

Health Savings Accounts in Medicaid

Several states have implemented HSAs in their Medicaid expansion programs. In these states, enrollees make monthly contributions to their HSAs instead of making payments to an insurer. Most of these states also make contributions to enrollee accounts. Account contributions are typically used to cover enrollees' copays for services. In a few states, contributions are not used for copays and instead accrue in the account and are disbursed to the enrollee upon departure from the program if certain requirements are met.



Opportunities

The concept behind HSAs is that enrollees have an incentive to use funds in their accounts thoughtfully because they can be rolled over and used for health care services needed in the future. [This approach](#) is intended to encourage people to be careful consumers of services and to reduce unnecessary utilization, which works to control health care spending.

Challenges

A key question is whether HSAs are a viable option for low-income individuals. Research has shown that HSAs may affect enrollees' [service utilization](#), leading to reduced utilization of preventive care and [increased use of more expensive care](#), and may unfairly [penalize enrollees with chronic conditions or disabilities](#). Further, implementing and managing HSAs may be [administratively burdensome and costly for states](#).

Another consideration for HSAs is that they may provide *too weak* an incentive to utilize services carefully, depending on how they are set up. In most states that have HSAs in their Medicaid program, enrollees make contributions to their accounts regardless of their service use; and in some of the states, monthly contributions are made in lieu of copays. If enrollees view the accounts as reserved for health care spending, they might feel that there is [no need to limit spending](#), at least until they have exhausted the account.

Lessons from the States



Arkansas Works

[Arkansas implemented HSA-like accounts](#), called Independence Accounts, in 2014. Enrollees between 50-138% FPL were expected to make monthly account contributions.

Since Medicaid has caps on how much enrollees can be charged quarterly, Arkansas had to track enrollees' health spending, income, and contributions to the accounts. Tracking this information was administratively burdensome and costly for the state; as a result, [Arkansas terminated account contributions and copays](#) for enrollees between 50-100% FPL in 2015. After suspending this requirement, the state projected that the administrative costs of the waiver program would be [cut in half](#) – from \$12 to \$6 million.

HSAs were kept in place for enrollees above 100% FPL. However, less than [1% of enrollees](#) were contributing to their accounts. This likely weighed in to the state's decision to [terminate Independence Accounts for all enrollees](#) in 2016.

Best Practices for Implementing Health Savings Accounts in Medicaid

- ✓ Use one type of enrollee cost sharing mechanism – either a monthly account contribution OR nominal copays for frequently used, low-value services.
- ✓ Provide clear and frequent communications about the role and purpose of accounts, and expectations about account contributions.
- ✓ Give enrollees a “grace period” to access care before implementing account contributions.
- ✓ Ensure that any 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.



**Read more in our issue brief,
[“Developing and Implementing Health Savings Accounts in Medicaid: Lessons from Pioneering States.”](#)**

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