Key Takeaways for Medicaid Health Expense Accounts

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States reluctant to accept federal funds for the Affordable Care Act's adult Medicaid expansion have proposed health expense accounts as a mechanism to "brand" their expansion as different. The states claim that these accounts will promote awareness of health spending and prudence in accessing services while incentivizing healthy behaviors, but the structure of these Medicaid health expense account programs raises doubts about how effectively they will achieve these policy goals. These accounts add administrative complexity, cost, and likely impede beneficiaries' access to care. The Healthy Indiana Plan (HIP), implemented in 2008, was the first demonstration to deploy such a model. CMS recently approved a modified "HIP 2.0" as part of Indiana's adult Medicaid expansion. CMS has also approved different health expense accounts in Michigan and Arkansas. All these models, approved using the demonstration authority in § 1115 of the Social Security Act, include premiums and, in some cases, higher cost sharing on beneficiaries. This fact sheet provides a brief overview and highlights some of the key ramifications of this approach. For a fuller discussion of health expense accounts, see NHeLP's Q & A on Health Expense Accounts in Medicaid.

Medicaid health expense accounts are not Health Savings Accounts (HSAs)

Though Medicaid health expense accounts are often compared to HSAs, the similarities are superficial. HSAs couple a tax-free (or at least tax-reduced) account for medical expenses with a high deductible health plan. The health plan provides a catastrophic care backstop, while the savings account encourages consumers to save money for future health expenses with contributions that roll over year to year.

Employer-sponsored HSAs have produced negligible long-term change in overall health spending or cost-efficiency. Spending on healthcare is not like spending in a grocery store. Comparison shopping is virtually impossible due to a lack of price transparency. Treatment decisions are highly influenced by provider recommendations, and often must be made in urgent circumstances resulting in little actual control over health spending. Enrollees in these plans tend to reduce both essential and discretionary care in roughly equal proportions the first year, but increase spending to prior levels in subsequent years resulting in slight or no long-term savings.[1] Moreover, the complex plan designs, with some services exempt from the deductible and others not, are widely misunderstood.[2]

Even if HSAs did work, Medicaid health expense accounts are structured differently. None of the approved Medicaid health expense accounts provide tax benefits to incentivize individual contributions, and only Indiana's provides a limited rollover. Rather, these Medicaid models attempt to achieve "savings" by shifting more costs to

beneficiaries or by creating consequences for individuals who fail to pay a premium. Unfortunately, evidence shows that program participants remain largely unaware of the incentives that purportedly encourage healthy behaviors or preventive screenings.

Key Policy Ramifications for Medicaid Health Expense Accounts

Instead of creating a streamlined, straightforward Medicaid program that expands access to care, Medicaid health expense accounts complicate health care delivery. They introduce premiums to a population that Congress determined should be exempt from premiums.[3] Prior experience documents that Medicaid premiums depress enrollment, and thus lead to more low-income individuals without coverage and, consequently, more uncompensated care.[4] Further, health expense accounts:

- **Increase administrative complexity without increasing efficiency of service utilization.** Indiana's new HIP model includes five possible benefit and cost sharing structures based on an individual's eligibility and payment history. Arkansas' new model will charge copays to beneficiaries who fall behind on their $5/month premiums, but nothing for those current on payments. This approach requires accurate and timely notification to providers regarding who pays copays and who does not. The administrative complexity to implement these accounts with thousands of tiny monthly transactions will likely cost far more than the programs take in, lead to incorrectly charged copays, and greatly decrease the chance that individuals understand the program's details.

- **Often include complicated incentives structures that are poorly communicated to enrollees and remain largely misunderstood.** Evaluations of Indiana's HIP program show that six years after implementation, only one in five enrollees know that they can access many preventive services free of charge. And only one in five enrollees understands she must complete certain preventive services to qualify for a full rollover. These facts indicate that overly complex incentives do not effectively encourage healthy behaviors.

- **Create new penalties for not paying premiums for individuals below the federal poverty line.** To date, CMS has refused to approve required premiums for individuals below the federal poverty line, prohibiting states from disenrolling someone for failure to pay. However, health expense accounts create new consequences for non-payment of premiums – such as fewer benefits or higher cost-sharing – that blur the boundary of what constitutes a "required" premium.

While health savings accounts in Medicaid are new, many of their features have been previously tested and found ineffective to reduce healthcare costs or incentivize healthy behavior. Monitoring and strong evaluation of these demonstrations will be critical to determine whether this model should continue past an initial demonstration stage. For more detailed analysis of the structure policy impact of these programs, especially Indiana's HIP program, see NHeLP's Q&A on Medicaid Health Expense Accounts.

Endnotes

[1] M. Kate Bundorf, Robert Wood Johnson Found., *Consumer-Directed Health Plans: Do They Deliver?* (2012), http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405; Judith H. Hibbard et al., *Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?*, 65 MED. CARE RES. REV. 437 (2008); Paul Fronstin & M. Christopher Roebuck, Employee Benefit Res. Inst., *Health Care Spending after Adopting a Full-Replacement, High-Deductible Health Plan With a Health Savings Account: A Five-Year Study* (2013), http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-13.No388.HSAs.pdf.

[2] Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCHIVE OF INT. MED. 1918 (2010); Mary E. Reed et al., *In Consumer-Directed Health Plans, A Majority of Patients Were Unaware of Free or Low-Cost Preventive Care*, 31 HEALTH AFF. 2641 (2012); Mary E. Reed et al., *High-Deductible Health Insurance Plans: Efforts To Sharpen A Blunt Instrument*, 28 HEALTH AFF. 1145 (2009).

[3] 42 U.S.C. 1396o-1.

[4] Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999); Samantha Artiga & Molly O'Malley, KFF, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf; Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106 (2005).