

2007 Fact Sheet:

Health Opportunity Accounts

THE BACKGROUND

The Deficit Reduction Act of 2005 allows states to redesign their Medicaid programs, creating more flexibility in benefit and cost-sharing designs and giving enrollees more opportunity to decide how they use their health-care benefits. One of these changes permits states to deliver health benefits through a Health Opportunity Account in conjunction with a high deductible health plan. These accounts – similar to the medical savings accounts used in private insurance coverage – will encourage Medicaid enrollees to assume greater responsibility for their own health care. Medicaid clients enrolled in this program will be able to make decisions about their own health care by choosing how to spend the money in their account. If they exhaust the account, their coverage reverts to regular Medicaid. But enrollees will have an incentive to keep an unspent portion in the account – because they can use that money for training, tuition or private insurance premiums when they are no longer on Medicaid. Overall, the accounts are aimed at helping clients make more appropriate and cost-efficient decisions on health care.

PARAMETERS FOR STATES

Under the new law, the federal government can select up to 10 states to establish local or statewide demonstration programs through a state plan amendment or by amending existing 1115 waivers. The demonstrations will offer a Health Opportunity Account to individuals who have been eligible for medical assistance for a continuous period of at least six months, who are not disabled and who are under age 65. Applicants also cannot be eligible for assistance because they are or were pregnant.

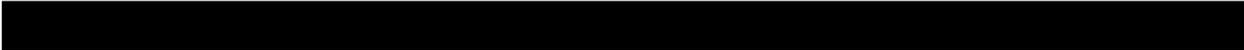
Other Health Opportunity Account program requirements include patient education, incentives for preventive services, enrollee education to increase awareness of the high cost of health care, the use of enrollment counselors, and providing transactions electronically and without cash. The program must be voluntary, and enrollment is effective for a period of 12 months but may be extended in 12-month increments with the consent of the enrollee. States can set the contributions to the savings account within parameters and may set rules around which services can be paid out of the account. When an enrollee is no longer eligible for Medicaid, the balance of the account will be reduced by 25% but the state will continue to administer the remaining funds in the account on behalf of the enrollee. The funds can be used to purchase health coverage, job training or tuition expenses, depending on the state.

HOW THE ACCOUNTS WORK

The Health Opportunity Account program will be funded by Medicaid dollars. The state will determine how much to place in the account, but it will be required to fund between 100% and 110% of the health plan deductible. Enrollees will be free to spend the account for medical-related expenses, including the purchase of services from non-participating providers or medical services not otherwise covered under the state Medicaid program. Within certain parameters, so long as it is used for medical services, it is the member's choice in how the account is used. When accessing Medicaid providers, the account would be debited at the current Medicaid rate. If the enrollee chooses non-participating providers, the account would be debited at up to 125% of the Medicaid rate. The benefit design could include coverage for preventive care at no cost to the enrollee. States would be encouraged to create incentives so enrollees use preventive services. For example, a state could increase the amount of its contribution to the accounts for clients who receive appropriate preventive services.

TARGET POPULATIONS

Some 28,800 households -- 32,100 adults and 46,400 children -- currently receive Transitional Medical Assistance (TMA) coverage in Washington State. This population would be ideal in a test of the HOA



concept because TMA families are transitioning from Medicaid and could use the access to HOA funds to retain their coverage through private insurance after leaving Medicaid. While the entire household would be eligible for HOA, the main focus would be on adults because the state provides comprehensive health coverage to children in families with incomes up to 250% of FPL. TMA clients are eligible for at least six months of coverage, although families with incomes below 185% of the Federal Poverty Level are eligible for an additional six months of coverage.

LIKELY STATE ISSUES FOR FURTHER STUDY

A number of issues must be resolved before Washington State commits to implementing a program that would dramatically change the way low-income individuals seek health care and pay for it. In addition, the existing delivery system must be evaluated to identify the organizations that can administer this product design, and the state infrastructure must be developed to administer such a contract. If a decision is made to pursue a Health Opportunity Account demonstration project, the state should issue a Request for Information to identify entities that could provide both the high deductible plan and the account, or entities that would partner to provide the two services. The successful organization must be able to provide a full array of administrative services and provide the required education, incentives, enrollment counselors and electronic transmission capabilities. In addition, any successful vendor should operate a nurse advice line to assist enrollees in health-care decisions and provide support for families enrolled in the program.

NEXT STEPS

Michael Leavitt, Secretary of Health and Human Services, told Governor Gregoire in a recent letter that his agency will soon give states considering this approach more information about the new Health Opportunity Accounts. Once the information is received, Washington State Medicaid staff will work with the federal Centers for Medicare and Medicaid Services to define specific program parameters. In addition, the state will explore possible legislative changes, review options with the Officer of Insurance Commissioner to assure regulatory compliance, determine impacts on ProviderOne and the Automated Client Eligibility System, and begin stakeholder discussions with providers, plan, clients and client advocates.