



# Developing and Implementing Health Savings Accounts in Medicaid: Lessons from Pioneering States

Melinda B. Buntin, Ph.D.

Professor and Chair, Department of Health Policy  
Vanderbilt University School of Medicine

John Graves, Ph.D.

Assistant Professor, Department of Health Policy  
Vanderbilt University School of Medicine

Nikki Viverette, MSW

Health Policy Analyst, Department of Health Policy  
Vanderbilt University School of Medicine

## Introduction

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Republicans' health reform proposals and anticipated regulatory guidance under the Trump administration aim to broaden state flexibility in the design and operation of Medicaid programs. Several of the proposed changes, including implementing Health Savings Accounts (HSAs) for Medicaid enrollees, build upon efforts currently underway in states that expanded their Medicaid programs with Section 1115 waivers.

There is currently little evidence on whether states that have implemented HSAs are achieving their goal of encouraging personal responsibility while reducing Medicaid program costs. The experience of states with 1115 waivers can therefore offer useful lessons on the design and effectiveness of these types of Medicaid reform.

The objective of this brief is to synthesize the available evidence on how HSAs in Section 1115 waivers have worked in several states, including Arkansas, Indiana, and Michigan. This brief includes a summary of these changes, available evidence from state waiver evaluations, and best practices for state and federal policymakers considering implementing similar programs.

### Section 1115 Medicaid

**waivers** allow the Department of Health and Human Services to waive specific Medicaid provisions and allow states to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. 1115 waivers can enable broad changes in eligibility benefits, cost sharing, and provider payments or focus on specific services and populations.



## Health Savings Accounts

### HSA in Medicaid Waiver Programs



Several states have used 1115 waivers to implement HSAs in their Medicaid expansion programs. In these states, enrollees make monthly contributions to their accounts instead of making payments to an insurer. Most of these states also make contributions to enrollee accounts. These 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, such as accessing preventive services or completing a health risk assessment. Unlike traditional HSAs, Medicaid HSAs do not provide a tax advantage and enrollees receive care from health plans without regard to a traditional deductible.<sup>1</sup> (See box below for explanation of HSAs for those with private insurance.)

HSA contributions are generally touted as having three purposes: 1) they can increase enrollees' responsibility for their health coverage, 2) they can familiarize enrollees with private insurance models, and 3) they may reduce costs to the state. 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 users of services and to reduce unnecessary utilization, which works to control health care spending.

#### HSA for the Privately Insured

Traditional HSAs have a three-fold tax advantage: contributions are tax-free; enrollees can put their contributions in stocks, bonds, or other investments, with the earnings accruing tax-free; and withdrawals are tax exempt if used for qualified medical expenses.<sup>2</sup> HSA contributions are also tax-deductible.<sup>3</sup>

The maximum HSA contribution in 2017 is \$3,400 for an individual and \$6,750 for a family. Individuals over age 55 can contribute an extra \$1,000 each year. Both individuals and employers can contribute to HSAs, but HSAs follow the individual, even if they change jobs or insurers. Unused balances roll over each year.<sup>4</sup>

HSAs are typically paired with a high-deductible health plan (HDHP). A HDHP is HSA-qualified if it has an annual deductible of at least \$1,300 for an individual or \$2,600 for a family.<sup>5</sup>



## Opportunities

Proponents of HSAs believe that owning account funds will encourage enrollees to engage more with their health care: considering the cost of care, the quality of a provider, and the evidence for choosing a particular treatment over another. There is some research that indicates high-deductible health plans (HDHPs) may offer an incentive for enrollees to manage health care costs carefully, but the effects of HSAs are less clear.

A review of several studies found that moving a population from a traditional plan to a HDHP resulted in a one-time reduction in health care spending of about 4-15%.<sup>6</sup> However, this same analysis found that an HDHP attached to a personal spending account, such as an HSA, may offset spending reductions found in HDHPs by about half, only reducing spending by 2-7%.<sup>7,8</sup>

In addition, several large, multi-year studies found that:

- Individuals with HSAs spent between 5-7% less than those in traditional health plans, with lower spending on prescription drugs steering most of the savings;<sup>9</sup>
- Moving individuals from traditional health plans to HSA plans reduced total spending by 25% in the first year, but spending decreases were not sustained over time;<sup>10</sup> and
- Those in HDHPs with a personal spending account, such as an HSA, spent 21% less on health care than those in traditional plans, with two-thirds of the cost-savings coming from fewer episodes of care. These enrollees also received 3-5% less preventive care than those in traditional plans.<sup>11</sup>

It should be noted that each of these studies look at personal spending accounts, such as HSAs, paired with HDHPs. Medicaid HSAs are not paired with HDHPs, and enrollees are provided care through health plans without being subject to deductibles. This may indicate that some of the findings about HDHPs and HSAs described above might not occur in Medicaid HSAs.

Further, with both HDHPs and HSAs, the reduction in spending could be due to a number of factors including enrollees decreasing use of low-value services, high-value services, or both; favorable selection due to HDHPs typically attracting younger and healthier individuals; or enrollees being more informed and judicious about their health care service utilization.



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## Challenges

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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 punish enrollees with chronic conditions or disabilities. Further, implementing HSAs may be administratively burdensome and costly for states.

## Service Utilization

HSA proponents believe imposing HSAs will help reduce health care spending because it will encourage enrollees to make thoughtful health care decisions since it is their funds that are being expended. However, many studies have concluded that reductions in health care spending are typically not a result of better-informed choices, but the result of individuals deciding to go without services or treatment because of cost.

The RAND Health Insurance Experiment demonstrated that when enrollees are given more financial responsibility for their care, they cut back on high-value, necessary care like preventive screenings just as much as they cut back on low-value, non-essential services.<sup>12</sup> Increased financial responsibility has also been associated with reduced use of clinician visits, medication adherence, and behavioral health services.<sup>13,14</sup> This is especially true for lower-income enrollees.<sup>15</sup> Further, research suggests that if enrollees are more conscious of costs, they may delay necessary care, which could increase utilization of more expensive care and hospitalizations.<sup>16</sup>



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 1115 waiver states, 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. When monthly contributions are due regardless of health care utilization, the incentive for enrollees to use services carefully may be weakened.<sup>17</sup> Further, 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.<sup>18</sup>

Finally, because health care costs increase for individuals with chronic conditions, disabilities, and other high-cost medical needs, the increased cost sharing responsibility of HSAs could create a larger burden for individuals with these conditions and may discourage these enrollees from accessing coverage or necessary care. This could potentially worsen health conditions and cost more in the long-run.

## Price Transparency

Many proponents also believe that HSAs will encourage enrollees to make better choices about their health spending by comparing prices for health care. However, a lack of information regarding the costs, effectiveness, and quality of care makes it difficult for this perceived benefit to be realized.

As of 2016, 43 states did not have laws meeting minimum standards for mandating patients to have access to health care cost information.<sup>19</sup> While some health plans provide information on the costs of providers and services, the aggregated information does not allow enrollees to determine the actual cost for a service from a specific provider.<sup>20</sup>

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Further, the RAND study suggests that for enrollees who do seek care for which they pay the full cost, the majority of them still defer to their providers' instructions without evaluating treatment options, benefits, or cost considerations.<sup>21</sup> This may be partly why one study found that price comparison tools, even when available, are not associated with lower health care spending.<sup>22</sup>

### Administrative Costs of HSAs

HSAs may also be administratively burdensome for states. There are large numbers of enrollees in these programs so there are a substantial amount of small monthly transactions that have to be managed, both in to and out of the accounts.<sup>23</sup> States also need to provide frequent notices to enrollees about changes to their account balances or payment amounts.<sup>24</sup>



## 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, ranging from \$5-\$25 (depending on income). Account funds were not used to pay for health care and instead accumulated in enrollees' accounts until they left the program.<sup>25</sup>

Since Medicaid has caps on how much enrollees can be charged quarterly (up to 5% of their household income), 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.<sup>26,27</sup> After Arkansas suspended this requirement, the state Medicaid agency projected that the administrative costs of the waiver program would be cut in half – from \$12 to \$6 million.<sup>28</sup>

HSAs were kept in place for enrollees above 100% FPL. However, less than 1% of enrollees were contributing to their accounts.<sup>29</sup> This likely weighed in to the state's decision to terminate Independence Accounts for all enrollees in 2016.<sup>30</sup>



### Healthy Indiana Plan

The Healthy Indiana Plan (HIP) implemented HSA-like accounts, called POWER Accounts, in 2015. Enrollees below 100% FPL have the option to make monthly contributions, but enrollees above 100% FPL are required to do so. Enrollees pay contributions equal to 2% of their household income (enrollees under 5% FPL pay \$1.00/month). Enrollees who make contributions are placed in HIP Plus, a plan that



provides enhanced benefits such as dental and vision. Enrollees below 100% FPL who do not make contributions are placed in the HIP Basic plan.<sup>31</sup>

The state also contributes to enrollee accounts the difference between the enrollee's annual contribution and \$2500. For example, if an enrollee's yearly contribution amount is \$200, the state would contribute \$2300. Account funds will roll over, but the amount of rollover depends on enrollment in HIP Basic or Plus and on obtaining certain preventive services outlined by the program. Rollover funds can be used to reduce contributions in subsequent years, and unused funds can be disbursed to an enrollee upon departure from the program.<sup>32</sup>

### Account Contributions

About 65% of HIP enrollees make monthly contributions, 81% of whom have incomes below 100% FPL.<sup>33</sup> After the first year of enrollment, over 62% of all HIP enrollees maintained a balance in their account.<sup>34</sup>

### Account Knowledge

In an HIP enrollee survey, only 48% of HIP Plus enrollees and 35% of HIP Basic enrollees understood they had an account, even though every enrollee had one.<sup>35</sup> Interestingly, over 90% of HIP enrollees required to make account contributions did so, despite enrollee disconnect with understanding what the accounts were.<sup>36</sup>

Among enrollees who reported having an account and were enrolled in HIP Plus, 40% reported checking their account balance monthly, and 27% reported asking their provider about the cost of care.<sup>37</sup> However, an analysis of the numbers shows that only about 19% of HIP enrollees who made account contributions checked their account balance monthly.<sup>38</sup> Large shares of respondents also showed a lack of understanding when answering a series of questions about their accounts.<sup>39</sup> Without enrollee knowledge of the HSAs, the perceived benefit of the accounts cannot be fully realized.

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### Service Utilization

An HIP evaluation found that enrollees who contributed to their accounts were twice as likely to obtain primary care (31% to 16%), had better medication adherence (84% to 67%), and relied less on the emergency department for treatment than enrollees who did not contribute to accounts. Further, 87% of HIP Plus members used preventive health services during their first year of enrollment.<sup>40</sup>

### Contribution Amounts

According to an HIP evaluation, 39% of enrollees below 100% FPL and 46% of enrollees above 100% FPL who made contributions reported that they sometimes, usually, or always worried about being able to afford contributions.<sup>41</sup> A survey of enrollees who were either placed in the Basic plan or were disenrolled from HIP Plus due to not making an initial contribution cited unaffordability as the reason (42% of those below 100%



FPL and 44% of those above 100% FPL).<sup>42</sup> Interestingly, of the survey respondents who made contributions, 85% of those below 100% FPL and 86% of those above 100% FPL reported they would pay more to remain enrolled in HIP.<sup>43</sup>

### Confusion about the Accounts

An HIP evaluation found that more than 46,000 individuals were found eligible for HIP but were not enrolled because they didn't make an initial contribution.<sup>44</sup> In a survey of these individuals, 44% of respondents said they couldn't afford the monthly payment or were confused about the payment process.<sup>45</sup> This may indicate that HIP's contribution requirement is burdensome and confusing and may be deterring a large number of eligible individuals from enrolling.

Enrollees also expressed confusion about the purpose of the accounts and the associated statements. Many enrollees did not understand that their account debit card was intended to be used at the point of service so that the provider could be reimbursed by the state. Further, some enrollees thought that the \$2500 amount represented a cap on services.<sup>46</sup>

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### Provider Perspective of the Accounts

Some providers have also viewed the account debit cards as an administrative burden. Although account debit cards enable providers to receive reimbursement faster, payments are at a discounted rate. Providers noted they would prefer to receive the full reimbursement rate, even if that means waiting longer for payment. Providers also noted that they often don't know all of the services to be received before the appointment begins so they cannot correctly process the account debit card at check-in.<sup>47</sup>

### Administrative Cost of the Accounts

In HIP, insurers collect enrollee contributions and administer the accounts. These costs are included in what the state pays the insurance companies, so the administrative expense of collecting cost sharing and managing the accounts is unclear.<sup>48</sup>



### Healthy Michigan Plan

In the Healthy Michigan Plan (HMP), enrollees above 100% FPL pay contributions and copays into HSA-like accounts, called MI Health Accounts. Contributions are no more than 2% of an enrollee's household income. Enrollees are not charged copays for health care services for the first six months of enrollment. After six months, an enrollee's copay amount is calculated based on the prior six months of utilization, and is re-calculated once a quarter. Copays that enrollees pay are disbursed to the health plan and do not accumulate in the account.<sup>49</sup>



Health plans are responsible for covering a certain amount of an enrollee's health care costs before enrollee's funds are used. The amount the health plan contributes (called 'first dollar' coverage) is the difference between \$1000 and the enrollee's annual contribution amount. For example, if an enrollee has a required annual contribution of \$300 each year, the health plan would be responsible for the first \$700 of services before using any of the enrollee's contributions.<sup>50</sup>

Enrollees' account funds roll over, but will decrease the health plan's contribution amount the next year. Enrollees can receive account funds when they leave the program.<sup>51</sup>

### Enrollee Experience with Accounts

In a survey of HMP enrollees, 91% of respondents thought the account contribution amounts and copays were affordable.<sup>52</sup> However, many enrollees indicated they did not understand how contributions and copays were calculated or how contributions were used. Some enrollees also did not understand why they had to pay in advance of accessing health care (account contributions).<sup>53</sup>

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### Payment Difficulties

Some enrollees, regardless of payment type, described challenges to making payments, including lack of internet access, problems navigating the website, lack of a bank account, limitations in accepted payment methods, fees associated with getting a money order, and lack of money. According to HMP's second annual report, the state is exploring additional payment methods to address these barriers.<sup>54</sup>

### Account Statements

In another enrollee survey, about three-quarters of survey respondents remembered receiving a MI Health Account statement.<sup>55</sup> Many described them as long and complicated and most did not see any relationship between the account statement and their health-related behaviors. However, among respondents who reported receiving a MI Health Account statement, 88% agreed that the statements help them be more aware of the cost of health care. Although 55% disagreed that the information in the statement led them to change their health care decisions, 57% agreed that the amount they might have to pay for prescriptions influenced their decisions about filling prescriptions.<sup>56</sup>

Enrollees reported that the statements did not encourage them to make changes in behavior because they viewed the statement only as a bill or source of information about their health care coverage. The cost of care assumed by their health plans and outlined in the statement was typically overlooked.<sup>57</sup>

### Cost of Health Care

Among survey respondents, 72% reported being likely to find out how much they might have to pay for a health service before accessing the service, 67% reported being likely to talk with their provider about how much different health care options would cost, 77% reported that they were likely to ask their provider to





recommend a less expensive prescription drug, and 76% reported that they were likely to check reviews or ratings of quality before choosing a provider or hospital.<sup>58</sup>

### Administration of Accounts

Michigan requires its health plans to contract with a single third party vendor to administer the accounts.<sup>59</sup> The health plans noted high administrative costs to collecting payments and differentiating payment amounts based on enrollee income, and expressed interest in having more flexibility for administering the accounts. Health plans also mentioned wanting to allocate more resources and attention to achieving cost savings through providing care management to high utilizers instead of the state-required healthy behavior program.<sup>60</sup>

### Further Evaluation

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Further evaluation of how these waiver elements are affecting enrollees and the state will be important to understanding if they are achieving their intended goals.

The Healthy Indiana Plan (HIP) is considered a model for Medicaid reform because it implements a variety of innovative approaches, including HSAs. However, because Indiana's waiver is unique, careful consideration may need to be given to how HIP affects enrollees, health outcomes, and the state budget.



HIP's interim evaluation was released July 2016 and includes information from the first year of implementation. Due to the length of time, better insight into HIP will be available in the program's second year report, due to CMS in April 2017, and their final evaluation, to be completed by March 2018.

The Healthy Michigan Plan's (HMP) interim evaluation report is due to CMS in June 2018, and their final evaluation report is due in May 2019. Michigan will also conduct the Healthy Michigan Voices Beneficiary Survey at least once a year with beneficiaries enrolled in HMP, individuals who have been disenrolled from HMP, and individuals who are eligible but unenrolled.

## Best Practices for Developing and Implementing Health Savings Accounts in Medicaid

States considering implementing Health Savings Accounts (HSAs) should consider the effects on enrollees with the effects on administrative and overall health care costs. HSAs can create burdens on enrollees, providers, and state administrative functions. However, for states interested in implementing HSAs, there are ways to alleviate some of the adverse effects. Some best practices for responsibly implementing HSAs are below.

### Use one type of enrollee cost sharing mechanism – either a monthly account contribution OR nominal copays for frequently used, low-value services.

- States should consider not charging both account contributions and copays, especially for enrollees under 100% FPL.
- Some enrollees prefer paying for coverage they actually use, instead of paying for care ahead of time (account contributions). However, incurring copays for individual health services can be burdensome for those who have chronic conditions, disabilities, or higher medical needs.<sup>61</sup>



### Provide clear and frequent communications about the role and purpose of HSAs, and expectations about account contributions.

- Provide enrollees with information about accounts at enrollment, and monthly with account statements.<sup>62</sup>
- Include several payment options, such as payment/money cards or credit cards, and in-person payments.
- Written materials should be simple, at an appropriate reading level, and in the enrollee's preferred language. They should also include information on where to call for additional assistance or questions.

### Give enrollees a "grace period" to access care before implementing account contributions.

- Individuals gaining coverage through Medicaid expansion may have limited experience with health insurance. Giving enrollees an opportunity to use services, understand the value of coverage, and develop a relationship with a provider before being responsible for account contributions may help reduce the negative effect on service use.<sup>63</sup>
- Program policies that connect the start of the coverage to making a payment can be an impediment to accessing coverage and care.<sup>64</sup>
- Delaying the start of HSAs can also provide states baseline service use data against which to measure the effect of the HSAs.

**Ensure that any penalties for non-payment don't disrupt ongoing episodes of care or limit enrollees' ability to work, attend school, or care for dependents.**

- States have found that disenrollment and lockout for failure to pay contributions reduce access to care, increase uncompensated care, and may cost more in the long run.<sup>65</sup> This disruption in care may be especially problematic for those with chronic conditions or behavioral health needs.
- Instead of disenrolling or locking enrollees out of coverage, some states have chosen to charge copays at the point of service for enrollees who fail to pay account contributions, or bill enrollees for cost sharing if they are unable to pay at the point of service.<sup>66</sup>
- If states do disenroll beneficiaries, they should be given an opportunity to maintain coverage through an in-person hearing or a "good cause" waiver. States should also make it easy for beneficiaries to reenroll.

**Make resources for cost, quality, and treatment comparison available.**

- Information about provider cost, quality, and effectiveness of treatment alternatives is sparse. Cost information is especially difficult to locate, even for proactive enrollees.
- Some insurers have begun pilot programs to report the fees it has negotiated for the most common medical procedures and to provide information about prices for prescription drugs.<sup>67,68</sup> Enrollees in these plans are more likely than those in other plans to ask providers about cost, consider treatment alternatives, check quality ratings, and pay attention to wellness and prevention practices.<sup>69,70</sup>

**Keep the HSA program simple.**

- Implementation of complex programs involves collaboration with a variety of stakeholders, sophisticated IT systems, and administrative costs.<sup>71</sup> Keeping programs simple will help minimize some of the burden of implementation for the state and complexity for the enrollee.

**Ensure frequent and objective evaluation is part of the HSA program.**

- The Centers for Medicare and Medicaid Services (CMS) requires program evaluation as part of waivers. Additional evaluations from trusted sources such as universities or state research organizations may also be helpful.
- Collecting evidence on the effect of cost sharing on enrollees' access to care, amounts collected, and costs to administer the program should be a part of regular evaluations.

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