Q & A: Health Expense Accounts in Medicaid

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Introduction

In considering whether to accept federal funds for the Affordable Care Act's (ACA) adult Medicaid expansion, several states are exploring approaches that establish individual accounts for beneficiaries to manage their Medicaid expenses. The Healthy Indiana Plan (HIP), implemented in 2008 and renewed in 2015, was the first demonstration to deploy such a model. Designed very loosely after Health Savings Accounts (HSA), HIP remains the only Medicaid program that couples a health expenses account with a high deductible insurance plan.[1] In late 2013, CMS approved a substantially different health expense account in Michigan's Medicaid expansion. A year later, Arkansas received CMS approval to implement yet another variation of health expense accounts in its Medicaid expansion premium assistance demonstration. All these models are closely tied to the imposition of premiums and, in some cases, higher cost sharing on beneficiaries. Under the Medicaid statute, however, individuals eligible through the adult expansion group should be exempt from premiums.[2] This Q & A reviews the differences between these models, explores the legal requirements that apply to health expense accounts in Medicaid and explains some of the policy ramifications of this approach to Medicaid expansion.

Q1: What types of health expenses accounts exist?

A: The three most common health expense accounts in today's market are HSAs, Health Reimbursement Accounts (HRAs) and Flexible Spending Accounts (FSAs). Each type, regulated through the U.S. tax code, allows individuals to use pre-tax income to pay for qualified medical expenses.[3] But they also differ in important ways.

Health FSAs are employer-sponsored benefits that allow employees to set aside pre-tax income to pay for qualified medical expenses.[4] In 2015, the maximum allowable set

[1] In 2008, South Carolina implemented a "Health Opportunities Account" (HOA) demonstration under 42 U.S.C. § 1396u-8, but this voluntary HSA-like program only enrolled 5 beneficiaries. Congress closed the door on new HOA demonstrations in 2009. *See* U.S. Gov't Accountability Off., *Medicaid: Health Opportunity Accounts Demonstration Program*, 2 (Dec. 11, 2011), http://www.gao.gov/products/GAO-12-221R.
[2] 42 U.S.C. § 1396o-1(b).
[3] 26 U.S.C. § 223.
[4] For a list of qualified medical expenses, *see* Internal Revenue Service ("IRS"), *Publication 502* (2013), http://www.irs.gov/pub/irs-pdf/p502.pdf.

aside was $2,550, although employers could set lower limits.[5] Employers may also contribute to FSA accounts. One of the key features of the Health FSA that distinguishes it from other health expenses accounts is that unused funds do **not** roll over to the following year, although the Internal Revenue Code permits a limited grace period. Also, FSA funds may not be used to pay insurance premiums.[6]

HRAs are employer-sponsored health benefit plans that allow employees to be reimbursed tax-free for their qualified medical expenses. These reimbursements are tax-deductible for the employer. Generally, HRAs must be integrated with a group health plan to satisfy ACA market reforms that bar annual limits on coverage.[7] They also differ from Health FSAs in that employees do not directly contribute to the account through salary deductions. Rather, employers provide all the contributions to and set the parameters for HRA accounts, such as the reimbursement cap and the scope of qualified expenses.[8] Unused HRA funds may roll over to the next year, but they stay with the employer if the employee changes jobs.

HSAs must be coupled with a high-deductible health insurance plan (HDHP).[9] Most HSAs are associated with employer-sponsored plans, but unlike other health expense accounts, HSA-eligible HDHPs are also available in the individual market. Employers and other individuals can contribute to an individual's HSA account, but the individual owns all the funds in her HSA. Like the other expense accounts, HSA contributions have tax advantages, either through deductions from pre-tax income like a health FSA, or through post-tax deductions from gross income. With an HSA, the individual pays out-of-pocket until she meets the HDHP's deductible, which must be at least $1,300 individual/$2,600 family in 2015.[10] She may use funds from the HSA for all qualified health expenses. Even after meeting the deductible, the individual may have to pay copays or coinsurance which she can also withdraw from her account. Leftover funds roll over into the following year and stay with the individual even if she changes to a different employer or type of health plan. Annual contributions to the HSA are capped like Health FSAs, but the cap is slightly higher ($3,350 for individuals/$6,650 for families in 2015).[11] HSA-linked HDHPs must cap enrollees' annual out-of-pocket expenses at no more than $6,450 individual/$12,900 family (in 2015).[12]

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[5] IRS, *Revenue Proc. 2014-61*, 14 (Oct. 30, 2014), http://www.irs.gov/pub/irs-drop/rp-14-61.pdf.
[6] IRS, *Publication 969: Health Savings Accounts & Other Tax-Favored Health Plans*, 16 (2013), http://www.irs.gov/pub/irs-pdf/p969.pdf.
[7] IRS, *Notice 2013-54: Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements*, http://www.irs.gov/pub/irs-drop/n-13-54.pdf. IRS has stated that standalone *retiree only* HRAs are not subject to ACA market reforms provisions that bar annual coverage limits. *Id.* at 12.
[8] IRS, *supra* note 6, at 17.
[9] HSAs were established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. 26 U.S.C. § 223(c)(1).
[10] IRS, *Revenue Proc. 2014-30*, 1 (May 12, 2014), http://www.irs.gov/pub/irs-drop/rp-14-30.pdf.
[11] *Id*.
[12] *Id*.

Q2: What are the similarities and differences between IRS-regulated health expense accounts and Medicaid health expense accounts?

The primary difference is the state – rather than the individual or employer – contributes the majority of funds. Also, of the three states with CMS-approved health expense accounts, only Indiana ties the account to an HDHP similar to an IRS HSA. Moreover, none of the Medicaid health expense accounts offer tax deductions or credits for contributions which the IRS-regulated health accounts do.

States reluctant to outright expand Medicaid have been actively exploring 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 the existing programs raises doubts about whether expense accounts can effectively achieve these policy goals. Moreover, the added administrative complexity, relative cost vis-à-vis traditional Medicaid, and impact on beneficiaries' access to care of these models have yet to be effectively evaluated.

Q3: What authority authorizes health expense accounts in Medicaid?

States wishing to establish Medicaid health expense account must obtain CMS approval for a demonstration project. To date, states have used § 1115 of the Social Security Act. Section 1115 authorizes the Secretary of HHS to waive limited provisions of the Medicaid Act as necessary to carry out "experimental, pilot, or demonstration projects…likely to assist in promoting the objectives of [the Medicaid Act]."[13] States using this authority must solicit and respond to public comment during project development, design an evaluation to test meaningful hypotheses the project will test, and show the project is budget neutral relative to the cost the Federal government would incur absent a demonstration.[14]

Q4: How does Indiana's HIP Medicaid demonstration work?

A: In early 2015 Indiana received CMS approval for "HIP 2.0," a § 1115 demonstration that extends the original HIP program for another five years. While the new version includes some significant changes, the basic structure remains the same – the state establishes a health expenses account, called a Personal Wellness and Responsibility (POWER) account for each enrollee that is used to pay for covered health expenses. Indiana state officials like to compare the POWER account to employer-sponsored HSAs, but the similarities are superficial. Like HSAs, HIP enrollees are enrolled in a high deductible health plan and enrollees pay for medical expenses out of their account until their expenses exceed the plan's deductible ($1,100 in 2014; $2,500 in 2015). After reaching the deductible, the contracted managed care organization (MCO) begins

[13] 42 U.S.C. § 1315(a).
[14] *See* 42 C.F.R. §§ 431.400-428. The budget neutrality requirement is not in statute or regulation, but is longstanding administrative policy. *See* 42 U.S.C. § 1315(e)(7).

paying for additional covered services. Employers, non-profit organizations and enrollees themselves can all contribute to the POWER account, similar to an HSA. However, this is where the similarities end.

HSAs offer the benefit of tax-free, or at least tax-deductible, individual contributions. This represents a sizeable incentive to contribute, especially for middle class individuals. HIP's POWER accounts offer no such tax advantages. Moreover, HIP restricts qualified expenses to Medicaid covered services, while an HSA includes an expansive list of qualified expenses, including over-the-counter medications (with a prescription) and acupuncture.[15] HSAs also permit an individual to withdraw her HSA funds for other purposes if she pays a tax penalty, which is not possible in HIP unless the enrollee leaves the program. Basically, the POWER account gives individuals little reason to contribute more than their required contribution.

Unlike a traditional HSA, the state funds the bulk of each enrollee's POWER account, ranging from $2,175 to $2,488 of the $2,500 deductible.[16] HIP enrollees are responsible for the remaining deductible through monthly "contributions" – effectively a premium amounting to 2% of household income. The state also ensures that the enrollee can meet the full deductible and access services even if she has an expensive healthcare need before she has paid her annual share.[17] Individuals who pay their contributions have no copays or per-service cost sharing apart from nonemergency use of the emergency department. Essentially, the HIP model differs little from a health plan that charges a premium with no cost sharing (apart from nonemergency ED use).[18]

HIP's rollover is designed to increase the use of preventive care. However, only 20% of HIP enrollees reported knowing the preventive care requirement. Overall, only one in ten actually benefitted from the rollover.

The only incentive HIP enrollees have to reduce (or ration) their service utilization is the chance to roll over leftover funds (including state and employer contributions) to reduce their monthly contribution the following year. But the HIP rollover differs from an HSA, where all unused contributions roll over automatically to the next plan year. Instead, HIP enrollees must complete certain preventive services to roll over any remaining state-funded contributions to their POWER account (See example).

[15] Ctr. for Medicare & Medicaid Servs. ("CMS"), *Healthy Indiana Plan (HIP) 2.0 Medicaid Section 1115 Demonstration Terms and Conditions*, 21 (Jan. 27, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

[16] In 2015, the individual contributions for HIP, set at 2% of household income, range from $12 to $325 per year.

[17] In cases where medical expenses exceed the state's contribution and the individual has not yet paid his full annual contribution, the MCO fronts the money to pay the provider and then collects as the individual pays through the rest of the year. CMS, *supra* note 15, at 18.

[18] If an enrollee leaves the program, she is entitled to a pro-rated share of her remaining personal contributions unless she is disenrolled for nonpayment of her premium, in which case the state retains 25% of her pro-rated share. *Id.*, at 21.

This complex "incentive" offers very delayed rewards that few understand and even fewer benefit from. Only 20% of current HIP members reported knowing of the rollover's preventive care requirement.[21] In 2013, just a third of members still eligible after 18 months had funds left to roll over, and only one in ten rolled over state funds.[22] Under HIP 2.0's higher deductible, more individuals should have leftover funds at year's end, but other problems with this complex incentive structure remain.[23] For example, even if the state successfully communicates the purpose of the deductible and rollover, deductibles reduce utilization indiscriminately and inefficiently. Enrollees with deductibles tend to cut out essential and nonessential care in roughly equal proportions.[24] Forgoing essential care may worsen health outcomes, and increase costs, down the road.

HIP Rollover Example

Sarah has an annual required HIP contribution of $250. Her annual individual contribution represents 10% of the $2500 HIP deductible. Sarah finishes the first year with $1000 left in her POWER account but does not complete preventive services. In this case, $100 (10% of her remaining funds) will roll over, reducing her required annual contribution to $150 the following year (assuming her income does not change). If Sarah had completed the preventive services requirement, the state would double her rollover to $200, meaning she would pay $50 the following year.[19] Note that while the rollover is triggered after 12 months, HIP waits until the **18th month** to calculate the rollover amount due to an administrative lag for MCOs to process outstanding claims. So Sarah would not receive any discount until halfway through the second plan year.[20]

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[19] CMS, *supra* note 15, at 22-23.

[20] Ind. Family & Soc. Servs. Admin. ("FSSA"), *Healthy Indiana Plan Demonstration Section 1115 2013 Annual Report & Interim Evaluation Report*, 29 (Oct. 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-pa.pdf.

[21] The 2012 HIP annual report claims that 26.3% of 12,875 respondents know of the preventive services/rollover connection. However, this excludes the 3,955 respondents who did not even know what a POWER account is. The correct denominator should be 16,830. FSSA, *Healthy Indiana Plan Demonstration Section 1115 Annual Report: Demonstration Year 5*, 59 (2013), http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf.

[22] FSSA, s*upra* note 20, at 31.

[23] Many HIP members do not stay enrolled for the 18 months required to receive a rollover. In 2012, 16.7% of HIP enrollees with required contributions were disenrolled within the first year or never fully enrolled due to nonpayment of their premiums. Thousands more lost coverage for failure to complete a renewal packet on time, because they obtained employer insurance or for other reasons. *Id.* at 29-30.

[24] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), http://www.rand.org/pubs/reprints/RP1114.html. For a broader discussion of the relationship between health care utilization and deductibles, *see* Katherine Swartz, Robert W. Johnson Found., *Cost-Sharing: Effects on Spending and Outcomes*, 4 (2010), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

Q5: How does HIP cost sharing differ from traditional Medicaid cost sharing?

A: Traditional Medicaid cost sharing centers on the use and cost of individual services. Enrollees who do not use any services pay no cost sharing. States may attach copays for particular services, and these copays can vary based on the enrollee's income. For all but a few services, copays for individuals below 100% FPL cannot exceed $4.00, while copays for individuals 100-150% FPL cannot exceed 10% of the agency's cost.[25] Total aggregate Medicaid cost sharing (including any premiums) may not exceed 5% of household income (calculated quarterly or monthly, at state discretion).[26]

The HIP approach levies "cost-sharing" charges through monthly contributions based on annual household income. Rather than paying copays for particular services, enrollees use their POWER account to pay the full cost of any service (based on Medicaid state plan rates) until they meet the deductible. The fact that the full cost of a service comes out of the POWER account (prior to reaching the deductible) is inconsistent with traditional Medicaid cost sharing regulations that limit enrollees' copayments for services used. For example, an individual making $1,000 per month (102% FPL in 2015) would be responsible for $240 of his annual HIP deductible (2% of annual income). Imagine his total annual health expenses cost exactly $1,000. Under the Medicaid statute, a state may not charge more than 10% of total service cost for individuals with incomes between 100%-150% FPL, or $100.[27] But in this case, HIP effectively charges the individual over twice the allowable limit for the services he actually used. In its approvals of HIP, CMS considers the monthly contribution a premium, not cost sharing, which circumvents this issue with per service cost sharing maximums.[28]

Under HIP 2.0, the state imposes per service copayments for individuals below 100% FPL who do not pay premiums. This also requires a waiver, because traditional Medicaid does not allow states to target cost sharing to specific individuals with incomes below 100% FPL.[29]

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[25] For more information on Medicaid cost sharing, *see* David Machledt & Jane Perkins, Nat'l Health Law Program, *Medicaid Premiums and Cost Sharing* (Mar. 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.VDqxjRZzA1I.

[26] 42 U.S.C. § 1396o-1(b)(1),(2); 42 C.F.R. § 447.56(f).

[27] The 10% maximum coinsurance can apply to nearly all non-exempt Medicaid services. The Act limits charges for prescription drugs and nonemergency ED use to fixed copays. However, such copays are likely less than 10% of total service cost. So 10% coinsurance overestimates the maximum allowable out-of-pocket for this individual.

[28] CMS, *supra* note 15, at 1 of waiver list.

[29] 42 U.S.C. § 1396o-1(a).

Q6: How does Michigan's health expense account work?

A: Currently Michigan is the only Medicaid program besides Indiana that has implemented a health expense account. (Arkansas' model has yet to be launched.) Apart from maintaining the basic concept of collecting monthly payments from enrollees, the state's § 1115 Medicaid expansion demonstration, known as the Healthy Michigan Plan, differs substantially from HIP. The "MI Health Account" program has no deductible and includes a more traditional per-service Medicaid cost sharing structure.

Michigan's Medicaid agency contracts with a third party to set up a health account for each enrollee. The enrollee then pays cost sharing (using a debit-type card).[30] The account tracks enrollees' total cost sharing. No copays exceed Medicaid's nominal maximum limits. Three months after enrollment (and every 3 months thereafter), the agency calculates each enrollee's average monthly cost sharing and then begins to charge monthly fees based on that average.[33] In effect, the state uses the health account to recoup copayments the individual accrued during the prior 3 months.

An individual earning over 100% FPL must also pay a monthly premium equivalent to roughly 2% of household income, which can be halved if she completes an annual health risk assessment.[34]

Example: MI Health Account[31]

John earns $729/month (75% FPL) and enrolled in Michigan's Medicaid expansion in April 2014. His monthly prescription for a generic antihypertensive has a $1 copay. In May, he visits the doctor for a fever ($2) and gets prescribed an antibiotic ($1). In June he visits the dentist for a cleaning ($3). Three months post enrollment, his total cost sharing comes to ([3x$1] +$2 + $1 + $3 = $9), which averages out to $3/month. Starting July 1, he is responsible for contributing $3/month to his MI Health account.[32]

Q7: How will Arkansas' health expense account work?

A: In December 2014, Arkansas received CMS approval for an 1115 demonstration variant on Michigan's model of health expense accounts.[35] Arkansas' approach sets up "Independence accounts" that require $5 monthly contributions (i.e. premiums) from individuals from 50-100% FPL in exchange for relief from standard per service copayments.[36] The state or a third party

[30] The state covers service and copay costs if the account has insufficient funds. (See box.)
[31] For more information on Michigan's "MI health account," *see* MI Health Account, http://www.michigan.gov/healthymiplan/0,5668,7-326-67957_69564-336716--,00.html (last visited Mar. 3, 2015).
[32] Healthy Michigan Plan Copays, http://www.michigan.gov/healthymiplan/0,5668,7-326-67957---,00.html (last visited Mar. 3, 2015).
[33] MI Health Account, *supra* note 31.
[34] *Id.*
[35] *CMS, Arkansas Health Care Independence Program § 1115 Demonstration Approval, (Dec. 31, 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf*.
[36] *Id.*, at 2.

administrator pays all copayments as long as the beneficiary remains current with his contributions, but stops paying if the individual falls behind. Beneficiaries above 100% FPL will pay $10-$25 per month based on their income, and those who fall behind on their contributions are penalized with higher per-service copayments and may be denied services if they cannot pay up front.[37] Beneficiaries who fail to pay their contributions will not be disenrolled. To be successful, Arkansas' system will have to track in real time whether beneficiaries are up-to-date on their payments, transmit that information reliably to both beneficiaries and their providers, and update immediately after a payment is made. It will require significant administrative expense and will likely lead to incorrectly charged copays if providers and beneficiaries are not adequately notified.

Q8: Does Medicaid allow monthly premiums as part of a health expense account model for the adult Medicaid expansion?

A: Premiums are a feature of every Medicaid health expense account proposal to date. However, the Medicaid Act forbids "premiums, enrollment fees or similar charges" for Medicaid enrollees below 150% FPL apart from a few specific exceptions.[38] In the three states with approved expense accounts, CMS has waived this "no premium" requirement using § 1115 of the Social Security Act as its authority. All such approvals stand on questionable legal ground. Among other issues, § 1115 is intended for novel innovations likely to promote the objectives of the Medicaid program. Previous demonstrations have already tested the effect of premiums on Medicaid populations, so the experimental value is highly questionable. Notably, the results of those experiments were consistent, and overwhelmingly negative – resulting in dramatically depressed enrollment.[39] By one model, premiums set at 1% of household income reduce participation by 17%, while premiums of 3% of household income reduce enrollment by nearly 50%.[40]

CMS has not approved a Medicaid expansion demonstration that imposes mandatory premiums for enrollees with income under 100% FPL. And CMS has said it will not approve such premiums. However, CMS has allowed both Indiana and Arkansas to use their health expense account models to force individuals below 100% FPL to either pay a monthly premium (with no copayments at the point of service) or make mandatory copayments for each service they use. CMS's approval certainly blurs the bright line policy of ensuring that very low income people's access to health is not conditioned on the up-front payment of a premium.

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[37] *Id.*

[38] 42 U.S.C. § 1396o(a)(1), 42 U.S.C. §§ 1396o-1(b)(1)(A). Exceptions include certain people with disabilities and individuals who qualify as medically needy through a spend down. 42 U.S.C. §§ 1396o(g), (i).

[39] 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).

[40] Leighton Ku & Teresa A. Coughlin, *supra* note 39.

Q9: What are the consequences for not paying the monthly premium?

A: Medicaid regulations clearly prohibit any consequences for nonpayment beyond disenrollment.[41] However, HIP 2.0 allows Indiana to disenroll *and lock out for 6 months* any enrollee with income over 100% FPL if he falls more than 60 days behind on his premium payments. For individuals below 100% FPL, the state may not disenroll beneficiaries for nonpayment, but it may switch them to a different plan with fewer benefits (no vision or dental) and charge copayments for most services. Arkansas also charges per service copayments. These waivers mark the first time CMS has allowed consequences for nonpayment beyond disenrollment in an adult Medicaid expansion with enhanced federal matching funds. Note that the consequences have nothing to do with encouraging more prudent use of services. They only encourage prompt premium payment and discourage Medicaid participation.

Health expense accounts in Michigan and Arkansas institute another potentially significant nonpayment consequence by shifting an enrollee's liability for copayments and premiums from Medicaid providers to the state.[42] Moreover, Michigan state legislation authorizing Medicaid expansion expressly permits the state to seek repayment through garnishing tax refunds or lottery winnings.[43] Traditionally, cost sharing debts accrue to individual providers, who have discretion to waive the copays on a case-by-case basis. These accounts do not apparently allow for such exceptions and instead create additional liabilities in the form of premiums paid to the state. The potential impact of these demonstrations on low-income beneficiaries' financial well-being is undetermined, but they certainly encourage the state to institutionalize debt collection and put low-income beneficiaries already in precarious financial situations at more risk. In Indiana's HIP 2.0, beneficiary liability accrues to the MCO, but the approval strictly limits activities an MCO can undertake to collect on beneficiary debts, such as prohibiting reporting the debt to a credit agency.[44]

Q10: Does the household 5% aggregate cap on Medicaid premiums and cost-sharing apply to health expense accounts?

A: Yes. The Medicaid statute requires the cap to be calculated on a monthly or quarterly basis.[45] While several states sought to apply it annually, CMS has not approved those

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[41] 42 C.F.R. §447.55(b)(5).
[42] CMS, *supra* note 35, at 12. Pennsylvania's Medicaid expansion demonstration includes a similar approval. CMS, *Healthy Pennsylvania Section 1115 Demonstration Approval*, 22 (Aug. 28, 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf.
[43] 2013 Mich. Pub. Acts, Act No. 107, § 105(d)(28),(29). It is unclear at this time how aggressively the state will act to recoup such debts.
[44] CMS, *supra* note 15, at 21.
[45] 42 U.S.C. §§ 1396o-1(b)(1)(B)(ii), (b)(2)(A). See also 42 C.F.R. § 447.56(f)(1).

requests. Applying the cap annually would expose beneficiaries to greater financial risk in the event of an acute medical event requiring significant one-time cost-sharing. One study of families on public insurance showed that 43% of annual medical expenses clustered into a single month, and over 57% fell within a single quarter.[46]

To date, CMS has not approved any annual caps, but it did waive the aggregate cap to allow Indiana to charge $1/monthly premiums even to individuals with income below $20/month. Medicaid regulations also require states to develop a methodology that "does not rely on beneficiary documentation" and includes any Medicaid cost sharing paid by other household members in the aggregate cap.[47] It remains unclear in some health expense account models how the state will track cost sharing for carved out services or for Medicaid-enrolled household members, especially those enrolled in traditional Medicaid, such as via a disability.

Q11: Does the health expense account model create incentives for shaping better health care seeking behaviors?

A: It is unclear. In Michigan and in Arkansas, the health expense account itself does little to incentivize cost-effective use of care. Michigan includes a provision to reduce monthly premiums for individuals who complete an annual health risk assessment, but this incentive is not directly dependent on a health expenses account.
HIP 1.0 covered the first $500 of preventive services at no charge. However, a survey in HIP's 2012 annual report casts doubt on this incentive's effectiveness. Only 76.5% of participants reported even knowing what a POWER account was.[48] Of those, roughly 70% believed, incorrectly, that excluded preventive services like annual check-ups *would* be deducted from their POWER account. In other words, fully five years after implementation 78% of HIP members either wholly misunderstood or were unaware that preventive services could be accessed free of charge.[49] Moreover, because the ACA's adult Medicaid expansion already prohibits cost sharing on many preventive services, HIP's "incentive" was no better than a standard Medicaid expansion.[50]

In Indiana's HIP, 78% of current members either wholly misunderstood or were unaware that preventive services would not be charged to their deductible.[48]

HIP 2.0 also promises, but likely will not deliver, more efficient spending. Enrollees who do not reach their $2,500 deductible may get a premium discount after 18 months. In

[46] Thomas M. Selden et al., *Cost Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?*, 28 HEALTH AFF. w607, w614 (2009).
[47] 42 C.F.R. § 447.56(f)(2).
[48] FSSA, *supra* note 21, at 55.
[49] 3,955 of 16,830 current members in a survey reported no knowledge of the POWER account. 9180 respondents who knew about POWER accounts expected annual exams to be deducted from their accounts. This totals 78% of all respondents. *Id.*, at 55, 58.
[50] HIP 2.0 covers recommended preventive services at no charge, and includes a $500 cap for additional preventive services. Without better enrollee outreach and education, however, this incentive will likely not work. CMS, *supra* note 15.

theory, this might incentivize cutting back generally on services, but **an incentive can only be effective if participants first know and understand how it works**. If one in four enrollees does not even know what a POWER account is, how many more do not know of the rollover? The state does not report that figure, but the preventive services incentive, which doubles the rollover, remains largely unknown years after HIP implementation. In 2012, *only 20%* of current members reported knowing the rollover's preventive services requirement.[51] Moreover, awareness appears to have worsened over time. The proportion of those with remaining funds who completed the preventive services requirements *decreased* from 55% in 2009 to just 30% in 2013.[52] Meanwhile, those who pay premiums in HIP have *no short-term incentive* to curb utilization. Remember, they pay the same monthly premium regardless of how many or what type of services they use (aside from nonemergency use of the ED).

*The proportion of HIP enrollees with remaining POWER account funds who completed the preventive services required for a full rollover **has decreased every year** – from 55% in 2009 to just 30% in 2013.*

Apart from the preventive services component, the rollover is not structured to incent highly cost-efficient services over "less necessary" services. When faced with deductibles like HIP, individuals tend to reduce as much on essential as less necessary care.[53] People forgo or skip doses of needed medications, avoid the dentist or delay preventive screening. This may later result in more expensive healthcare episodes. Imagine someone who puts off refilling an asthma inhaler prescription for a few weeks due to the copay, but then suffers an attack and ends up hospitalized. Health expenses accounts with rollover incentives might increase the odds of such occurrences.

Q12: Is the health expense account model good health policy?

A: To the extent that it increases the cost sharing burden on low-income beneficiaries or imposes a monthly premium, no. The principal effect of premiums is reduced enrollment.[54] Many low-income individuals will simply not sign up and remain uninsured. The impact of decreased enrollment may not show up on demonstration evaluations because individuals who do not enroll, or who are disenrolled for nonpayment, by default are not part of satisfaction surveys. But reduced enrollment will likely lead to worse health outcomes for some low-income residents. Notably, reducing participation through imposed premiums shifts costs from Medicaid to the hospitals that provide uncompensated care for the remaining uninsured. Ultimately, everyone pays slightly higher premiums to cover this uncompensated care.

Health expense accounts that only track enrollees' cost sharing also have questionable value. Arkansas' demonstration amendment to establish a health expense account suggests the accounts will "promote accountability, personal responsibility…and

[51] FSSA, *supra* note 21, at 59.
[52] FSSA, *supra* note 20, at 31.
[53] Emmett B. Keeler, *supra* note 24.
[54] *Supra* note 39.

encourage and reward responsible choices."[55] The state offers little evidence supporting the model's educational potential, let alone how it might justify the added administrative burden of implementing and properly maintaining the accounts, collecting the premiums, and tracking (and providing notice) in real time who should and should not be charged copays. Moreover, the notion of an enrollee as a "cost-conscious consumer" in a free market health care system is flawed. The health care market is not a grocery store where everyone freely chooses what and how much to buy. The persistent lack of price transparency in health care makes it nearly impossible for a "health care consumer" to "shop" effectively. Moreover, an enrollee may well put off going to the doctor due to a higher copay or a chance to "save" money in his account, but someone who is really sick will end up either at the doctor now or the (more expensive) hospital later. In these cases providers, not patients, drive most decisions about how many services and when they are needed.[56]

Conclusion

Health expenses accounts in Medicaid exemplify politics over policy. They differ markedly from private-market HSAs, HRAs and FSAs. Evaluations of Indiana's HIP demonstrate that its financial incentives are overly complicated, poorly communicated, and unlikely to bolster health outcomes or the cost-efficiency of health care. The stated goal to increase enrollee "accountability" and health care literacy is not supported by enrollee surveys revealing widespread misunderstanding of the incentive structure.

However, currently implemented Medicaid health expenditure accounts do have real policy effects, including:

- implementing premiums that likely suppress enrollment;
- increasing administrative complexity and expense; and
- shifting beneficiaries' cost sharing liability to the state, potentially exposing them to state recoupment.

Despite their questionable policy value, Medicaid health expense accounts are likely to spread. New variations that use per-service copays as a penalty for failure to pay premiums will likely present new access barriers, add administrative costs and complexity, and increase confusion among enrollees and providers about when to apply copays. This represents a new and concerning direction for Medicaid health expense accounts.

[55] CMS, *supra* note 35, at 3.
[56] Katherine Swartz, *supra* note 24, at 10.