UTAH HEALTH POLICY PROJECT
455 East 400 South, Suite 312; Salt Lake City, Utah 84111 www.healthpolicyproject.org

Health Savings Accounts
Poor Choice for Medicaid & the Low-Income Uninsured

Background

Health Savings Accounts (HSAs) were originally intended for employers and individuals in the private insurance market who wanted more affordable coverage options. Beginning in 2005, the Federal government has allowed states to explore the use of HSA look-a-likes to provide coverage to their low-income populations.

States that have employed these types of programs are finding that while these "HSA" Medicaid plans may provide short-term savings to state budgets, these savings are offset by higher costs and cost shifting to their overall health care system. As Utah explores broad health system reforms and strategies to contain costs, it will be prudent for Utah to learn from other states' experience with the use of HSAs in Medicaid.

What are HSAs and HOAs and how are states using them in Medicaid

Health Savings Accounts (HSAs)

Established in 2003 under the Medicare Modernization and Improvement Act, HSAs offer a tax shelter for people who purchase health insurance policies with high deductibles. HSAs are touted as a way to bring down spiraling health care costs. With "skin in the game," proponents argue, consumers will shop around for cheaper health care and make more prudent use of their benefits.

Medicaid HSAs differ from private market HSAs in several ways. Medicaid HSAs are generally funded by state contributions, rather than by individuals. Beneficiaries then use the state funds to enroll in health plans or to pay for medical services. States have the option of either rolling over unspent funds into the beneficiary's account for the following year or allowing the beneficiary to withdraw unspent funds as cash or in the form of a voucher. Unlike traditional HSA plans, individuals do not get a tax break. Because the Medicaid HSA gives ownership of the saving account to the beneficiary, state financed HSAs share a similar philosophy with private market HSAs: People take greater responsibility in what they purchase when using their own money—or that's the hope. The analogy may work in principle for the Medicaid population, but probably not in practice.

Beginning this year, Indiana began using HSAs to expand coverage to many of their uninsured. Using flexibility provided by the "Affordable Choices Initiative" to spend existing federal funds to cover the uninsured, the State of Indiana created an HSA look-a-like to expand coverage to adults with income between 22% and 200% of the poverty level. Indiana did not, however, use HSAs to replace regular Medicaid coverage for current enrollees.

Health Opportunity Accounts (HOAs)

Introduced with The Deficit Reduction Act of 2005 (DRA), HOAs are accounts into which a state may deposit up to $2,500 per adult and $1,000 per child. The account holders must meet deductible responsibilities before they can access Medicaid services. States can choose how much the deductible will be, but are limited to no more than the amount the state contributes to the account plus an additional 10 percent. The money in the account must be used to purchase health care services. Once individuals meet their deductible, "regular" Medicaid benefits kick in.

For example, in a state that uses the maximum deductible allowed, adults with HOAs would have to pay a deductible of $2750. The state would deposit $2,500 into the account, and the enrollee would be responsible for the remaining $250. If an enrollee's health care costs exceed their deductible of $2,750 ($2,500 + $250) then regular Medicaid benefits will kick in. However, these individuals are at risk of facing a serious shortfall in their coverage. The $250 out of pocket required will in most cases be too expensive for this population, and therefore many will be unable to access their full benefits and go without care.

The DRA allows for 10 states to develop HOA demonstration programs. Currently, South Carolina is the only state approved to offer HOAs within their Medicaid program.

HSAs & HOAs are risky for Utah's lowest income populations

The risks of HSAs and HOAs are significant and potentially incompatible with the broader goals of health system reform. Over the last year Utah has begun the process of developing strategies to reign in health care costs, improve quality, and cover the uninsured. There is widespread recognition that, to control costs, we must improve quality and create incentives for people to use preventive and wellness care. HSAs and HOAs, however, are options that can conflict with these goals.

There a several questions Utah should ask when deciding if any populations could benefit from HSAs:

1. Are HSAs cost effective?

Indiana's plan is more expensive overall than regular Medicaid and provides fewer services.[1] In the Healthy Indiana Plan, the state pays providers at the Medicare rate, which is higher than the regular Medicaid reimbursement rate. Further, enrollees' out-of-pocket costs are higher. For all this additional money, enrollees receive less comprehensive coverage than they would have under regular Medicaid.

2. Are HSAs compatible with other proven cost containment and quality improvement mechanisms like medical homes?

HSA's appear to be incompatible with the medical home care delivery model, a system of coordinated care that has been shown time after time to improve health outcomes and control costs. South Carolina has recognized this problem. Because the medical home model shows so much promise in terms of controlling costs, South Carolina has given their Medicaid enrollees a choice between setting up an HSA and enrolling in a medical home. *If* HSAs are considered as an expansion option for low-income uninsured Utahns or as a replacement for the PCN (Primary Care Network, which provides coverage for primary and preventive care only), the same choice should be made available.

3. Is the plan affordable to eligible individuals?

In Indiana, the answer appears to be ***no***. Indiana requires individuals to make monthly payments of up to 5% of their income into their HSA. However, research shows that the low-income population is very sensitive to even relatively modest out-of-pocket costs.[2] Further, low-income individuals often have fluctuating incomes and limited ability to cover unexpected costs, which may make it difficult to consistently make the payments over time. As a result, Indiana's required payment may serve as a barrier to enrollment for many eligible individuals.

4. Does the coverage meet people's health care needs?

The benefits covered under an HSA plan are more limited than regular Medicaid and subject to lifetime caps (Indiana has a $1,000,000 lifetime cap). This puts individuals with chronic or other expensive health conditions at great risk of exhausting their benefits and going without otherwise cost-effective preventive and wellness care.

5. Will the plan effectively encourage personal responsibility, transparency, and preventive care?

A primary goal of HSAs is to influence health care choices by encouraging consumers to become more aware of health care costs. However, because health cost information is often difficult for consumers to access, particularly for low income populations that may have limited access to technology and education, this goal will go largely unrealized. Designing a system that will allow beneficiaries to easily monitor the cost of health care services and shop for providers presents enormous and perhaps insurmountable challenges. Further, in order for the accounts to encourage utilization of preventive care, beneficiaries need to be clearly educated about how preventive and wellness care will ultimately improve their health and save money.

---

[1] Judith Solomon, "Paying More for Less: Healthy Indiana Plan Would Cost More than Medicaid While Providing Inferior Coverage," Center on Budget and Policy Priorities, January 24, 2008.

[2] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.