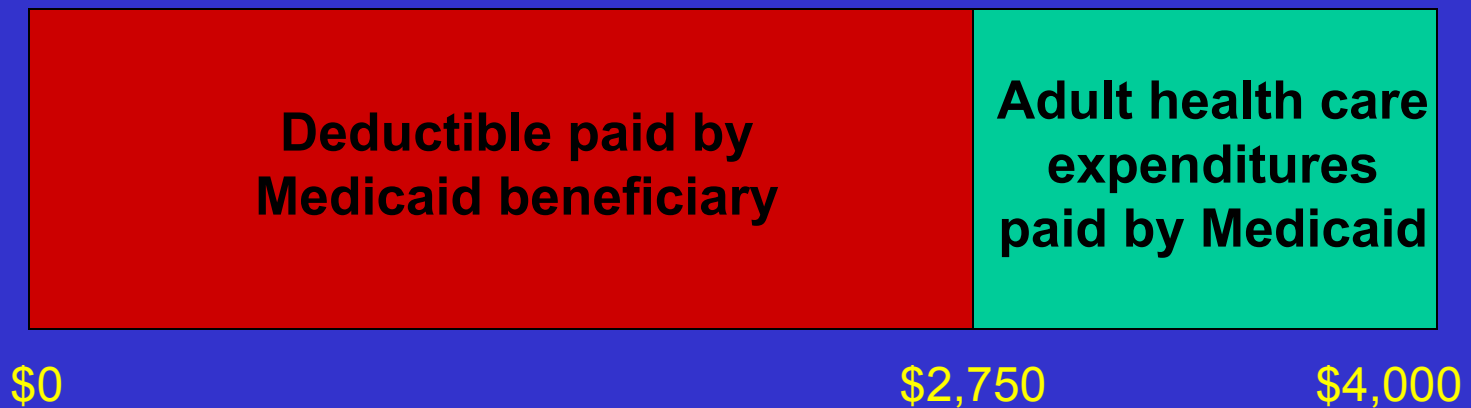
Health Opportunity Accounts: Fiscal Structure



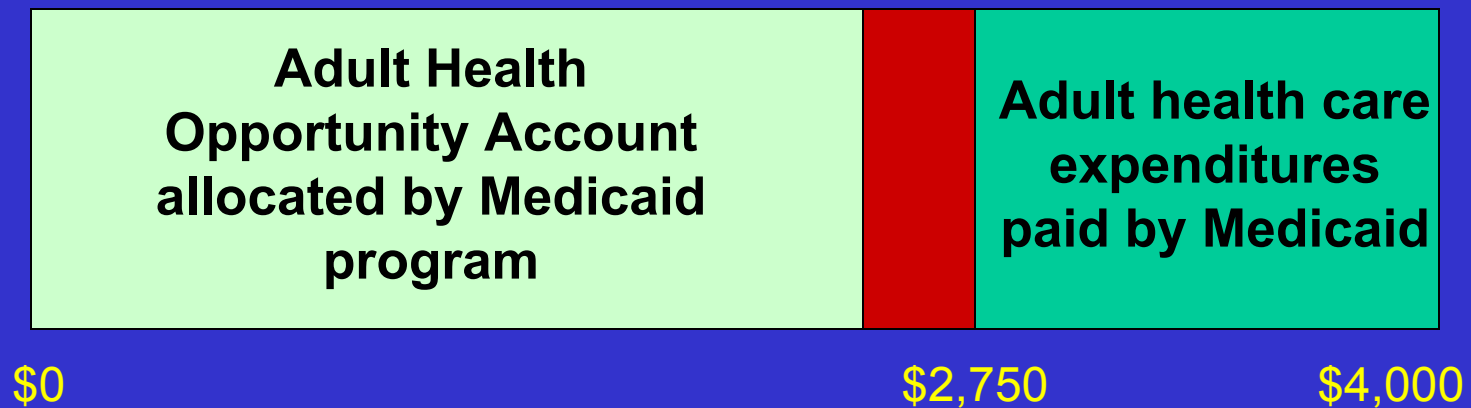
\$0

\$4,000

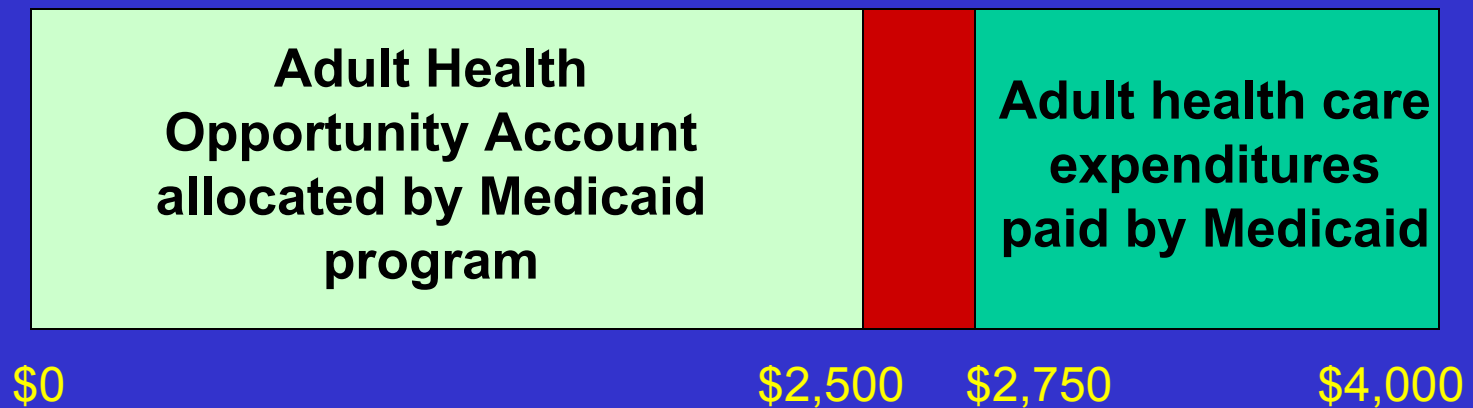
Health Opportunity Accounts: Fiscal Structure



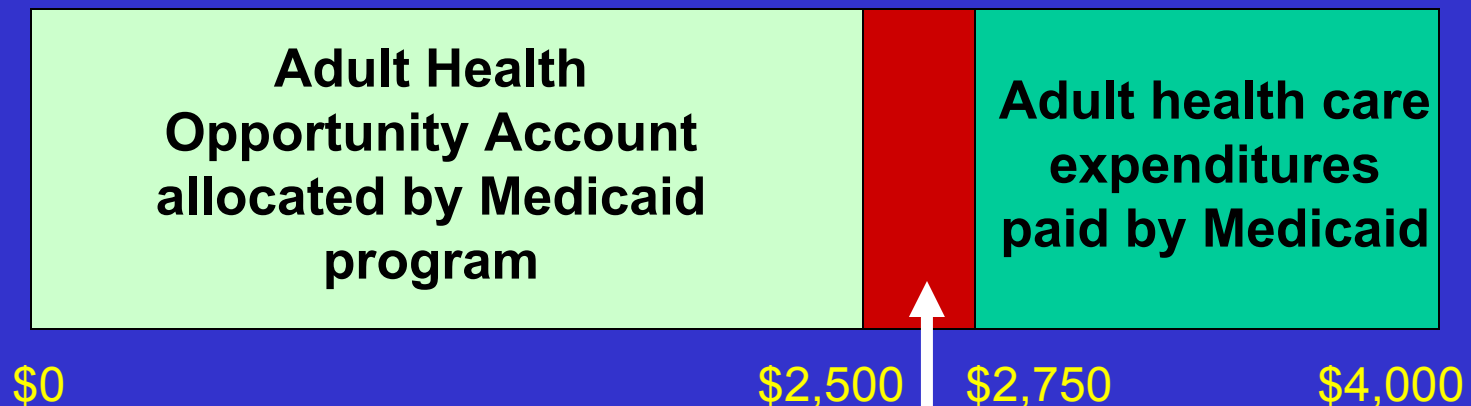
Health Opportunity Accounts: Fiscal Structure



Health Opportunity Accounts: Fiscal Structure



Health Opportunity Accounts: Fiscal Structure



Deductible paid by
Medicaid beneficiary
= \$250
= 10% of HOA allocation

HOA Allocations and Deductibles

Beneficiary ages	HOA allocation	Corresponding maximum deductible without HOA coverage
Ages 0-18	\$1000 (maximum)	\$100
	\$500	\$50
	\$250	\$25
Ages 19-64	\$2500 (maximum)	\$250
	\$1500	\$150
	\$750	\$75

HOAs Over Time

- **Balance carries over year to year**
 - **States may set maximum balance**
- **Upon departure from Medicaid**
 - **25% of balance is returned to gov't**
 - **Remaining balance may be used for up to 3 years for:**
 - Purchase of health insurance coverage
 - Job training and tuition (at states' option and if approved by DHHS), if HOA has been held for ≥ 1 year

Questions about HOAs

- Program perspective
 - How to maximize benefit for program?
 - How to minimize beneficiaries' risk exposure to 10% deductible?
- Beneficiary perspective
 - How many enrollees would be likely to pay out of pocket as part of the deductible?
 - How many enrollees would have a positive HOA balance at the end of 1 year?

Who Might Do Best with HOAs?

- **Medicaid Programs**
 - Allocate HOAs to individuals who are likely to have expenditures at those HOA levels
 - Even better? – Enroll beneficiaries who will cost share for expenditures in excess of HOA allocation
- **Beneficiaries (“consumers”)**
 - Enroll if very *unlikely* to have expenditures → retain HOA balance, roll over to next year → carry forward for other health care expenses

Research Goals

- Identify programmatic strategies to enroll Medicaid beneficiaries in HOAs who are most likely to benefit and least likely to face the deductible
- Identify programmatic strategies to optimize program “bottom line”
- Compare programmatic strategies using simulation models of national data

Research Design

- **Analysis and policy simulation for Medicaid enrollees in Medical Expenditure Panel Survey (MEPS), 2000-2003**
- **Inclusion criteria:**
 - **12 months continuous enrollment in Medicaid**
- **Exclusion criteria:**
 - **Age ≥ 65 years**
 - **Disabled**

Research Design: 2 Phases

- **Phase 1**
 - Identify sociodemographic characteristics associated with total expenditures < HOA allocation limits
 - Identify health care utilization patterns associated with total expenditures < HOA allocation limits
- **Phase 2**
 - Develop programmatic HOA strategies based on findings from Phase 1
 - Conduct simulations of HOA strategies

Study Sample

- Children continuously enrolled in Medicaid for 12 months
 - N=3,455
- Non-elderly adults continuously enrolled in Medicaid for 12 months
 - N= 1,183
 - Total sample = 4,638

Annual Total Expenditures

	Median Total Expenditures	Mean Total Expenditures
Children enrolled in Medicaid for 12 months	\$151	\$780
Non-elderly adults enrolled in Medicaid for 12 months	\$572	\$2,827

Factors Associated with Health Care Expenditures < HOA Allocation

	% with spending <\$250/\$750	% with spending <\$500/\$1500	% with spending <\$1000/\$2500
Children enrolled in Medicaid for 12 months			
Non-elderly adults enrolled in Medicaid for 12 months			

Factors Associated with Health Care Expenditures < HOA Allocation

	% with spending <\$250/\$750	% with spending <\$500/\$1500	% with spending <\$1000/\$2500
Children enrolled in Medicaid for 12 months	52.3	68.2	81.9
Non-elderly adults enrolled in Medicaid for 12 months			

Factors Associated with Health Care Expenditures < HOA Allocation

	% with spending <\$250/\$750	% with spending <\$500/\$1500	% with spending <\$1000/\$2500
Children enrolled in Medicaid for 12 months	52.3	68.2	81.9
Non-elderly adults enrolled in Medicaid for 12 months	47.2	59.2	67.0

Multivariate Analyses: Sociodemographic Factors Associated with Health Care Expenditures < Allocation

- **Children**

- *More likely to have expenditures < HOA allocation:*

- **Adolescents** (12-17) vs children aged 0-5
 - **Hispanic and black children** vs “other” (mostly non-Hispanic white) children
 - **No health care utilization** compared with any health care utilization (outpatient visits, emergency department, hospitalization, prescription drugs)

Multivariate Analyses: Sociodemographic Factors Associated with Health Care Expenditures < Allocation

- **Adults**

- *More likely to have expenditures < HOA allocation:*

- **Men** vs women
 - **Younger adults 18-45 years old** vs adults aged 56-64
 - **Hispanic and black adults** vs “other” (mostly non-Hispanic white) adults
 - **No health care utilization** vs any health care utilization

Phase 2: HOA Program Simulations

- Program enrollment targeting strategies:
 - 1) No targeting
 - 2) Adolescents only (12-17)
 - 3) Males only (any age)
 - 4) Young adult males only (18-45)
 - 5) Hispanic and non-Hispanic black only
 - 6) Hispanic and non-Hispanic black males only
 - 7) Adult males if not previously hospitalized
 - 8) Adult males if not previously hospitalized *and* not previously seen in emergency department

Phase 2: Methods

- **Use same national data of Medicaid enrollees**
 - **Inclusion: 24 months of continuous Medicaid enrollment**
- **Take 5% subsamples of the overall sample, to simulate enrollment**
 - **1000 simulations for each strategy**

Phase 2: Outcome Measures

HOA
Program
Enrollees

Phase 2: Outcome Measures

HOA
Program
Enrollees

*Spend \leq HOA
allocation*

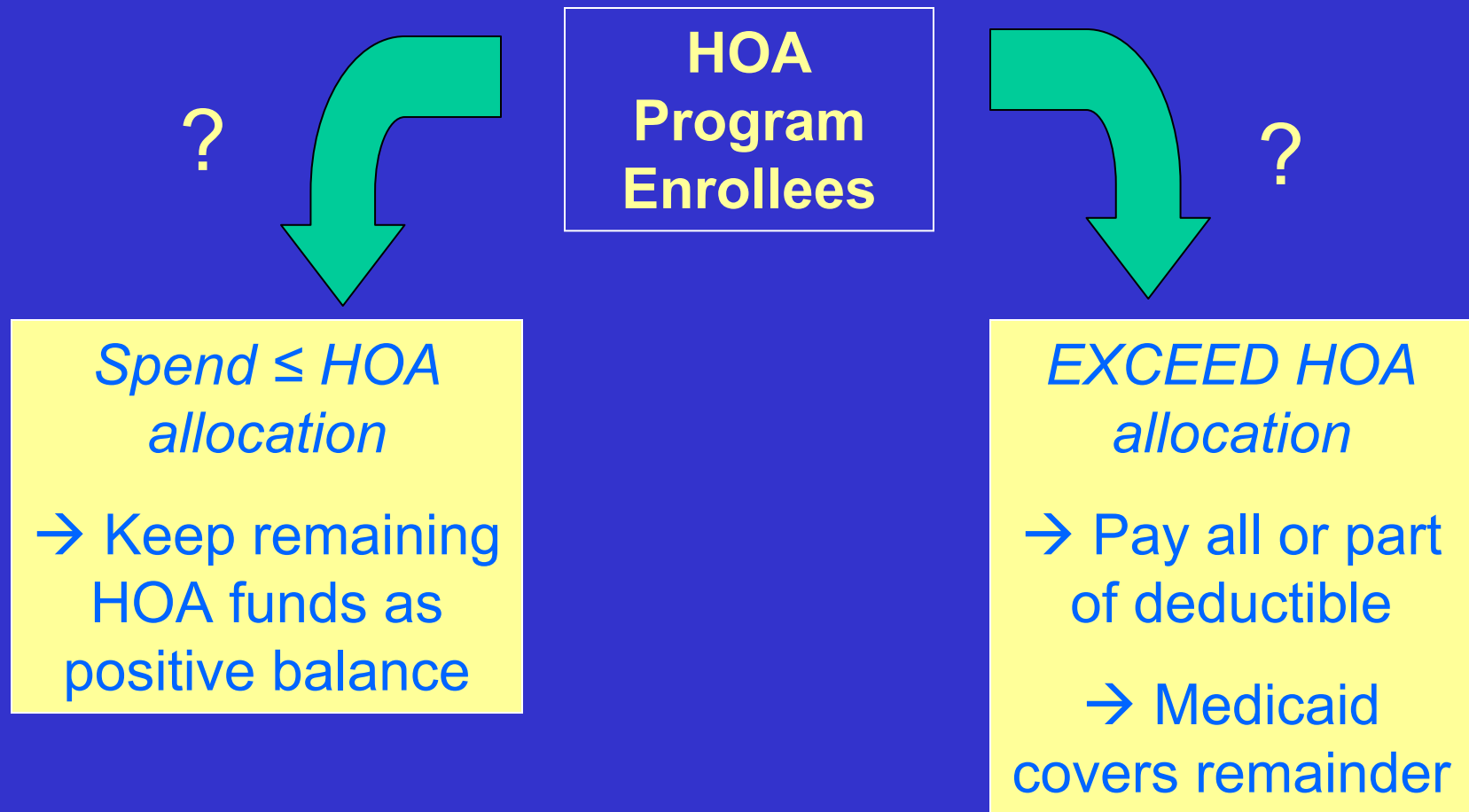
→ Keep remaining
HOA funds as
positive balance

*EXCEED HOA
allocation*

→ Pay all or part
of deductible

→ Medicaid
covers remainder

Phase 2: Outcome Measures



Phase 2: Outcome Measures

- **Mean proportion of enrollees who would exceed their HOA allocation**
 - Adults & children separately
- **For those who exceeded allocation:**
 - Mean expenditure exceeding allocation
 - Mean proportion of enrollees exceeding HOA who would be asked to pay full deductible
- **For those who did *not* exceed allocation:**
 - Mean HOA balance at end of year

HOA Program Simulations: Proportion exceeding HOA allocation

Program	Low HOA allocation (adult/child)	Maximum HOA allocation (adult/child)
No restrictions		
Adolescents 12-17		
Males only		
Young adult males 18-45		
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

HOA Program Simulations: Proportion exceeding HOA allocation

Program	Low HOA allocation (adult/child)	Maximum HOA allocation (adult/child)
No restrictions	48.4/40.6	28.7/13.6
Adolescents 12-17		
Males only		
Young adult males 18-45		
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

HOA Program Simulations: Proportion exceeding HOA allocation

Program	Low HOA allocation (adult/child)	Maximum HOA allocation (adult/child)
No restrictions	48.4/40.6	28.7/13.6
Adolescents 12-17	39.2	16.2
Males only		
Young adult males 18-45		
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
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No restrictions	48.4/40.6	28.7/13.6
Adolescents 12-17	39.2	16.2
Males only	44.6/42.5	29.0/15.6
Young adult males 18-45		
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

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Males only	44.6/42.5	29.0/15.6
Young adult males 18-45	30.3	17.2
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

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Young adult males 18-45	30.3	17.2
Hispanic & black	41.8/34.9	23.0/10.6
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

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Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

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Males only	44.6/42.5	29.0/15.6
Young adult males 18-45	30.3	17.2
Hispanic & black	41.8/34.9	23.0/10.6
Hispanic & black males	37.9/37.4	23.6/12.8
Males if not previously hospitalized		
Males if not previously hosp or in ED		

HOA Program Simulations: Proportion exceeding HOA allocation

Program	Low HOA allocation (adult/child)	Maximum HOA allocation (adult/child)
No restrictions	48.4/40.6	28.7/13.6
Adolescents 12-17	39.2	16.2
Males only	44.6/42.5	29.0/15.6
Young adult males 18-45	30.3	17.2
Hispanic & black	41.8/34.9	23.0/10.6
Hispanic & black males	37.9/37.4	23.6/12.8
Males if not previously hospitalized	40.6	25.0
Males if not previously hosp or in ED		

HOA Program Simulations: Proportion exceeding HOA allocation

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No restrictions	48.4/40.6	28.7/13.6
Adolescents 12-17	39.2	16.2
Males only	44.6/42.5	29.0/15.6
Young adult males 18-45	30.3	17.2
Hispanic & black	41.8/34.9	23.0/10.6
Hispanic & black males	37.9/37.4	23.6/12.8
Males if not previously hospitalized	40.6	25.0
Males if not previously hosp or in ED	37.7	22.8

HOA Program Simulations: For enrollees *exceeding* the allocation...

- >75% paid the full deductible in all cases
 - For most strategies, usually >85%
- Mean expenditures in excess of the deductibles
 - For adults: \geq \$4300
 - For children: \geq \$1450

HOA Program Simulations: For those who did *not* exceed the HOA allocation...

Program	Mean HOA balance for adults (\$2500 allocation)	Mean HOA balance for children (\$1000 allocation)
No restrictions		
Adolescents 12-17		
Males only		
Young adult males 18-45		
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

HOA Program Simulations: For those who did *not* exceed the HOA allocation...

Program	Mean HOA balance for adults (\$2500 allocation)	Mean HOA balance for children (\$1000 allocation)
No restrictions	\$1977	\$795
Adolescents 12-17	--	\$812
Males only	\$2081	\$795
Young adult males 18-45	\$2186	--
Hispanic & black	\$2029	\$814
Hispanic & black males	\$2169	\$813
Males if not previously hospitalized	\$2101	--
Males if not previously hosp or in ED	\$2123	--

Summary: HOA Program Simulations

- **Optimal HOA targeting strategy, to minimize enrollees' exposure to deductible**
 - **Adults: Young adult males**
 - **Children: Hispanic and black beneficiaries**
- **Optimal HOA targeting strategy, to maximize enrollee cost-sharing via deductible**
 - **No restrictions**
- **Optimal HOA targeting strategy, to maximize HOA positive balance for enrollees who don't exceed allocation**
 - **Hispanic and black beneficiaries**

What is the Bottom Line for Medicaid Programs with HOAs?

Program	Program net per adult enrollee (\$2500 allocation)	Program net per child enrollee (\$1000 allocation)
No restrictions		
Adolescents 12-17		
Males only		
Young adult males 18-45		
Hispanic & black		
Hispanic & black males		
Males if not previously hospitalized		
Males if not previously hosp or in ED		

What is the Bottom Line for Medicaid Programs with HOAs?

Program	Program net per adult enrollee (\$2500 allocation)	Program net per child enrollee (\$1000 allocation)
No restrictions	-\$368	-\$514
Adolescents 12-17	- -	-\$695
Males only	-\$261	-\$558
Young adult males 18-45	-\$1,822	- -
Hispanic & black	-\$364	-\$565
Hispanic & black males	-\$238	-\$613
Males if not previously hospitalized	-\$1,489	- -
Males if not previously hosp or in ED	-1,609	- -

Negative values indicate *loss* for Medicaid program per enrollee.

Potential Tensions in HOA Demonstration Project Design

- Administrative complexity
- Appeal of program recruitment strategy
- Maximizing competing principles of consumerism:
 - Cost-sharing maximized at *lower* HOA allocation levels; better program outcomes
 - Saving for future health care encounters maximized at *higher* HOA allocation levels

Limitations of Analysis

- **Cannot identify pregnant women in MEPS**
- **Cannot identify all disabled individuals with certainty**
- **Simulation of program participation using Medicaid data from non-HOA setting**
 - **Cannot know with certainty whether utilization and expenditures would be different with HOA program in place**
 - **Have not examined economic impact of individuals' departure from Medicaid**

Implications for HOA Implementation

- **Programs that target enrollment into HOAs**
 - May diminish cost-sharing vs no targeting
 - May enhance HOA savings for participants
 - **Greater yield with sociodemographic targeting vs utilization-based targeting**
 - May increase enrollment
- **Importance of consumers'/Medicaid beneficiaries' role in development of demonstration projects**
 - **Competing priorities (program vs beneficiaries)**

Challenges in HOA Implementation

- What to do about women's HOA program enrollment, vis-à-vis pregnancy?
- How to handle timing of annual HOA allocations?
- What to do about limit-setting on carried-over HOA balances?
 - How will that affect program fiscal picture over 5-year demonstration period?