Health Savings Accounts — Lessons from States; Questions for Policymakers

Amy Clary and Trish Riley

Recent state waivers can inform the question of whether and how low-income individuals could benefit from health savings accounts (HSAs) with high-deductible health plans (HDHPs).[1] State experiences incorporating health savings accounts into Medicaid can be instructive, as policymakers consider the role of HSAs in proposed health care reforms. This brief looks at health savings and similar accounts in Michigan and Indiana.

HSAs are tax-exempt accounts that people with high-deductible health plans can use to pay for qualified medical expenses with tax-free dollars.[2] HSAs are paired with HDHPs to help people pay out-of-pocket costs—but generally not premiums[3]—until they reach their deductible and the plan itself starts paying. Individuals and their employers can contribute to an HSA, and employees leaving jobs can generally keep their HSA balances to pay for future medical expenses tax-free. HSA expenditures for non-medical expenses may be taxed.

For 2016, in order for a plan to be considered an HDHP and be paired with an HSA, the deductible had to be at least $1,300 for self-only coverage, or $2,600 for family coverage.[4] The average annual deductible in 2016 for an employer-sponsored, HSA-qualified HDHP was $2,295 for an individual and $4,364 for a family.[5] However, a single person with an HDHP could pay up to $6,550 for copays and deductibles before insurance started paying for costs, and a family could pay up to $13,100 out of pocket, not including premiums (see Table 1).

Table 1. Annual HSA-Eligible HDHP Deductibles and Out-of-Pocket Maximums (2016)

	Minimum Deductible[6]	Average Deductible for Employer-Sponsored HDHPs[7]	Maximum Out-of-Pocket Payments (includes copays and deductibles; excludes premiums)[8]
Self-only	$1,300	$2,295	$6,550
Family	$2,600	$4,364	$13,100

Do HSAs Work for Low-Income People?

HDHPs paired with HSAs (or with health reimbursement arrangements) are sometimes called "consumer-driven health plans," because consumers must pay for more of their care out of pocket before insurance assists. Some payers believe that this responsibility leads consumers to make more savvy choices about their health spending, although a lack of price transparency in health care can make this difficult for consumers.[9] Others raise concerns about the scope of the benefit package in an HDHP, the exposure of consumers and hospitals to out-of-pocket costs, and the value of HSAs to lower-income people who may not pay taxes or who lack the means to pay for out-of-pocket expenses.

The growing[10] prevalence in the large-group market of HDHPs with HSAs points to the desire of many employers to lower premiums[11] for health insurance and shift[12] more responsibility for health spending to their employees. However, this strategy has yet to be robustly tested in the individual market. In 2015, 78 percent of people covered by HDHPs with HSAs were in the large group market.[13] The individual market accounted for only 10 percent of HSA-eligible HDHP enrollees in 2015, according to America's Health Insurance Plans.[14] Only a quarter of the plans sold nationwide in 2015 as part of the ACA individual marketplace were HSA-qualified, even though the average deductibles for silver and bronze plans were well above the HDHP minimum, according to a Health Affairs health policy brief.[15] Much remains to be learned about how successfully individuals, particularly those with lower incomes, navigate HSAs without the support of an employer's human resources department—and possibly without a regular paycheck.

The tax advantages of HSAs make them attractive to people who want to save money tax free, so in 2016, the IRS limited tax deductions on HSA contributions to $3,350 for individuals and $6,750 for families.[16] For lower-income people who are more concerned with paying for their health care than with saving money tax-free, the implications of HDHPs are mixed.

- If a person is healthy with little need for care, the lower premium of an HDHP may be attractive.[17]
- However, at least one study associated HDHPs with reduced adherence to prescription medication,[18] and a survey found that privately-insured low-income adults with high deductibles reported skipping recommended care or avoiding going to the doctor when sick because of their deductible.[19]
- The Rand Health Insurance Experiment found that low income people with high blood pressure who received care with no cost sharing "saw greater reductions in blood pressure than did their counterparts with cost sharing."[20] The finding raises questions about the impact on the poor of requiring them to pay out-of-pocket for their care, although the experiment did not directly address HSAs and HDHPs.
- Some also attribute a rise in hospitals' bad debt among insured patients to high-deductible plans.[21] When patients do not pay deductibles and copays, hospitals often invest resources into collecting debts from individuals, rather than from insurance companies or other payers.

What can we Learn from States?

Recent waivers can inform the question of whether and how low-income individuals could benefit from HSAs. As of January 2017, seven states have been granted a Section 1115 waiver to test alternative methods of expanding Medicaid eligibility to all adults under 138 percent of the federal poverty level.[22] Indiana[23] and Michigan[24] were both granted waivers to incorporate HSAs or similar accounts into their Medicaid expansions. Their experiences may prove helpful to other policymakers seeking to incorporate HSA-eligible high-deductible health plans into Medicaid.

Healthy Indiana

In January 2015, the Centers for Medicare & Medicaid Services (CMS) approved the Healthy Indiana Plan 2.0 Section 1115 demonstration waiver.[25] In late January 2017, the state requested an extension of the plan through January 2021.[26] The Healthy Indiana Plan (HIP) pairs a high-deductible health plan with a "personal wellness and responsibility" (POWER) account similar to an HSA, which can be used to pay deductibles for covered services. The plan was designed by Seema Verma,[27] who has since been nominated to serve as the Administrator for the Centers for Medicare & Medicaid Services.[28]

According to Indiana officials, the HSA-like POWER account, with its year-end rollover, encourages beneficiaries to be engaged, "cost-conscious consumers" who take responsibility for their use of health care services and obtain care in appropriate settings.[29] The $2,500 POWER account, fully available on the first day of enrollment, is funded by a combination of the participant's contributions and the state Medicaid program.

Alongside incentivizing recommended preventive services, HIP 2.0 uses a stick: people with incomes above the poverty line who fail to make POWER account payments of roughly 2 percent of their income will be locked out of HIP coverage for six months, with some exceptions for medically frail populations, pregnant women, and some others.[30]

According to an evaluation by the Lewin Group, in the first year of the program, roughly 2,677 people, or six percent of HIP Plus enrollees with incomes above poverty, were locked out of coverage for six months for failing to make POWER account payments.[31]

- An additional 21,445 former HIP Plus members below poverty were downgraded to HIP Basic for failing to make POWER account payments. HIP Basic, which is intended for people with below-poverty incomes who do not contribute to a POWER account, excludes dental and vision coverage, and requires copays for in- and outpatient services as well as prescription drugs.[32]

Affordability was an issue for some HIP participants. Forty-five percent of HIP Plus members reported that they sometimes, usually, or always worried about affording the required contributions to their POWER accounts.

- A survey of 173 HIP Basic members found that 30 of them reported not making POWER account payments because they were unaffordable.
- 97 of the surveyed members cited confusion about their membership, plan type, or payment process as the reason for not making payments.[33]

Indiana officials report that in the first year of HIP 2.0, beneficiaries who contributed to their POWER accounts were more likely to obtain primary care, adhere to their prescription drug regimens, and avoid the emergency department, compared to members who did not contribute to their accounts.[34]

Healthy Michigan

In December 2015, CMS approved the Healthy Michigan Plan Section 1115 demonstration waiver amendment.[35] Starting April 1, 2018, the Healthy Michigan Plan will require beneficiaries with incomes between 100 and 138 percent of the federal poverty level to choose between two delivery system models:

- Receiving coverage through an ACA marketplace plan, or
- If they satisfy the state's Healthy Behavior requirements, receiving coverage through the Healthy Michigan Plan, with a requirement to make contributions to a MI Health Account.[36]

Like Indiana, the Healthy Michigan Plan requires people above the poverty line to pay up to 2 percent of income toward their healthcare costs, and all beneficiaries to pay copayments through the MI Health Account, in compliance with federal regulations.

Unlike Indiana, people would not be locked out of the program or denied services for failing to pay. However, state law requires the Michigan Department of Health and Human Services (MDHHS) to work with the state treasury to offset the state tax returns and lottery winnings of Healthy Michigan participants who fail to pay their Healthy Michigan debts.[37]

Also like Indiana, beneficiaries can reduce the amounts they are charged by complying with the plan's healthy behaviors recommendations. The Healthy Behaviors Incentive Program is intended to encourage beneficiaries to improve their health outcomes as well as to maintain and implement additional healthy behaviors as identified in collaboration with their health care providers.[38] The program requires an initial primary care visit for new members and annual health risk assessments, and rewards participants with reduced copays, and when applicable, contributions, for healthy behaviors. There are also incentives for managed care providers who work with their Healthy Michigan patients to fill out a health risk assessment.

MDHHS has contracted with the University of Michigan Institute for Healthcare Policy to evaluate the Healthy Michigan plan, and will report findings in 2019.[39] A 2015 evaluation of members' experiences using the MI Health Accounts found that "many interviewed beneficiaries agreed that payments were reasonable," but that some members encountered practical barriers to making payments, such as lacking a bank account or Internet access.[40] According to Healthy Michigan's second annual report, the MDHHS is exploring additional payment methods to address these barriers.[41]

Questions for Policymakers

The state experiments with incorporating HSA-like accounts into their Medicaid programs raise important questions for policymakers going forward:

- Given that the individual market accounted for only 10 percent of HSA-eligible HDHP enrollees in 2015, according to AHIP,[42] how robust is the evidence base for HSAs in the non-group market? What additional evidence is needed to inform federal and state policy on the use of HSAs in Medicaid, in light of the limited experience with HSAs in the individual market and among low-income populations?
- Would federal or state contributions to the HSA be robust enough to ensure that beneficiaries receive and pay for all needed care?
    - What are the potential medium- and long-term impacts on beneficiary health and costs if beneficiaries forego needed care?
- How could policymakers ensure that HSA contributions offset the negative effects of deductibles on the poor and chronically ill?
- What tools and supports are needed to teach beneficiaries to make the most of their HSAs? Are prices transparent enough to facilitate educated choices?
- Should Medicaid programs that require monthly payments from beneficiaries include "carrot" and "stick" elements to incentivize healthy behaviors?
    - Would disenrollment be one of the sticks? If so, what is the impact on health and costs of disenrolling Medicaid beneficiaries?
    - How would policymakers select and monitor incentivized behaviors?
- What resources would states need to administer an account-based incentive system? Are there implementation lessons to be learned from the Medicaid Incentives for Prevention of Chronic Diseases or other demonstrations?[43]

Conclusion

The account-based plans used by Indiana and Michigan to encourage Medicaid beneficiaries to be engaged, cost-conscious consumers demonstrating "personal responsibility" may hold important lessons for policymakers, as a new administration considers changes to the health care payment and delivery systems.[44] More research on the impact of such plans on poor and vulnerable populations would be helpful to state policymakers considering the impact of such plans on state budgets, and on the health of their populations.

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Support for this work was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.