

South Dakota Legislative Research Council

Issue Memorandum 97-21

Medical Savings Accounts and Other Medicaid Funding Concepts

On March 25, 1997, the House Health and Human Services Committee voted to request a study be executed regarding, "alternative funding options for Medicaid used in other states, with specific attention to the use of medical savings accounts in Montana." This issue memorandum will attempt to address that request.

Medical Savings Accounts

In recent years medical savings accounts (MSAs) have gained notoriety as a potential means of lowering medical expenditures through personal responsibility and free-market mechanisms. More specifically, many have desired a chance to also explore utilizing MSAs in the Medicaid field, an entitlement program which costs state and federal governments up to \$140 billion annually. As of this writing, however, no state has yet implemented such a plan.

Basic medical savings accounts are somewhat akin to individual retirement accounts, in that both allow for tax-deferred deposits, up to an annual maximum figure, which are placed into a personal account. Under an MSA, this money may be drawn upon for medical needs at any time. At year's end, any unused funds may remain in the account tax-free for future medical needs (or, in some scenarios, may be withdrawn for personal use).

Medical savings accounts work in

conjunction with high-deductible, catastrophic health insurance policies, which are less expensive to maintain than traditional health insurance policies.¹ Money in the MSA pays the deductible on the insurance policy, and only when this deductible is fully met does the policy begin paying for health care costs.

The debate in recent years over the pros and cons of medical savings accounts has been heated. Supporters argue that MSAs will foster intelligent and cost-conscious utilization of health care, without stripping the consumer of rights and privileges. As Steve Forbes states:

They [MSA holders] could shop for their own doctors, medicine, and health care supplies with the peace of mind that (a) they know for sure what their maximum out-of-pocket costs will be; (b) they have real catastrophic insurance that won't leave them destitute; (c) they have control over their own care and are subject neither to excessive government rules nor to impersonal HMOs; (d) if they can keep their health expenses down, the money invested in their Medical Savings Accounts will actually grow over time and so be available to them in the future.²

¹ Tobler, Laura. "Medical Savings Accounts: An Update." *NCSL Legisbrief*. Aug./Sept. 1996. Vol. 4, No. 32.

² Forbes, Steve. "Missed Opportunity." *The American Enterprise*. November/December 1997, 43.

Opponents argue that MSAs would encourage many people, especially the poor, to put off necessary health care expenditures, thus causing their personal health care costs to become even higher in the end. In some instances, opponents fear that account-holders will be prone to spend MSA money on gambling or substance abuse, instead of health care.³ Opponents also argue that though the young and healthy may stand to gain from MSAs, certain populations (older individuals, women, and those with health problems) have little to gain, and may actually end up paying higher premiums than under other systems.⁴

MSAs for Medicaid

In some ways these debates take on deeper meaning when applied to Medicaid. The stakes are high. Medicaid costs are an undeniably large portion of state budgets, and of the federal budget. Yet Medicaid populations are also among the most fragile ones served by the health care industry.

Proponents, such as Bill Styring of the Hudson Institute, argue that, “Medicaid has conditioned its recipients to look upon health care as free. It creates an incentive to overuse and abuse medical services. The challenge, therefore, is to craft a plan that would enable former welfare recipients to develop a sense of personal responsibility in using the health care system, while ensuring that they have the care they need.”⁵

Commentators such as Mr. Styring believe that free market tendencies (the “invisible hand,” if you will) will make MSAs successful. Under this viewpoint, most

³ Gardner, Jonathan. “Cuts may fuel Medicaid MSAs.” *Modern Healthcare*. June 12, 1995, 26.

⁴ Moon, Marilyn. “Winners and Losers Under Medical Savings Accounts.” *Spectrum*. Winter 1997, 26-29.

⁵ Styring, Bill. “How to Wean the Poor From Medicaid.” *Wall Street Journal*. October 2, 1996, A18.

Medicaid recipients are rational consumers who will overuse medical care when it is free, but who will use it wisely when there is something to be gained from such behavior. At the same time, a safety net (i.e., catastrophic health insurance) will still be in place to keep such individuals from disaster.

Opponents, however, have little faith in this approach, and feel enough consumers will act against their best interest (out of need or out of incomplete education) as to make MSAs a dangerous experiment. As one source puts it, “Establishing Medicaid MSAs and rebating unused dollars would give beneficiaries an incentive to delay necessary primary care, resulting in more costly hospital stays.”⁶

However, these debates are mainly theoretical at this point, since no state yet has a working Medicaid medical savings account plan. In recent years several states, including Virginia, Texas, Indiana, Oregon, Louisiana, and West Virginia, have all given serious thought to MSAs for Medicaid, but none has implemented the idea. Montana, however, is the one state well on the road to doing so. Earlier this year the Montana Legislature passed H.B. 538, empowering the state Department of Public Health and Human Services to plan for and execute a Medicaid medical savings account pilot project.⁷

A preamble to this legislation points to the legislature’s intent in beginning the pilot program:

The legislature finds that among the contributing causes of the increase in the cost of the medicaid program has been the lack of sufficient incentive by participants in the medicaid program to conserve government funds used to pay for medicaid medical benefits. The

⁶ Gardner.

⁷ For language see *Montana Code Annotated 1997*, § 53-6-901 through 910.

legislature believes that treatment of medicaid funds as the personal funds of medicaid recipients would provide that needed incentive.⁸

A contractor selected for this project is currently setting up a design plan, and waiver requests to the Health Care Financing Administration (HCFA) will follow. Therefore, several months will elapse before the program is in operation. The Montana Legislature is hoping to garner data regarding the MSAs' level of success by 2001, and the pilot program will only be in effect until that time.

The pilot project is the result of a study done by a subcommittee of the Legislative Audit Committee which was established to explore the viability of medical savings accounts within Medicaid. The legislation calls for the Department of Public Health and Human Services to randomly choose between 1,000 and 5,000 Medicaid eligible individuals to voluntarily take part in the study. Planning and waiver development of the project have been contracted out for approximately \$75,000. Data gathering is also being contracted out at an estimated cost of \$25,000 annually. All other project costs must be covered under existing appropriations.

A fiscal note regarding this legislation which was prepared by the Montana Office of Budget and Program Planning estimates that program savings will amount to 5% per individual. The estimated total for savings is thus \$82 per adult per year and \$45 per child per year. The fiscal note includes a disclaimer, however, stating, "The financial incentive for participants to recover funds not spent on care may encourage some participants to delay or avoid preventative and primary care. This may have an impact on an individual's health status, and may subsequently increase Medicaid costs in the

future." Such uncertainty is bound to continue until the project is completed.

Other Forms of Medicaid Cost Savings

Urged to action by high Medicaid costs, states have placed great priority on finding ways to reduce expenditures in this area. In South Dakota itself, Medicaid costs the state approximately \$45 million in general funds, over six percent of all general fund expenditures. Such costs as these have brought about a variety of ideas for cost containment nationwide, a few of which are profiled below.

Managed Care

Almost all states have initiated some manner of Medicaid managed care program in order to lower the utilization of Medicaid-purchased health care, as well as to increase access to care and oversight of care given. South Dakota has established a "primary care case management" system, whereby Medicaid eligibles choose or are assigned to a specific primary care physician who must act as a health care "gatekeeper" for all primary care and for all specialty referrals. This is a rather basic managed care approach, made to conform to the state's lack of a managed care infrastructure. Other states have also established Medicaid managed care structures which range from primary care case management to full-blown full-risk capitation programs, whereby the states contract with health maintenance organizations for the complete managed care of Medicaid patients.⁹

Managed care programs require waivers from the Health Care Financing Administration (HCFA) and also often involve high start-up costs, depending especially upon the depth of changes proposed. Most states, however, have

⁸ § 53-6-901

⁹ Please refer to Issue Memorandum 97-17, "Medicaid Managed Care," for further information.

reported long term cost reductions.¹⁰

Estate Recovery

Since the inception of the Medicaid program the states have had the authority to pass laws dealing with recovery of estates in cases where Medicaid was paying for extensive and long-term care. However, this permission was turned into a mandate with the Omnibus Budget Reconciliation Act of 1993. This act declared that states must seek recovery of estates for individuals in nursing facilities and other long-term medical institutions, individuals over age 55 when receiving Medicaid, and individuals who received Medicaid by having additional resources disregarded under a long-term care insurance policy.¹¹

This translates into the following South Dakota Codified Law language:

Any payment of medical assistance by or through the Department of Social Services to an individual who is an inpatient in a nursing facility, an intermediate care facility for the mentally retarded, or other medical institution, is a debt due to the department. Any payment on behalf of any person fifty-five years of age or older for nursing facility services, home and community based services, intermediate care facility services for the mentally retarded, hospital and prescription drug services, is a debt due the department.¹²

¹⁰ Arizona is a good example here. The Arizona Care Cost Containment System, now 15 years old, was one of the nation's first Medicaid managed care programs. It had a lengthy and expensive start-up period, but has since held medical cost hikes to less than five percent per year. (Stuart, Elaine. "Healthy Diets." *State Government News*. June/July 1995, 25.)

¹¹ Sabatino, Charles and Erica Wood. *Medicaid Estate Recovery: A Survey of State Programs and Practices*. American Association of Retired Persons, Public Policy Institute. September 1996, 2-4.

¹² Please refer to SDCL 28-6-23 through 25, as well as Administrative Rules of South Dakota Chapter 67:48:02.

Estate recovery measures recouped \$815,108 for the Department of Social Services in FY96.¹³ These actions are coordinated through the office of the departmental secretary, and executed by the Office of Recoveries and Investigations.

Fraud and Abuse Investigation

Waste, fraud, and abuse in health care is relatively high in Medicaid and elsewhere. Some of this abuse can be eliminated by both greater education and such stop-gap measures as are found in managed care. However, a large amount of abuse is simply fraud, and this can only be contained through investigation and correctional action.

The South Dakota Department of Social Services recovers up to \$225,000 annually through fraud investigation. However, such investigations save the program far more money by uncovering and eliminating disreputable actors.

The National Center for Policy Analysis points out a problem in state-sponsored investigation of fraud and abuse, however. Due to federal matches, moneys recovered by the states must be shared between the state and the federal government, and this means that for each dollar recovered, a state only receives a matter of change.¹⁴ For instance, of the \$210,500 recovered by the state in FY97, only \$63,150 was retained by South Dakota. The rest went back to the federal government. Where is the incentive, the National Center for Policy Analysis asks, for the states to commit the necessary resources to fighting fraud and abuse?

Their proposed answer is the formation of block grants for Medicaid, leaving Washington out of Medicaid administration.

¹³ "Annual Statistical Report." S.D. Department of Social Services. Fiscal Year 1996, 28.

¹⁴ Cantwell, James. "Reforming Medicaid." National Center for Policy Analysis. August 1995.

Under such a scenario the states would keep 100% of the funds they recover. Obviously, however, this is far from a simple answer.

Summary

One source has been quoted as saying that, "Medicaid is like a balloon. When you push on one side of it, it blows out the other side." There are no easy answers. Partly for this reason many ideas for lowering the cost of Medicaid have not gotten very far or have

taken years to develop. Medical savings accounts, for instance, present a divisive issue, as managed care once did (and often still does). Tight federal controls, as well as evolving federal law, make it difficult for states to experiment with Medicaid dollars. The risks of a mistake, in human terms, make such experimentation difficult as well.

This issue memorandum was written by William E. Pike, Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.
