2014-2015

The Texas Way Program: Consumer Engagement Through Health Savings Accounts

The Texas Way is a uniquely Texan, private market-based health insurance coverage program that will improve the health of low-wage working Texans and strengthen the state's economy. As proposed, the Texas Way Program:

- Connects uninsured Texans with private insurance coverage choices;
- Requires personal responsibility;
- Promotes appropriate utilization of health care services; and
- Reduces inefficient health care spending.

By requiring covered individuals to pay for a portion of their care and incentivizing the appropriate utilization of health care services, the Texas Way Program avoids the pitfalls of traditional entitlement programs. The Texas Way Program is the fiscally responsible approach to reducing the number of uninsured without adding to the state's Medicaid rolls.

Health savings accounts are a core element of the Texas Way Program. The precise details of Texas Way HSAs will have to be worked out between the state and the Centers for Medicare & Medicaid Services. However, the intent of HSAs is to:

- encourage consumer engagement in health care decisions;
- promote personal responsibility; and
- reduce overall health care costs.

By requiring HSAs of Texas Way Program enrollees, Texas would be at the forefront of using HSAs and high-deductible health plans in a public insurance program. Only Indiana has experience using HSAs/HDHPs with a publicly insured population.

HSAs: What Are They?

HSAs are used in conjunction with HDHPs. The objectives are to control costs and empower enrollees to be active purchasers of health care services, rather than just passive consumers.

Since entering the health insurance market in 2004, HSAs/HDHPs have become one of the fastest growing insurance products in the nation. Nearly 18 million Americans are enrolled in an HSA/HDHP, with enrollment increasing at an average annual rate of 15 percent since 2011. Texas has the second-highest HSA/HDHP enrollment, with more than 1 million enrollees.

Typically, enrollees fund the HSA and use the money to pay for all medical expenses up to the deductible amount of their health plan. After meeting their deductible, enrollees use HSA funds to pay for any medical expenses not covered by their health plan, such as copayments.

HSAs Are Effective at Changing Consumer Behavior and Reducing Health Care Costs

Research from a variety of sources has shown that HSAs are highly effective at helping consumers make value-based health care decisions and at lowering health care costs without sacrificing health care quality:

- An independent evaluation of the Indiana HSA/HDHP for Healthy Indiana Plan enrollees shows high levels of enrollee satisfaction, enrollee funding of the HSA, use of preventive health care services and understanding of how the HSA works as well as declining use of the hospital ER as a primary source of care.

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- A five-year Employee Benefit Research Institute study of health care spending after a large Midwest employer replaced its traditional insurance plans with HSA/HDHPs found that total health care spending decreased by 25 percent across all categories in the first year. There were additional declines in pharmacy and lab spending in subsequent years.
- A 2011 Employer and Account Holder survey found that 54 percent of HSA account holders reported having set aside more money than ever before to pay for health care costs, and 28 percent reported the account encouraged them to shop for lower-cost prescription drugs.
- Use of HSA/HDHPs in Indiana's state employee health insurance program reduced total health care costs by more than 10 percent and encouraged more prudent use of hospital emergency departments and higher use of generic, lower-cost medications.

HSAs/HDHPs: The Indiana Experience

Indiana instituted the Healthy Indiana Plan in 2008 to provide coverage for uninsured adults with incomes below 100 percent of the federal poverty level. HIP enrollees are covered through an HDHP with an annual deductible of $1,100. A companion HSA is funded by both the state and the individual up to $1,100. There is no additional required point-of-service cost-sharing, such as copayments, so there is no need to fund the HSA beyond the plan deductible amount.

Enrollees are required to contribute two percent of their annual income to the HSA, with contributions made monthly. The state contributes any remainder of the required HSA funding up to the deductible amount. To ensure that the account is fully funded on the first day of service, the state prefunds the account. Failure to maintain monthly contributions results in disenrollment from the program and a waiting period of 12 months to re-apply.

To encourage the use of preventive health care, the state allows HIP enrollees to roll over any remaining HSA balance (including the state's contribution) and offset required contributions in the next year if they receive at least one age- and gender-appropriate preventive health care service. The first $500 of preventive health care services is also exempt from the deductible so enrollees do not have to tap into their HSA to receive preventive health care.

Indiana has submitted a waiver request to CMS to expand HIP to include uninsured adults with incomes up to 138 percent FPL and make some modifications to the HSA/HDHP structure, including:

- Increasing the deductible and required HSA funding to $2,500/year;
- Changing the enrollee contribution from 2 percent of annual income to a flat amount based on poverty level;
- Giving enrollees with incomes less than 100 percent FPL a choice between enrolling in 1) a basic benefit package that applies co-payments to services and does not require HSA contributions or 2) an enhanced benefit package (includes dental and vision coverage) that requires HSA contributions but not copayments;
- Reducing the enrollment lock-out period for failure to make HSA contributions from 12 months to six months – would apply only to enrollees with incomes above 100 percent FPL.

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