



## Educating Beneficiaries About the Cost of Care: Health Accounts in Arkansas, Indiana, and Michigan

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### Executive summary

As part of section 1115 Medicaid expansion demonstrations, Arkansas, Indiana, and Michigan introduced individual health accounts designed to engage beneficiaries in their care and make them more cost-conscious consumers. Health accounts can promote several broad goals: (1) educating beneficiaries about the costs of health care; (2) facilitating incentives for certain healthy behaviors (such as the receipt of preventive care); and (3) demonstrating the benefit of making regular, predictable payments (also called contributions) instead of facing unpredictable costs when seeking care. Health accounts also share some features with Health Savings Accounts (HSAs), which offer tax-deferred treatment of savings for medical expenses to people enrolled in high-deductible commercial health plans (U.S. Department of the Treasury 2015). The three demonstrations, despite sharing similar goals, vary substantially in the design and implementation of their beneficiary health accounts. In this brief, we highlight similarities and differences among the states in how the accounts function (including the roles of states, plans,<sup>1</sup> and providers) and in how beneficiaries experience their health accounts (including the information they receive through regular account statements). As part of ongoing implementation monitoring, our findings will inform future evaluation work on the effectiveness of these health accounts in achieving their stated goals.

Health accounts in Indiana and Michigan have a predetermined value and are funded in part by beneficiaries, who contribute according to their income, with the state or health plan making up the rest. Costs associated with health care received are then deducted from the accounts. Funds remaining at the end of the enrollment year can roll over to future enrollment years. The states provide opportunities to reduce account contributions by completing a healthy behavior such as receiving a preventive service. In contrast, Arkansas's accounts, which the state discontinued in June 2016, were funded solely by beneficiaries. Contributions were not used to pay health care costs, and there were no incentives for healthy behaviors. We include Arkansas in this brief because its account design and implementation provide a useful comparison to Indiana's and Michigan's accounts. In all three states, beneficiaries disenrolling from the program are allowed either to withdraw a portion of the funds remaining in their accounts or to use those funds to offset out-of-pocket costs associated with private insurance or Medicare.

In Indiana, health plans are primarily responsible for account administration, and plans vary in the amount and type of information they provide to beneficiaries regarding their accounts and incentives. In Arkansas and Michigan, account management is separated from health care management, with contracted third-party administrators managing the health

### THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some of these new approaches being tested under 1115 authority draw on established practices in commercial health insurance, such as cost-sharing at levels that exceed Medicaid limits and financial incentives for pursuing healthy behaviors. Other new approaches involve partnerships with private-sector entities, such as issuers that offer qualified health plans. However, Medicaid beneficiaries have lower incomes and poorer health status than most privately insured individuals and Medicaid expansion demonstrations have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

account programs. Providers have little responsibility for account administration, although they may enforce copayment requirements or help beneficiaries complete incentivized healthy behaviors.

The health account components of these three demonstrations are too recent for an assessment of their impacts on beneficiary behavior, service use, or costs of care;<sup>2</sup> however, we can begin to assess beneficiaries' understanding of their accounts and the role the accounts play in their states' demonstrations. Beneficiaries in Indiana appear to have good understanding of the consequences of nonpayment, and beneficiaries in Michigan report familiarity with the MI Health account statements (Dorr Goold et al. 2016b; Kieffer et al. 2015; Lewin Group 2016). In other respects, early evidence suggests that understanding of the requirements and function of beneficiary accounts is limited in both states. Contribution payment rates are much higher in Indiana than in Michigan, a disparity that is likely attributable in part to a large difference in the consequences for nonpayment.<sup>3</sup> Arkansas discontinued its accounts before conducting a formal assessment of beneficiary understanding of and engagement with the accounts.

Future evaluation work should take advantage of the similarities and differences among health account programs, as well as between states with such programs and other states that lack health accounts but share similar features. For example, although Montana's demonstration does not have a formal beneficiary health account program, it does communicate with beneficiaries about their health care costs through regular statements; therefore, it can serve as a point of comparison with states that issue statements tied to actual accounts. Similarly, Iowa has no accounting feature, but it does provide incentives for healthy behaviors. Comparing Iowa to Indiana and Michigan can shed light on whether beneficiary health accounts are more or less effective than approaches not involving accounts in nudging beneficiaries to complete healthy behaviors. In all cases, it will be crucial to assess beneficiary understanding of the requirements and incentives in their states' demonstrations. If evidence suggests that beneficiaries do not understand the account programs, it will be difficult to attribute any observed changes in beneficiary behavior to the account component of their states' demonstrations.

## Introduction

Many states have expanded their Medicaid programs to cover childless adults, bringing to the fore a focus on controlling rising health care costs while also providing quality coverage for low-income populations. Some states with Section 1115 demonstrations are basing their expanded Medicaid programs on commercial insurance principles, hoping to contain costs, promote personal responsibility and engagement, and prepare

beneficiaries to transition to employer-sponsored insurance or other private coverage without compromising access to care for vulnerable populations.

As part of their Section 1115 demonstrations, Arkansas, Indiana, and Michigan have introduced beneficiary health accounts.<sup>4</sup> Beneficiaries contribute funds according to their income, and the account balance can be drawn down to pay for certain medical expenses. The accounts are intended to educate beneficiaries about the cost of care and encourage cost-conscious behavior when seeking health care services. The states hope health accounts will illustrate to beneficiaries how the health care system functions and the true costs of care more clearly than traditional Medicaid coverage can. In addition, the accounts may help states defray rising costs of care by providing incentives for beneficiaries to obtain cost-effective care rather than make costly, unpredictable trips to the emergency department (ED).

The accounts in these three demonstrations are too recent for an assessment of their impacts on beneficiary behavior, service use, or costs of care to be possible. However, variation in account features and implementation across states will create opportunities to compare outcomes and identify which elements may have been most effective. This brief, part of an ongoing series to monitor demonstration implementation, addresses the following research questions, with the aim of informing future evaluation work:

- What is the states' main purpose or goal for the accounts?
- How do the accounts function? How similar are they to more traditional HSAs?
- What are the roles of states, plans, and providers in administering the accounts?
- What kind of information and statements do beneficiaries receive about their accounts?

We highlight similarities and differences in account design and implementation in the three states, focusing on how features of the accounts influence beneficiaries' experiences with their states' demonstrations. We also explore preliminary findings regarding beneficiary understanding of, and engagement with, the accounts to date. These findings will help inform future evaluations of the impact of health accounts and other beneficiary engagement strategies on broader access, quality, and cost outcomes.<sup>5</sup>

## Purpose of the health accounts

In all three states, individual health accounts are intended to inform beneficiaries about the cost of health care, but the states have other objectives as well. Indiana's Personal Wellness and Responsibility (POWER) account and Michigan's MI Health

account encourage the efficient use of health care and receipt of preventive care. Indiana's POWER account and Arkansas's Health Independence Account (HIA) demonstrate the benefits of paying regular, predictable contributions,<sup>6</sup> instead of unpredictable copayments or other health care costs at the point of service. Arkansas also anticipated that the HIAs would teach beneficiaries about commercial health insurance principles and smooth their transition to other coverage.

## Account design

As an incentive for engaging in cost-conscious behavior, beneficiaries in all three states contribute to their accounts by paying monthly contributions, and they can be rewarded when account funds remain at the end of the enrollment year and/or upon exiting the program. To help beneficiaries monitor the balance of funds and payment activity in the accounts, monthly or quarterly statements are sent to beneficiaries under all three demonstrations.

Health accounts in the three states share some features with HSAs. HSAs were created in 2003 and offer tax-preferred treatment of savings for medical expenses to people enrolled in high-deductible commercial health plans (U.S. Department of the Treasury 2015). Health accounts and HSAs have three primary characteristics in common: (1) beneficiary contributions help fund the account, (2) contributions fund medical expenses, and (3) unused funds may roll over from year to year.

Despite these common features, substantial variation exists in the accounts' design and function, reflecting the states' individual goals for, and uses of, their respective accounts. In the rest of this section, we explore the unique designs and features of the accounts, which are summarized in Table 1.

**Indiana's POWER account.** The POWER account functions as a \$2,500 annual deductible to which both the beneficiary and the state contribute. Healthy Indiana Plan (HIP) 2.0 beneficiaries must pay 2 percent of their annual income into the mandatory account as monthly contributions, and the state contributes the rest at the beginning of the enrollment period.<sup>7</sup> Claims for the first \$2,500 of covered services are paid out of the POWER account, except for the cost of preventive services, which have no beneficiary cost sharing. If a beneficiary spends his or her account down completely, the health plan then covers all costs, with no additional beneficiary cost sharing other than for non-emergency use of the ED. Beneficiaries use a POWER account debit card to simulate a direct debit from their account at the point of service, which also allows providers to generate a receipt showing the account balance before and after the service that the beneficiary can review upon swiping the card.

The POWER account provides an incentive for beneficiaries to use health care services judiciously by allowing a portion of the remaining account balance to roll over from one enrollment year to the next, potentially decreasing or eliminating beneficiaries' future contribution amounts. Indiana also uses the POWER account to provide an incentive to use preventive health care services. If a beneficiary obtains at least one recommended preventive service for his or her age and sex, the annual account rollover amount will be doubled.<sup>8</sup> The rollover benefit mimics a similar feature of HSAs, which typically allow an unlimited amount of unspent funds to be rolled over from one year to the next.

**Michigan's MI Health account.** Similar to the POWER account, the Healthy Michigan Plan's (HMP) MI Health account functions as a \$1,000 deductible for which the beneficiary and his or her health plan share responsibility. Beneficiaries with income above 100 percent of the federal poverty level (FPL) must pay monthly contributions equal to 2 percent of their income once they reach their seventh enrollment month. The monthly contributions accumulate in the accounts and can be disbursed to the health plan to cover the cost of health services received. The health plan pays their portion of the deductible first, and only when that is exhausted are beneficiary contributions to the MI Health account drawn down (Exhibit 1). If beneficiaries receive services in excess of \$1,000, their entire annual contribution amount is disbursed to their health plan to pay for services. Beneficiaries with incomes less than or equal to 100 percent of the FPL are not required to pay contributions, and the plans are responsible for paying 100 percent of the cost of all covered services.

As an incentive to engage with a primary care provider, beneficiaries who complete certain healthy behaviors (which amount to establishing a primary care relationship)<sup>9</sup> receive account credits that reduce their required contribution by 50 percent for the remainder of the enrollment year.<sup>10</sup> The health plan-funded portion of the \$1,000 deductible increases accordingly.

All HMP beneficiaries, regardless of income,<sup>11</sup> are also subject to copayments for all services except preventive care and management of chronic conditions, which have no beneficiary cost sharing. Copayments are paid into the MI Health accounts along with monthly contributions, but unlike the contributions, copayments do not accumulate in the accounts; they enter the accounts and are then distributed to providers as payment.

As with the POWER account, if any funds remain in the MI Health account at the end of the enrollment year, they roll over to the next year. Unlike the POWER account, however, the MI Health account rollover does not reduce future beneficiary monthly contributions. Instead, the health plan's contributions to

the account will decrease by the amount of the rollover, reducing the plan's share of the \$1,000 annual deductible. The MI Health account rollover feature therefore does not financially benefit beneficiaries in the short run. However, if beneficiaries accumulate significant self-contributed funds in their accounts, those funds can be returned when they exit the program to facilitate the purchase of private health insurance. The ability to accumulate savings is a feature the MI Health accounts share with HSAs; however, an important difference is that HSA funds cannot be used to pay insurance premiums. For this reason and others, the state avoids describing the accounts as HSAs.

**Arkansas's Health Independence Account.** Arkansas's now-closed HIAs were primarily repositories for Health Care Independence Program (HCIP) beneficiaries' voluntary monthly contributions. Beneficiaries were encouraged, but not required, to pay monthly contributions based on their income level. These contributions would exempt beneficiaries from point of service cost-sharing on a month-by-month basis. At the point of service, beneficiaries who were current on their contributions had no cost-sharing responsibility for services received. Beneficiaries who failed to pay their contribution in the previous month had to pay a copayment. Each beneficiary received a MyIndyCard debit card, which was activated upon enrollment and covered all cost sharing for two months. After the initial two-month period, continued activation required a monthly contribution. A beneficiary presented his or her MyIndyCard at the point of service, and the provider scanned the card to ascertain whether the beneficiary was responsible for a copayment. A beneficiary who did not present a MyIndyCard was liable for copayments regardless of whether he or she was current on contributions.

While funds in the POWER and MI Health accounts were used to pay health care costs, HIA funds were not drawn down to cover the cost of services received. Instead, the accounts functioned primarily as an inducement to contribute to a savings vehicle. Beneficiaries who paid six or more monthly contributions in a year were eligible to receive the balance of their account (up to \$200) when they left the program to buy employer-sponsored insurance or meet Medicare cost-sharing requirements. Thus, all three account programs featured a savings component intended to help beneficiaries save money to defray future health care costs.

On January 1, 2017, Arkansas ended the HCIP and replaced it with Arkansas Works, which does not have a beneficiary health account program. Instead, beneficiaries with incomes above the FPL are required to pay contributions equal to 2 percent of annual income as well as copayments for some services. The state reported that the HIAs were terminated due to high administrative costs. It expects the new contributions requirement will be less expensive to implement because beneficiaries can pay contributions directly to their Qualified Health Plan (QHP), eliminating the need for a third-party administrator to manage the accounts.

#### EXHIBIT 1. MI HEALTH ACCOUNT FUND DISBURSAL CALCULATIONS

Health plan-funded amount = \$1,000 deductible minus the beneficiary's annual contribution amount. For example:

- Beneficiary who pays \$20 monthly contributions:  
 $\$1,000 - (\$20 \times 12) = \$760$  health plan-funded amount
- Same beneficiary completes healthy behaviors:  
 $\$1,000 - (\$10 \times 12) = \$880$  health plan-funded amount
- Same beneficiary rolls over \$100 of their account balance to the next enrollment year:  
 $\$1,000 - (\$20 \times 12) - \$100 \text{ rollover} = \$660$  new health plan-funded amount

\*The beneficiary's contribution amount is reset to \$20 per month until he or she completes the healthy behaviors in the next enrollment year.

**Table 1. Details of beneficiary accounts, 2014 – 2016**

Account feature	Indiana POWER Account	Michigan MI Health Account	Arkansas Health Independence Account [Closed June 30, 2016]
<b>Source(s) of funding</b>	State and beneficiary	Health plan and beneficiary	Beneficiary only
<b>Tracking cost of care</b>	Tracks services used for all beneficiaries and debits individual account value as services are received  Preventive service use does not draw down the account value  Account balances are accessible when swiping POWER account debit card at the point of service	Tracks accrual of copayments, contributions, and credits earned for all beneficiaries  Debits costs of services beneficiaries receive  Preventive service use and chronic care management services do not draw down the account value	Tracks services used when beneficiary presents MyIndyCard, but funds are not drawn from individual accounts
<b>Contributions into accounts</b>	Monthly contributions made to POWER accounts by all individuals.  Contributions mandatory above 100% FPL	Mandatory monthly contributions made to MI Health accounts for individuals above 100% FPL	Voluntary monthly contributions made to HIAs for individuals above 100% FPL
<b>Basis for monthly payment amount</b>	2% of income for those >5% FPL; \$1 for those at or below 5% FPL	2% of income for those >100% FPL	Fixed amounts, as listed below
<b>Monthly payment amounts for those with income 0–100% FPL</b>	0–5% FPL; \$1  6–100% FPL; \$1 - \$20 <sup>a</sup>	\$0	Not applicable: those with incomes below 100% FPL did not have access to HIAs <sup>b</sup>
<b>Monthly payment amounts for those with income &gt;100% FPL</b>	>100–133% FPL; \$20 - \$26 <sup>a</sup>	>100–133% FPL; \$20–\$26 <sup>a</sup>	>100–115% FPL; \$10  116–133% FPL; \$15
<b>Health care cost education</b>	Monthly statements of contributions and cost sharing, or cost sharing avoided by making account contribution	Quarterly statements of cost sharing and healthy behavior credits	Monthly statements of cost sharing, or cost sharing avoided by making account contribution
<b>Financial rewards for incentivized behaviors</b>	Regular contributions maintain HIP Plus enrollment, including exemption from copayments (except nonemergent use of the ED)  Account funds first \$2,500 of care. Funds remaining at end of enrollment year can be rolled over. Members who receive preventive services can have the rollover doubled.  The beneficiary's share of unused contributions can be refunded when leaving the program	Monetary credits for completing healthy behaviors appear in MI Health account and can be used to reduce contributions and copayments  Account contributions can be returned for the purpose of purchasing private insurance after leaving Medicaid	Account contributions waive copayment obligations  If the beneficiary makes six or more contributions during the enrollment year, up to \$200 of account balance can be returned after leaving Medicaid for the purpose of purchasing private insurance or to pay for Medicare cost sharing
<b>Consequences of nonpayment for those subject to contributions</b>	60-day grace period followed by disenrollment and six-month lockout for beneficiaries with income >100% FPL. Those with income ≤100% FPL remain enrolled, but move to HIP Basic.	No beneficiaries are disenrolled for nonpayment, but the state will garnish state tax returns and lottery winnings (if applicable) for missed payments	Beneficiaries are subject to QHP copayments at the point of service but cannot be disenrolled

<sup>a</sup> Amounts were calculated using the FPL for a household size of one and the 2016 FPL threshold (\$11,880), and are rounded to the nearest whole dollar.

<sup>b</sup> Special Terms and Conditions authorize the state to collect monthly contributions of \$5 for beneficiaries with income between 50 and 100 percent of the FPL, but the state chose not to implement this policy.

ED = emergency department; FPL = Federal Poverty Level; HIA = Health Independence Account; HIP = Healthy Indiana Plan; POWER = Personal Wellness and Responsibility; QHP = Qualified Health Plan.

## Implementation and administration of the accounts

In all three states, contractual partners establish and administer the health accounts. Here, we discuss the roles and responsibilities of the states, third-party administrators, and health plans in implementing and administering the accounts. We also consider the more limited role providers play in the accounts.

### A. Roles of the states, health plans, and third-party administrators

In Indiana, the three health plans have primary responsibility for administering and maintaining the accounts for their covered beneficiaries. In Arkansas and Michigan, the state contracts with a third-party administrator to operate the accounts. Indiana's approach creates a single point of contact for beneficiaries; the division of responsibilities in Arkansas and Michigan creates multiple points of contact, which may confuse some beneficiaries. In all three states, state Medicaid agencies have only minor or supervisory roles in the day-to-day operation of the accounts.

In **Indiana**, the main contact beneficiaries have with the state about the accounts occurs during initial enrollment, renewal, and redetermination (if the beneficiary experiences a mid-year change in circumstance). The state is responsible for calculating the monthly contribution amount at these times and also plays a role in reconciling the accounts at year end or when a beneficiary exits the program.

The health plans are the beneficiaries' main point of contact regarding the POWER accounts and have primary responsibility for implementing and administering the accounts. The health plans educate beneficiaries about the accounts, mail monthly account statements, and collect and track monthly contribution payments. The account statements, whose format the state must approve, include the account balance, the beneficiary's monthly and annual contribution amounts and any past due amounts, the state's annual account contribution amount, and service use to date. The plans also address beneficiary questions or complaints about the accounts and calculate the annual rollover under the direction of the state.

In **Michigan**, the third-party administrator has primary responsibility for implementing and administering the MI Health accounts. The state collects quarterly monitoring data, tracks completion of healthy behaviors, and creates the account statements and other beneficiary communication materials. The third-party administrator is then responsible for most of the day-to-day operations of the accounts, beginning with sending a welcome letter to beneficiaries once they reach their seventh enrollment month, at which point they must start making copayments and (for those above 100 percent of the FPL) paying contributions. The administrator also responds to beneficiary

questions, conducts ongoing beneficiary education about the accounts, mails the quarterly statements, and collects required copayments and contributions.<sup>12</sup> The third-party administrator is also responsible for recalculating contribution amounts following changes in beneficiary income, tracking completion of the healthy behaviors, and determining when beneficiaries have paid more than 2 percent of their income in copayments.<sup>13</sup>

Health plans in Michigan have a more limited role in the account program. Although the plans report that they often receive calls from beneficiaries asking about their account balance or amount owed, they must refer all account-related questions to the third-party administrator. One Michigan plan serving HMP beneficiaries reported that this division of responsibilities was challenging for the plan and confusing to the beneficiary. The plans provide some beneficiary education about the accounts, but mostly about the incentivized healthy behaviors and how they affect contributions.

Finally, the state regularly solicits feedback from stakeholders including beneficiaries, health plans, and vendors to evaluate the MI Health account features and functions, and identify where account or statement changes could improve beneficiary understanding of the accounts and the program more generally.

In **Arkansas**, as in Michigan, a third-party administrator had primary responsibility for implementing and administering the HIAs. The state created all beneficiary communication materials and determined the voluntary monthly contribution amount. The third-party administrator was responsible for all other account operations, including sending a welcome packet with the MyIndyCard and educational materials about the account; maintaining the MyIndyCard website, which showed account information and accepted online contributions; managing the call center and responding to beneficiary questions; processing all MyIndyCard transactions; distributing copayments and coinsurance to providers; maintaining the master account of state funds used to pay QHP copayments and coinsurance; and distributing account funds to eligible beneficiaries when they exited the program.

The state reported that the QHPs had no substantive role in the accounts, other than referring beneficiaries to the third-party administrator for answers to questions about the accounts. We were unable to speak with the Arkansas third-party administrator or participating QHPs for this issue brief, so we cannot report on their experiences educating beneficiaries about the accounts, responding to beneficiary questions, or whether beneficiaries seemed to understand the division of labor between the third-party administrator and QHPs.

### B. Role of providers

The role of providers in the health account component of each state's demonstration is limited. In all three states, Medicaid agencies, health plans, and third-party administrators conduct

provider education; but providers mainly need to know what copayments, if any, to collect from beneficiaries at the point of service. Providers in each state have several ways to determine copayment amounts, including through provider handbooks, online provider portals, plan/program websites, plan/third-party administrator call centers, and emails, newsletters, and in-person visits from plans and/or third-party administrators.

In Indiana, providers have no interaction with the POWER accounts except to swipe the beneficiaries' POWER account debit card at the point of service. In Michigan, providers have no direct interaction with the MI Health Accounts, but they do play a large role in helping beneficiaries complete the healthy behaviors, which can result in decreased monthly contributions. The state reported that providers are required to tell beneficiaries that they do not collect copayments at the point of service and to post state-mandated materials regarding the accounts and the HMP in their offices.

A 2016 Michigan provider survey found that a majority of providers were very or somewhat familiar with how to complete and submit an HRA (71 percent and 58 percent of providers, respectively). However, only 36 percent of providers were very or somewhat familiar with the healthy behavior incentives that beneficiaries face, and only 25 percent were very or somewhat familiar with beneficiaries' out-of-pocket costs (Dorr Goold et al. 2016a). Thus, while many providers do understand their role in the HMP, the survey suggests a majority would benefit from further education about their role in helping beneficiaries complete healthy behaviors, the financial benefits to beneficiaries of doing so, and the costs beneficiaries face when they access care.

In Arkansas, providers were responsible for swiping beneficiaries' MyIndyCards to determine whether they owed copayments at the point of service. The third-party administrator designed the system to approve the copayment request in real time as the provider swiped the card. The state reported that, early in the system rollout, there was some confusion among providers, who tried to collect standard QHP copayments from beneficiaries instead of the smaller copayments allowed under the HCIP. In response, the third-party administrator conducted additional webinars and in-person meetings with providers, and the state reported that providers quickly became accustomed to the HCIP and the MyIndyCard system.

## Account statements: Encouraging beneficiary engagement with the accounts

Periodic account statements are the main method states use to communicate account information to beneficiaries and to encourage beneficiaries to regularly monitor and engage with their accounts. To meet these goals, statements must clearly communicate relevant information. Overly long, complicated, or infrequent statements may deter beneficiaries from fully engaging with their accounts.

We reviewed example or redacted statements from the three plans in Indiana and the Michigan third-party administrator. Example HIA statements from Arkansas were not available at the time of writing. We examined variation across the statements in content, style, and language (Table 2).<sup>14</sup> Key findings include:

- To educate beneficiaries about the cost of care, all Indiana and Michigan statements list health care services received and the amount the provider was paid.
- In Indiana, to encourage efficient use of care, the statements show how the costs of services are deducted from the POWER account balance. Information on Indiana's rollover incentive varies by plan.
- To encourage beneficiaries to complete healthy behaviors, such as obtaining preventive care, most statements from Indiana and Michigan include at least some information on preventive services received, whether the healthy behavior requirement has been met to earn rewards, and how preventive services are exempt from cost sharing.
- Statements in Indiana also illustrate the benefits of paying regular contributions instead of unpredictable point-of-service copayments by showing a \$0 copayment amount for services that HIP Plus beneficiaries receive. HIP Basic statements show the copayment amount for services received, but do not explicitly demonstrate the potential savings that could be realized if the beneficiary began making contributions and moved up to HIP Plus at renewal.

**Table 2. Information included in health account statements, 2015**

Statement feature	Indiana			Michigan Maximus (third-party administrator)
	Health Plan #1	Health Plan #2	Health Plan #3	
<b>Statement length</b>	4 pages	2 pages	2 or more pages, depending on the length of the table showing services received	8 pages
<b>Statement frequency</b>	Monthly	Monthly	Monthly	Quarterly
<b>Summary account statement</b>	Yes – page 1	Yes – page 1	No	No
<b>Summary statement content</b>	Account balance to date Contributions summary to date Recent account activity	Account transactions and contributions paid	Not applicable	Not applicable
<b>Content of the body of statement</b>	Graphs showing what types of services account funds were spent on (preventive, nonpreventive, prescriptions) and how expenses were paid (from account, covered by health plan [“traditional coverage”], member responsibility)  Table of claims transactions using claims codes (plainness of language accompanying claims codes unknown)	Table of claims transactions using claims codes and medical terminology associated with each claims code  Table of claims transactions for preventive services, showing \$0 deduction from account and whether preventive service requirement was met	One page of generic language about the statement, the difference between Plus and Basic, and the rollover  Account activity table showing services received, amount of provider payment, and remaining account balance using claims codes and simple language  Contributions table showing monthly amount owed and total owed by beneficiary and state	Introductory letter  Payments section showing total owed, payment amounts, and payment history  One page of generic language explaining account payments  List of services received and copayments owed using simple language without claims codes  One page of generic language explaining services and copayments  Monthly payment coupons
<b>Shows amount paid to providers for services</b>	Yes	Yes	Yes	Yes
<b>Preventive service information provided</b>	Amount of spending on preventive care included in spending graph	In body of statement, as described above	Basic information on generic language page about how use of a preventive service will double the rollover amount  Some claims in account activity table show cost as \$0, but no explanation of reason for \$0 deduction	Single generic language line in the payments section  Similar generic line in the services and copayments section (some services are listed in the claims section with \$0 copay, but they are not flagged specifically as preventive care)
<b>Indicates whether incentivized healthy behavior has been completed</b>	No, and no mention of the doubled rollover incentive for receiving preventive services	Yes	No, but does contain a reminder about the doubled rollover incentive	Yes

Note: In Indiana the health plans are responsible for administering the POWER accounts and sending the account statements; we reviewed account statements from all three HIP health plans. In Michigan the third-party administrator is responsible for administering the MI Health accounts, including sending the account statements, for all HMP health plans. Example account statements were from 2015 and were received in February 2016.

## Early evidence on beneficiary engagement with the accounts

States are optimistic that health accounts can motivate beneficiaries to be more engaged in their own health care, and early evidence is beginning to accrue about how beneficiaries interact with the accounts. In this section, we discuss state reports of beneficiary engagement with the accounts, as measured by contribution and copayment payment rates, beneficiary feedback, findings from beneficiary surveys conducted as part of state interim evaluation reports, and an evaluation of the MI Health account statement. The findings in this section represent experience in the first one to three years of these demonstrations. They are early findings, and over time reported rates may change due to demonstration maturation and increased beneficiary experience.

### A. Contribution payment rates to date

Contribution payment rates vary by state, with Indiana experiencing much higher rates of payment than Arkansas and Michigan. The extent to which statements and other account-specific incentives drive payment rates is unclear, as other incentives and program features may contribute to the observed differences in contribution payment rates.

**Indiana's** interim evaluation shows that contribution payment rates are high; during the first demonstration year, more than 90 percent of beneficiaries both above and below the FPL who were ever enrolled in HIP Plus made the required contributions to stay in HIP Plus (Lewin Group 2016). POWER account statements show beneficiaries enrolled in HIP Plus the benefit of their contribution payments by listing a \$0 copayment amount on all services received, which may serve as a reminder of this Plus benefit and encourage beneficiaries to continue making contribution payments.

However, beneficiaries also have other strong incentives to make their contributions. Beneficiaries must make contributions to maintain enrollment in HIP Plus, which provides access to vision, dental, and enhanced pharmacy coverage, and beneficiaries with incomes greater than 100 percent of the FPL who do not make contribution payments are disenrolled from the program and locked out for six months. Loss of vision and dental benefits, disenrollment, and lockout are likely the primary motivations for beneficiaries' high payment rates. Indeed, 97 percent of surveyed HIP beneficiaries with income over 100 percent of the FPL were aware of the disenrollment penalty, and 78 percent of surveyed beneficiaries with income below 100 percent of the FPL were aware of the penalty even though they were not subject to it (Lewin Group 2016).<sup>15</sup>

In **Michigan**, from program inception in October 2014 through April 2017, 32 percent of contributions ever owed were paid, and 39 percent of copayments ever owed were paid (Maximus 2017). Contributions and copayments are required, but beneficiaries cannot be disenrolled for nonpayment.<sup>16</sup> Because they cannot be disenrolled, some HMP beneficiaries may lack motivation to make regular payments. However, awareness that beneficiaries cannot be disenrolled is too limited to fully explain the high-levels of non-payment. About half (52 percent) of surveyed HMP beneficiaries did not know whether they could be disenrolled for not making payments, and another 15 percent incorrectly believed that they would be disenrolled for nonpayment, meaning that 33 percent of beneficiaries knew that they could not be disenrolled for nonpayment of copayments or monthly contributions (Dorr Goold et al. 2016b).

Other factors may also contribute to disparities in payment rates between Indiana and Michigan, including differential understanding of the account statements, Indiana's greater number of payment options (including an option to pay by credit card), and confusion about the use of the term "contribution" rather than "premium." As of this writing, Michigan was revising the account statement based on beneficiary feedback (as discussed in the next section), which may improve payment rates in the future.

**Arkansas's** now-closed HIA is the only account for which participation was voluntary. The state reported that, of approximately 46,000 beneficiaries with incomes above the FPL who were eligible for the accounts, approximately 7,700 (17 percent) made at least one contribution payment at any point during their HCIP enrollment. Of those who made at least one contribution payment, 2,253 beneficiaries (29 percent of those making at least one contribution, or 5 percent of all eligible beneficiaries) made six or more payments in the past year and were eligible to receive the balance of their account (up to \$200) when they left the program. The state reported that it was common for beneficiaries who made multiple payments to make them sporadically instead of regularly. Although state officials did not believe that beneficiaries were trying to "game the system" (for example, by paying their contributions only in the months when they knew they would need health care services), irregular payment patterns could indicate strategic behavior.

### B. Beneficiary responses to accounts

Both Indiana and Michigan have assessed user experience and satisfaction with the accounts in their respective demonstrations through interim evaluation reports, surveys of beneficiaries, and, in Michigan, surveys of providers. The HIAs operated for a relatively short time, and Arkansas did not formally survey beneficiaries about its accounts. In general, the Indiana and

Michigan evaluations found that beneficiaries may not yet fully understand the complex incentive and engagement strategies in their respective states' demonstrations.

In **Indiana**, 66 percent of surveyed HIP Plus and 46 percent of HIP Basic beneficiaries reported hearing of the POWER account, of whom 72 percent of HIP Plus and 76 percent of HIP Basic beneficiaries reported knowing they themselves have such an account. Among those beneficiaries who reported knowing they have an account, 51 percent of HIP Plus and 57 percent of HIP Basic beneficiaries reported checking their account balance at least every few months. Thus, about 24 percent of all surveyed HIP Plus and 20 percent of all surveyed HIP Basic beneficiaries reported checking their POWER account balance every few months or more frequently.

The Indiana survey also measured beneficiaries' understanding and use of incentivized preventive services. Only 9 percent of all surveyed HIP Plus and 7 percent of surveyed HIP Basic beneficiaries knew that the costs of preventive services are not deducted from their POWER accounts; a majority incorrectly believed that preventive service costs would be deducted and many responded that they did not know.

Regarding the preventive service rollover incentive, a majority of both HIP Plus and HIP Basic beneficiaries knew that if they received a recommended preventive service, their end-of-enrollment year POWER account balance may be rolled over for the next year (65 percent and 57 percent, respectively). However, on more detailed program-specific questions the proportion of correct responses were lower. Specifically, 52 percent of surveyed HIP Plus beneficiaries knew that if they did not get a recommended preventive service, any funds remaining in their POWER accounts at the end of the enrollment year would not be doubled in the rollover (an additional 21 percent responded "don't know"). Thirty-five percent of surveyed HIP Basic beneficiaries knew that if they did not get a recommended preventive service, any funds remaining in their POWER accounts at the end of the enrollment year would not be rolled over (32 percent responded "don't know"). The reason for these mixed response rates is unclear and it is difficult to assess with confidence how well beneficiaries understand their preventive service incentives.

Indiana beneficiaries are getting preventive services at rates that exceed their understanding of demonstration incentives as documented in survey data. Seventy-four percent of beneficiaries enrolled for 10 to 12 months in either HIP Plus or HIP Basic received a qualifying preventive service, as identified through claims data. These patterns suggest that other factors—such as intrinsic beneficiary motivation or prompts from care providers—also play a role. The list of qualifying preventive services is comprehensive, so beneficiaries may get these services as part of their regular care regimen without knowing that they also qualify as

incentivized preventive care. In addition, all three health plans in Indiana report providing additional financial incentives, such as gift cards, for receipt of preventive care (Contreary and Miller 2017). The availability of immediate cash rewards may contribute to high rates of preventive service receipt.

In 2015, **Michigan** evaluated the MI Health account statement. The researchers interviewed beneficiaries to assess their understanding of, and satisfaction with, various components of the statement (Kieffer et al. 2015). Key findings indicated that the account statements were not fulfilling their role of educating beneficiaries about the account and other program features. Specifically:

- The introductory letter had little lasting influence on beneficiaries: many remembered seeing it but did not read it, and some did not remember receiving it at all.
- Most beneficiaries did not read most of the statement; instead, they looked for the amount owed.
- The summary sections and references to key information were positively received by the beneficiaries, but most had not read them before the interview.
- The tables and graphics in the statement were confusing, and they did not effectively communicate how much the beneficiary owed and why.

The state reported that, based on the findings from the MI Health account evaluation and other beneficiary feedback, the state was revising the account statement to reduce the length, simplify the format, and clarify language and figures to more effectively educate beneficiaries about the complex relationship between making regular payments, using health care effectively, and increasing savings in the long run. When we were collecting information for this report, the new statement had not been implemented; therefore, we cannot comment on beneficiary responses to, and understanding of, the new statement.

Despite some confusion about the account statements, acknowledged by the state officials we interviewed, beneficiary awareness of the MI Health account and the account statement is high.<sup>18</sup> Most Michigan survey respondents (75 percent) reported receiving a MI Health account statement; of these, 89 percent agreed or strongly agreed that they carefully review each statement to see how much they owe, and 88 percent agreed or strongly agreed that the statements make them more aware of the cost of health care (Dorr Gould et al. 2016b).

## Implications for evaluating demonstration outcomes

Although the accounts in Arkansas, Indiana, and Michigan have similar goals, variation in the account functions and implementation may lead to differing outcomes across the states. As a voluntary program with relatively limited take-up and no linked incentive to promote healthy behaviors, the HIAs in Arkansas are unlikely to have had a major impact on beneficiary outcomes. The POWER account program in Indiana and the MI Health account program in Michigan are integral parts of demonstration-level incentives to adopt healthy behaviors and use health care judiciously.

Reward mechanisms for healthy behavior completion (such as preventive service receipt) in both states have the potential to succeed. The fact that Michigan beneficiaries can earn rewards in the current enrollment year, whereas Indiana beneficiaries can only earn rewards in subsequent enrollment years, might result in stronger healthy behavior incentives in Michigan. However, operational features in Indiana suggest the potential for a larger impact on beneficiary contribution payment rates and cost conscious behavior. Specifically, Indiana's policy of disenrolling beneficiaries who do not make contribution payments generates a strong incentive to make regular contributions. Rewards for using health care judiciously may also be more salient in Indiana since beneficiaries can earn reduced contribution payments in subsequent enrollment years, whereas beneficiaries in Michigan do not receive any reward for using health care services judiciously until they exit the program and receive their remaining account funds, if any.

Differences in account design will be important to consider when assessing the impact of health accounts on beneficiary behavior, service use, or costs of care. Lessons may also be drawn from comparisons to states with similar goals, but whose demonstrations do not include health accounts. Beneficiary understanding of and engagement with the accounts will also have an impact on outcomes, as well as our confidence in attributing observed changes in beneficiary behavior to their

interactions with the accounts. Below, we briefly discuss these two topics: (1) opportunities to learn from comparisons between states with and without health accounts and (2) opportunities to explore variation in beneficiary understanding of account features and functions.

### A. Evaluating incentives for healthy behaviors with and without health accounts

Financial incentives for certain healthy behaviors (such as use of preventive services) are a feature of many states' demonstrations. In Indiana and Michigan, the incentives operate through a health account. Several other state demonstrations use healthy behavior incentives but do not explicitly structure their programs around health accounts. This variation in state demonstration design provides an opportunity to compare rates of healthy behavior completion in each state, to help illuminate the extent to which health accounts are an effective strategy for nudging beneficiaries to engage in desired behaviors.

Montana's demonstration can provide a point of comparison as a state with an account-like function within its demonstration, but no formal health account program. In Montana, beneficiaries pay 2 percent of their annual income in contributions. Beneficiaries are not subject to copayments for services received until the cumulative cost of the copayments they incurred (but did not have to pay) exceeds the quarterly amount they pay in contributions. As in Michigan, beneficiaries do not make copayments at the point of service. Rather, providers submit claims to the state's third-party administrator, which assesses the beneficiary's copayment obligation. If the beneficiary has incurred copayments up to 2 percent of his or her income, the administrator informs the provider that the beneficiary is eligible to pay copayments, and the provider bills the beneficiary for the amount due. As in Indiana and Michigan, preventive services are exempt from copayments; however, unlike in those states, Montana's demonstration does not have any explicit incentives for healthy behaviors, and the account statements are not intended to teach beneficiaries about the demonstration. As the administrator processes claims, beneficiaries receive statements summarizing their service use,

## ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

including their total amount of incurred contributions and copayment obligations. Like an account statement, the summary allows beneficiaries to monitor their health care use and observe when they receive preventive services that do not have copayment requirements. To our knowledge, however, Montana does not attempt to nudge behavior through the statements (for example, by alerting beneficiaries when they are approaching the 2 percent income threshold in copayments or by reminding beneficiaries that preventive services are provided at no cost to them).

Iowa may provide a good point of comparison in determining whether accounts are more effective than other means of nudging beneficiaries to encourage desired behaviors. Iowa's demonstration has no formal account or accounting function like those in Arkansas, Indiana, or Michigan; however, it does have a healthy behavior incentive that, when met, exempts the beneficiary from contribution payments in the following year. Because Iowa's demonstration has no accounting function that generates regular statements, however, beneficiaries may need to be reminded of the healthy behavior incentive in other ways. Beneficiaries may be more (or less) likely to read an account statement than a reminder letter, providing an opportunity to evaluate the impact of different methods of beneficiary communication on beneficiary behavior or engagement.

## B. Measuring beneficiary understanding of account design

As with other methods of beneficiary engagement, any effect that health accounts may have on adopting healthy behaviors or other outcomes will depend on whether beneficiaries understand their incentives and obligations and translate that understanding into action.

Variation in states' methods of communicating with beneficiaries about the accounts and associated incentives (from formal account statements to health plan-specific reminder letters) will help determine which features of the account programs' education and outreach strategies make them easier or harder for beneficiaries to understand, and what impact that variation in beneficiary understanding has on outcomes. Perhaps beneficiaries engage in desired (and even incentivized) behaviors at a high rate without being nudged by a health account program. If most of the evidence suggests that beneficiaries do not understand the account programs, it will be difficult to attribute any changes in beneficiary behavior to their engagement with their accounts.

## METHODS AND DATA SOURCES

Descriptive information about Section 1115 demonstrations is based on Mathematica's analysis of demonstration documents for Arkansas, Indiana, Iowa, and Michigan, as listed below.

- Arkansas Special Terms and Conditions, Approval Period: September 27, 2013–December 31, 2016; as amended January 1, 2015. Section 1115 demonstration monitoring reports: 2015 Q3.
- Arkansas 1115 Waiver Extension and Amendment Application. June 28, 2016.
- Indiana Special Terms and Conditions, Approval Period: February 1, 2015–December 31, 2018. 2015 annual report.
- Iowa Wellness Plan Special Terms and Conditions, Approval Period: January 1, 2014–December 31, 2016; as amended December 31, 2014. Section 1115 demonstration monitoring reports: 2014 Q1–Q4; 2015 Q1; 2014 annual report.
- Michigan Special Terms and Conditions, Approval Period: December 30, 2013–December 31, 2018. Section 1115 demonstration monitoring reports: 2014 Q1–Q4; 2015 Q1; 2014 annual report.
- Michigan Adult Coverage Demonstration Section 1115 Quarterly Report. Demonstration Year 6 (January 1, 2015–December 31, 2015), Federal Fiscal Quarter 1 (October 1, 2015–December 31, 2015).

We also conducted key informant interviews with Medicaid officials in Arkansas, Indiana, and Michigan in May and August 2016 and with health plan representatives from all three Indiana health plans and three of the eleven Michigan health plans in January to May 2016. We designed interview protocols to clarify information in the Special Terms and Conditions and monitoring reports for each demonstration and to assess the implementation of demonstration policies. A lead interviewer and a note taker were present at each interview.

## References

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U.S. Department of the Treasury. "Health Savings Accounts (HSAs)." Updated December 1, 2015. <https://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx>.

## Endnotes

<sup>1</sup> In Indiana's Healthy Indiana Program (HIP 2.0) and Michigan's Healthy Michigan Plan (HMP), beneficiary care is provided through managed care organizations (known as managed care entities in Indiana). In Arkansas's Health Care Independence

Program (HCIP), also known as the Private Option, beneficiary care was provided by Qualified Health Plans (QHPs).

<sup>2</sup> Indiana's previous Medicaid program, HIP 1.0, had health accounts as well. However, the accounts, incentives, and population served differ between HIP 1.0 and HIP 2.0 in ways that make it difficult to draw direct comparisons about the effect of the accounts.

<sup>3</sup> In Indiana, beneficiaries above 100 percent of the federal poverty level (FPL) who do not make contribution payments are disenrolled and locked out of the program for 6 months. In Michigan, beneficiaries who are noncompliant with cost sharing are not disenrolled, but the state can garnish beneficiaries' state tax returns and lottery winnings (if applicable) to recover the unpaid cost-sharing amount.

<sup>4</sup> Arkansas's Health Independence Accounts (HIAs) closed as of June 30, 2016. To avoid confusion, we refer to all the accounts in the present tense, except when discussing the HIA individually.

<sup>5</sup> For more information on the sources we used for this report, please see the "Methods and Data Sources" box at the end of the brief.

<sup>6</sup> Most states use the term "contribution" rather than "premium" to describe monthly payments made as part of their demonstration to account for the differences between a traditional premium in a commercial health plan versus the regular contribution payments made by Medicaid beneficiaries. For example, unlike with traditional premiums, at least a portion of beneficiary contributions can be refunded to beneficiaries when they exit the program in all three states. We therefore use the term "contribution" in this report.

<sup>7</sup> Beneficiaries with income between 0 and 5 percent of the FPL are an exception; they must contribute \$1 per month. Beneficiaries with incomes below the FPL cannot be disenrolled for failure to make these payments, but they are instead enrolled in HIP Basic, which requires copayments at the point of service and does not include dental, vision, or enhanced pharmacy coverage. For more details on contribution payments, see Bradley et al. 2017.

<sup>8</sup> HIP Plus and HIP Basic beneficiaries are both eligible for the account rollover, but the size of the rollover varies across these two components of the program. For HIP Plus beneficiaries, the rollover amount is doubled if they meet the preventive service requirement. However, HIP Basic beneficiaries face more requirements. To receive any rollover, they must have obtained at least one recommended preventive service for their age and gender, and they must agree to move up to HIP Plus and start paying monthly contributions. The rollover for Basic beneficiaries also cannot reduce contribution amounts in the next enrollment year by more than 50 percent.

<sup>9</sup> HMP's healthy behaviors are (1) completing a health risk assessment with a primary care provider, and (2) agreeing to

address or maintain one healthy behavior (such as quitting smoking or getting a flu shot).

<sup>10</sup> Beneficiaries with income  $\leq$ 100 percent of the FPL who have no required contributions receive a \$50 gift card.

<sup>11</sup> Except for those exempt under federal law, such as beneficiaries who have paid more than 5 percent of their annual income in copayments.

<sup>12</sup> Michigan uses quarterly account statements, but beneficiaries usually pay copayments and applicable contributions in equal monthly installments using monthly payment coupons provided in the statements.

<sup>13</sup> For HMP beneficiaries with incomes of any level, after they pay 2 percent of their income in copayments, their future copayment responsibility will be reduced by 50 percent if they have completed the healthy behaviors requirements.

<sup>14</sup> Michigan was revising the MI Health account statement based on extensive beneficiary feedback. However, because the revised statement was not available at the time of this study, we only comment on the older version of the statement here.

<sup>15</sup> A total of 600 HIP 2.0 beneficiaries were surveyed, 420 of whom were Plus beneficiaries and 180 of whom were Basic beneficiaries.

<sup>16</sup> For beneficiaries who are noncompliant with cost sharing, the state can garnish beneficiaries' state tax returns and lottery winnings (if applicable) to recover the unpaid cost sharing amount. (Beneficiaries are considered noncompliant if [1] they have not made any cost sharing payments in more than 90 days, or [2] they have paid less than 50 percent of their cost sharing obligation as calculated over a one-year period.)

<sup>17</sup> The 10- to 12-month period is the longest enrollment duration observed during the first year of the program and represents 25 percent of all surveyed beneficiaries.

<sup>18</sup> The key informants we spoke with in Michigan's Medicaid agency in 2016 acknowledged that account statements confused beneficiaries, and expressed their intent to change the statement to improve beneficiary understanding.