HSAs, Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Section 1115 Medicaid Waivers: Lessons from Pioneering States

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Speakers

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Agenda

- HSAs, Cost Sharing, Payment Enforcement, Healthy Behavior Programs
- Opportunities and Challenges
- Lessons Learned
- Best Practices
- Questions
Health Savings Accounts
Background

• Enrollees make monthly contributions to their accounts instead of making payments to an insurer. States may also contribute.
• Contributions typically cover enrollees’ cost sharing or accrue in the account and are disbursed to the enrollee upon departure from the program.
• Medicaid HSAs do not provide a tax advantage and enrollees receive care from health plans without regard to a deductible.
Opportunities

Proponents believe HSAs can:
• increase enrollees’ responsibility for their health coverage;
• familiarize enrollees with private insurance models; and
• reduce costs to the state.
Challenges

HSAs may:
• affect service utilization;
• lack some cost-savings potency due to scarcity of price transparency tools; and
• be an administrative burden to the state.
Evidence

- Service Utilization
- Price Transparency
- Administrative Costs
Arkansas Works

- Accounts implemented for enrollees between 50-138% FPL in 2014.
- Due to administrative cost, terminated contributions and cost sharing for enrollees between 50-100% FPL in 2015.
- Cut administrative costs of the waiver program in half – from $12 to $6 million.
- Accounts kept in place for enrollees above 100% FPL. However, with less than 1% of enrollees contributing, the state terminated all accounts in 2016.
Healthy Indiana Plan

• Enrollees above 100% FPL required to contribute.
• State contributes the difference between the enrollee’s annual contribution and $2500.
• 65% of HIP enrollees make monthly contributions.
• Only 48% of enrollees who contribute understood they had an account, even though 90% continued to make contributions.
• Enrollee confusion about the purpose of the accounts, associated statements, and account debit card.
• Cost was a concern for 39% of enrollees below 100% FPL and 46% of enrollees above 100% FPL.
Best Practices

- Consider one type of enrollee cost sharing mechanism.
- Provide clear and frequent communications about the purpose of accounts.
- Give enrollees a “grace period” before implementing account contributions.
- Ensure that penalties for non-payment don’t disrupt ongoing episodes of care.
- Make resources for cost, quality, and treatment comparison available.
- Keep the HSA program simple.
- Ensure frequent and objective evaluation is part of the HSA program.
Cost Sharing
Most 1115 waiver states have adopted monthly contributions and modest copays for their Medicaid expansion population.
Proponents expect that cost sharing will:
- offset some state costs;
- increase enrollees’ responsibility for their health coverage;
- reduce unnecessary utilization; and
- familiarize enrollees with private insurance models.
Challenges

Cost sharing may:
• decrease enrollment;
• decrease service utilization;
• increase the use of more expensive forms of care; and
• be administratively burdensome.
Evidence

- Access to Coverage
- Access to Care
- Long-Run Spending
- Administrative Burden
Healthy Michigan Plan

- Enrollees above 100% FPL pay contributions that are no more than 2% of an enrollee’s household income. All enrollees are responsible for copays.

- Enrollees are not charged copays for the first six months of enrollment. After six months, copay amounts are calculated based on the prior six months’ utilization. Re-calculated once a quarter.

- 91% of respondents to an HMP enrollee survey thought that the amount they pay for coverage was affordable, but only 30% of those who owe contributions and 37% of those who owe copays have paid them.

- Nearly 50% of enrollee survey respondents did not know if contributions were charged monthly regardless of health care use.
Best Practices

- Target copays for services that may be overused.
- Give enrollees a “grace period” before implementing cost sharing.
- Keep the cost sharing program simple.
- Ensure frequent and objective evaluation is part of the cost sharing program.
Payment Enforcement
Most 1115 waiver states have payment enforcement mechanisms in place to encourage enrollees to pay cost sharing, which may include charging copays at the point-of-service, service denial, disenrollment, or lockout from coverage.
The goal of payment enforcement is to ensure enrollees engage with the cost of their health care. Without payment enforcement mechanisms, states have little recourse if enrollees do not participate in cost sharing.
Payment enforcement mechanisms may:
- limit enrollees’ access to coverage and care; and
- be unpopular with providers.
Evidence

Access to Coverage and Care

Providers’ Perspective
Healthy Indiana Plan

• Enrollees above 100% FPL who don’t make contributions are disenrolled and locked out of coverage for six months.

• In HIP’s first two years, 5% of enrollees with incomes above 100% FPL were disenrolled and locked out.

• For those disenrolled, unaffordability was the most common reason cited (44%). The next most common reason cited was confusion about the payment process.

• Disenrolled individuals were less likely to make appointments for care and to fill a prescription.

• Many also remained uninsured (47%) at the time of the enrollee survey.

• Enrollees below 100% FPL were also more likely to miss a payment (57%) than those above 100% FPL (51%).
Best Practices

1. Communicate expectations about monthly contributions and cost sharing up front.
2. Ensure that penalties don’t disrupt ongoing episodes of care or limit enrollees’ ability to work, attend school, or care for dependents.
3. View enforcement as an opportunity to communicate with enrollees.
4. Keep payment enforcement simple.
5. Ensure frequent and objective evaluation is part of the payment enforcement program.
Healthy Behavior Programs
Some 1115 waiver states have used incentives for enrollees to engage in healthy behaviors. These incentives include reducing or eliminating cost sharing, rolling over Health Savings Account funds, providing enhanced benefits, or providing cash rewards.
Opportunities

- Since lower-income populations face higher rates of obesity, smoking, substance abuse, heart disease, diabetes, and stroke, encouraging healthy behaviors could be valuable.
- Financial rewards have been shown to be effective for one-time or short-term activities.
Challenges

- Healthy behavior programs are not effective in changing behaviors that require maintenance;
- Enrollees are often not aware of healthy behavior incentives;
- Lower-income individuals may have environmental factors that make compliance with healthy behavior activities difficult; and
- Healthy behavior programs may be administratively burdensome for states.
Evidence

- Changing Long-Term Behaviors
- Enrollee Participation
- Environmental Barriers
- Administrative Burden
Healthy Michigan Plan

- Enrollees above 100% FPL are required to complete healthy behavior activities.

- Only 17% of beneficiaries enrolled in a health plan for at least six months completed the activity. Many did not understand what the incentives were or the connection between the activity and the incentives.

- Enrollees noted that the more immediate receipt of the gift card, as opposed to a future reduction in contribution amounts, was a greater incentive.
Best Practices

- Ensure enrollees are aware of incentives.
- Create incentives for one-time or short-term activities.
- Make incentives worth it.
- Make the healthy behavior program simple.
- Ensure frequent and objective evaluation is part of the healthy behavior program.
Questions?
Department website
https://medschool.vanderbilt.edu/health-policy

Issue briefs and 1-pagers
https://medschool.vanderbilt.edu/health-policy/medicaid-lessons-pioneering-states

Health Affairs blog
http://healthaffairs.org/blog/2017/06/07/state-medicaid-lessons-for-federal-health-reform

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