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Health Policy Brief

Health savings accounts in the individual market

Young adults may need more than they think to cover health care expenses

Executive summary

Congress created health savings accounts (HSAs) in late 2003 as a way to reduce health care costs by placing more responsibility in the hands of consumers and making them more price-sensitive. Since then, many markets have seen steady growth in HSA-compatible insurance plans.

The new administration and Republican Congressional leadership have been vocal supporters of enhancing HSA policies across all markets, including the individual market.[1] Deloitte explored the current state of HSAs in the employer, Medicaid, and individual markets to find:

- **The employer market's experience with high-deductible health plans (HDHPs) and HSA-compatible plans can provide many lessons for the individual market.** Research and evidence have shown that younger employees contribute less to their HSA than older employees, healthier individuals find them more attractive than unhealthy individuals, the arrangements are favored by high-income households over lower-income households, and HDHPs can reduce health care utilization and spending.
- **Experience with health accounts in Medicaid programs could also translate to the individual market.** Experience with health accounts in Indiana's and Michigan's Medicaid programs suggests that low-income consumers may become more price-sensitive and accountable for their own spending, but also may face barriers that are less common in the group market (e.g., absence of checking accounts or internet access can make it difficult to make payments or check balances easily).
- **HSAs are not prevalent on the individual market.** Much of this may be due to several conflicting Internal Revenue Service (IRS) and Affordable Care Act (ACA) policies.
- **Many policies, including ones in the American Health Care Act (AHCA), have been put forward to expand HSAs and plans that are eligible to be paired with them.** Most have yet to gain widespread traction with lawmakers, however.
- **Young adults would likely need considerable funds in an HSA to pay for the typical outpatient hospital visit, a service that is less common than an emergency visit but is far more expensive.** A review of plan designs in several markets and comparison to the average cost of an outpatient hospital visit revealed what costs consumers under age 30 would face with an HDHP. In the five markets we examined, a 27-year-old would need to have between $3,617 and $6,572 in an HSA to cover the cost of the average outpatient hospital visit. Meanwhile, the average 25- to 34-year-old in the group market holds an account balance of only $1,414.

HDHPs combined with HSAs may hold the promise of encouraging people to shop for coverage, but many employers have found they have needed to invest in tools and education to help people use them. Health plans may need to consider enhancing tools and support to consumers as HDHPs and HSAs become more prevalent in the individual market.

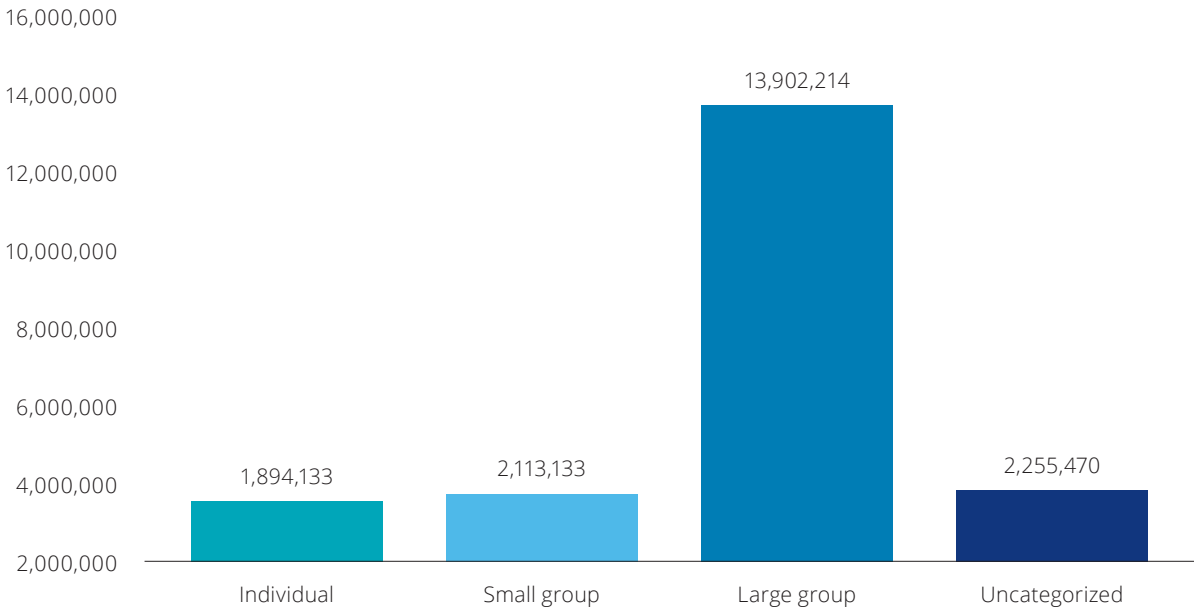
Background

Congress created HSAs under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as a way to reduce costs by placing more responsibility in the hands of consumers and making them more price-sensitive. This was accompanied by a steady growth in HDHPs: As of 2016, nearly a quarter of people in employer-based plans were enrolled in an HDHP, and 90 percent of consumers in the individual market were enrolled in HDHPs in 2015.[2]

Not all HDHPs can be paired with an HSA, but enrollment in HSA-compatible HDHPs also has grown substantially, reaching nearly 20.2 million people in 2016 (up from slightly more than one million in 2005). The large group market represents the vast majority of enrollment in these arrangements (78 percent). But more than 1.8 million people in the individual market are enrolled in HSA-compatible HDHPs, according to one estimate.[3] (See Figure 1.)

The different sizes of each market can make it difficult to compare whether HSA-compatible plans are more common in some markets versus others because only survey data exists on these figures and it may not be representative of the entire market.

Figure 1. Most enrollees in HSA-compatible plans are in the large group market



Source: America's Health Insurance Plans, "2016 Survey of Health Savings Account—High Deductible Health Plans," February 2017

HSAs allow health care consumers (and their employers, if in the group market) to deposit pretax money into a savings account. Consumers can then use these funds for qualified medical expenses as long as they are enrolled in an HDHP. Differing from other consumer-driven health plan accounts, such as health reimbursement arrangements (HRAs) and flexible spending accounts (FSAs), the individual owns the HSA account and can take it with them when they leave their job. Several tax advantages apply to HSAs:

- Contributions are deductible from taxable income.
- Distributions for qualified medical expenses are excluded from taxable income.
- Interest and other capital earnings on assets in the account can build up tax-free.[4]

The IRS requires that HSA-compatible HDHPs meet minimum deductible and maximum out-of-pocket (OOP) requirements and sets limits on how much individuals and those with family coverage can contribute to an HSA. In 2017, individuals enrolled in self-only coverage may contribute up to $3,400 per year to an HSA. Furthermore, plans must have a deductible of at least $1,300 and the OOP maximum cannot exceed $6,550 in order to qualify as an HSA-compatible HDHP. HDHPs also cannot cover any services (aside from preventive care) before the deductible is met.[5]

HSAs are widely used in the group market, and this experience could provide some lessons for the individual market

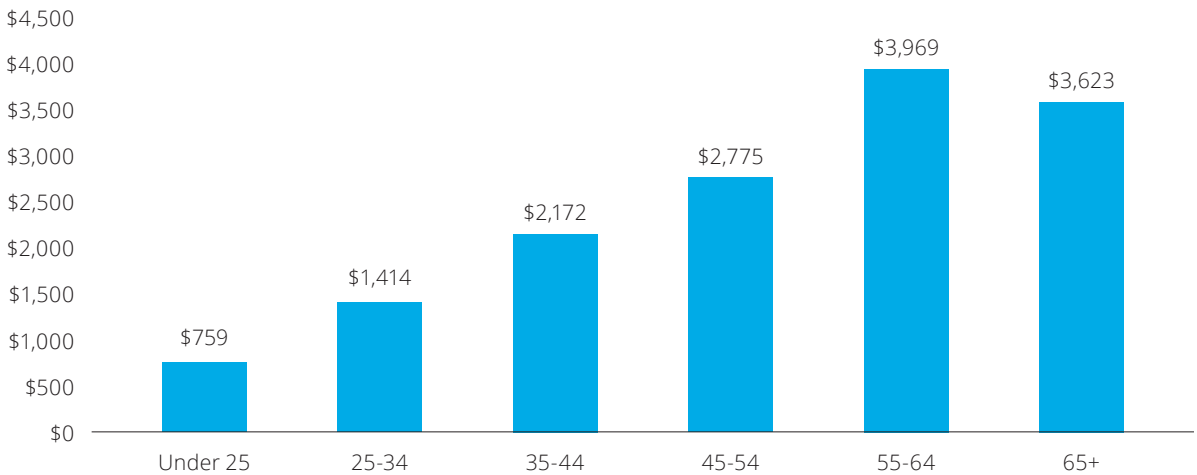
Most HSA-compatible plans are in the large group market.[6] Employers often pair HDHPs with HSAs and make a contribution into the account for employees to use when they need services. The IRS only requires that employers that make HSA contributions make them equally to all employees. Nearly half (47 percent) of employees with an HSA received a contribution from their employer in 2015.[7]

The employer market's experience with HDHPs and HSA-compatible plans has shown that younger employees contribute less to their HSA than older employees, the arrangements are more attractive to healthier individuals than individuals with chronic diseases, they are favored by high-income households over lower-income households, and HDHPs can deter some people from seeking necessary care.

Younger employees often contribute less to their HSA than older employees

The Employee Benefit Research Institute (EBRI) found that less than one-half (45 percent) of people who had an HSA made contributions to their account in 2015. Moreover, account balances vary by account holder age. (See Figure 2.)

Figure 2. 25- to 34-year-olds have lower account balances, on average, than older HSA holders



Source: Paul Fronstin, EBRI, "Health Savings Account Balances, Contributions, Distributions, and Other Vital Statistics, 2015: Estimates from the EBRI HSA Database," November 2016

HSA-compatible plans can be more attractive to healthy individuals

HDHPs coupled with an HSA can be attractive options for people who have few health issues because premiums are generally low and the funds they hold in their accounts are enough to pay for occasional health expenses. On the other hand, individuals with chronic conditions may find them less attractive due to their higher cost burden.

To meet IRS requirements to be HSA-compatible, HDHPs cannot cover any services (aside from preventive care) before the deductible is met. Individuals who are healthy and utilize only preventive services, or have the occasional cold or sore throat, will typically have little to pay out throughout the year. In contrast, people with chronic conditions or ongoing health issues are more likely to use services throughout the year. If enrolled in an HDHP, they would be responsible for covering 100 percent of the costs for these services, until the deductible is met, and the money in their HSA might not be enough to cover the expense. While the premiums for HDHPs are often lower than for other products, the fact that the consumer is responsible for all of the costs before hitting the deductible can be a deterrent to enrollment for sicker individuals but an attractive incentive for healthier individuals.[8]

HSAs are typically favored by high-income individuals over low-income individuals

High- and low-income individuals tend to view HDHPs in very different lights. For high-income individuals, HSA-compatible plans are often viewed as tax shelters, where they can put money away tax-free for use in retirement. Indeed, there are many benefits related to having a large HSA account balance when entering retirement. Once account-holders become eligible for Medicare, HSA funds can be used on a broader set of health care expenses (e.g., Medicare premiums). (See sidebar.) HSA contributions also help individuals reduce taxes on their current income.

One problem, some experts say, is that many low-income individuals enroll in HSA-compatible HDHPs to take advantage of the low premiums, but often cannot afford to set aside the money to fund the account. This might be one reason why less than half (45 percent) of HSA owners contributed to their account in 2015.[9]

The Government Accountability Office (GAO) found evidence to suggest that HSAs are more attractive to higher-income individuals. In a 2007 study, it determined that incomes were higher among tax filers who had HSA activity: In 2005, tax filers who reported using an HSA had an adjusted gross income (AGI) of $139,000, while other tax filers had an average AGI of $57,000. This was true across all age groups.[10]

HSA funds can be used on medical expenses, even in Medicare

Medicare enrollees cannot continue contributing to an HSA, but the funds individuals have left in their accounts can be used after someone turns 65 and enrolls in Medicare. HSA funds can be used to pay Medicare Parts A, B, and D premiums, as well as premiums for Medicare Advantage. HSA funds may not be used on premiums for Medigap coverage, however. In addition, individuals who remain enrolled in employer coverage after they turn 65 can use their HSA funds to pay their share of the premiums. The "catch-up" contribution that individuals may make once they turn 55 allows people to put even more money into an HSA before they retire.[11]

HDHPs can reduce utilization and spending

Many advocates of HDHPs paired with HSAs say that these arrangements make consumers more price-sensitive and encourage them to shop around for health services. This is likely because the money they have to spend on health care before reaching their deductible is their money—the HSA account is owned by the consumer, not their employer.

However, some research suggests that HDHPs create a financial incentive to avoid care, which could lead to health issues down the road.

- Claims data from one large Midwestern company found that low-income individuals received fewer flu vaccinations than higher-income workers after moving into an HSA plan. In addition, there was an increase in emergency services and inpatient hospital admissions among low-income workers.[12]
- Another firm that required all of its employees to move into an HDHP found that few employees were comparison shopping. Instead, they reduced their spending on services—both preventive and unnecessary ones. This happened despite the fact that the employer contributed $3,750 (the amount of the deductible) into an HSA account. One researcher suggested that the employees, especially lower-income ones, were unable to forecast their health care spending for the year so they neglected to seek care for minor issues, saving their money for later in the year in case they needed it.[13]

Lessons learned from employers and Medicaid HSA-like programs indicate that these arrangements can make enrollees more sensitive to their own spending patterns and to the cost of care, which can help make them informed consumers in the long term.

Access to cost and quality information can lead consumers to spend less

Studies of consumers with HSAs have found that people who use cost and quality information roll over more funds on average ($1,006) at the end of the year than those who do not use that information ($932).[14] This indicates that individuals who are basing health care decisions on the cost and quality information they have access to may spend less OOP.

Many employers are making cost (or price) transparency tools a standard part of their HDHP and HSA strategy. For example, Honeywell began offering its employees a service called Surgery Decision Support in 2006. The tool helps employees understand the different options they have when facing a possible surgical procedure. The company found that one-in-five of the employees who used the service opted against surgery, and nearly all of the participants (98 percent) were satisfied with the program.[15]

In another example, when FedEx decided to implement an HDHP, it developed a strategy for educating its employees on the changes. Many consumers reacted positively to the tools the company promoted through the campaign: Use of online cost-estimator and comparison tools rose 42 percent, and more than 70 percent of the employees said they looked more closely at their options for the next plan year.[16]

Other research has attempted to identify health care services that are "shoppable"—for example, a standard office visit with a primary care physician or a knee replacement surgery—and those that are not shoppable—such as emergency visits or urgent surgical procedures. The Health Care Cost Institute found that less than half (43 percent) of spending on behalf of consumers with employer-sponsored insurance could be considered shoppable services.[17] It may be difficult to be a "consumer" of services when faced with an urgent condition.

Many employers are making cost (or price) transparency tools a standard part of their HDHP and HSA strategy.

Medicaid health accounts have changed enrollee utilization patterns

Several states use Medicaid section 1115 demonstration waivers to incorporate HSA-like arrangements into their program designs. Two of these include the Healthy Indiana Plan (HIP) 2.0 and the Healthy Michigan Plan. Both programs pair the "HSA" with an HDHP, but have different requirements governing beneficiary contributions. Early evidence from the Indiana program suggests that consumers that are required to make monthly contributions to an HSA-like arrangement used fewer unnecessary services and more preventive services. Other evidence from the Michigan program suggests that many low-income consumers face barriers that are uncommon in the group market (e.g., lack of internet access makes it difficult to check account balances).

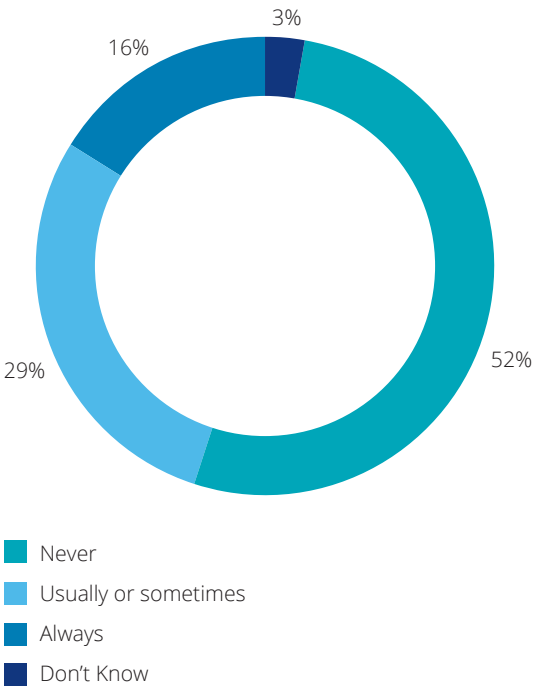
The Healthy Indiana Plan (HIP) 2.0

The HIP 2.0 is considered by many a model for HSA use in Medicaid program design. HIP 2.0 pairs an HDHP with an HSA-like account called a Personal Wellness and Responsibility, or POWER, account. Beneficiaries may enroll in two different options, depending on their income level: HIP Plus or HIP Basic. Beneficiaries with incomes between 100 and 138 percent of the federal poverty level (FPL) must enroll in HIP Plus, where they are required to make monthly or annual contributions to the POWER account based on their income. Beneficiaries with incomes below 100 percent of the FPL can select between HIP Basic and HIP Plus, where they have access to additional benefits (e.g., vision, dental, bariatric surgery) but also must make monthly or annual contributions to the POWER account based on their income.

Evidence:

- **Most beneficiaries stayed current on their POWER accounts.** More than 90 percent of beneficiaries above and below the FPL consistently contributed to their POWER accounts and remained enrolled in HIP Plus. Approximately eight percent of HIP Plus enrollees below the FPL made at least one payment but failed to continue making contributions and were bumped from HIP Plus to HIP Basic. Only six percent of HIP Plus members above the FPL were dis-enrolled from the program for failure to make continuous payments into their POWER accounts. More than half (52 percent) of HIP Plus members said they were never concerned about making their POWER account contributions. (See Figure 3.)

Figure 3. More than half of Indiana's HIP Plus members said they were never concerned about making contributions to their POWER account



Source: The Lewin Group, Inc., "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016

- **Rates of non-urgent visits to the emergency department (ED) were lower among HIP Plus members.** Members are responsible for a copay if they go to the ED for a non-urgent condition: $8 for the first visit, $25 for each subsequent visit. Plus members were less likely to visit the ED for a non-urgent reason (23.5 percent) than Basic members (25.4 percent).
- **HIP Plus members used preventive services more than HIP Basic members.** Under HIP 2.0, the beneficiary's share of leftover POWER account funds rolls over to the next year, and that amount is doubled if they receive at least one qualifying preventive service. This provides an incentive not only to use the account funds efficiently, but also to receive preventive services. When surveyed, 86.5 percent of HIP Plus members and 61 percent of HIP Basic members said they received at least one qualifying preventive care service during the 2015-2016 plan years.[18]

The Healthy Michigan Plan

The Healthy Michigan Plan also was approved under an 1115 waiver and began in April 2014. It allows members to select a health plan rather than being automatically enrolled into one. The Healthy Michigan Plan also allows beneficiaries to reduce cost-sharing requirements by participating in Health Risk Assessments and engaging in healthy behavior as measured by physician-administered surveys. Cost-sharing reductions earned through these methods can be awarded to members as a gift card or applied to the member's MI Health Account, a kind of HSA arrangement.

Evidence:

- **Information about the accounts was confusing to many members.** Many members reported that the welcome letter they received with information about the MI Health Account was confusing. Many also reported being confused about the monthly statements they received.
- **Members who did understand the statements valued them.** Sixty-five percent of MI Health Account members said they agree that monthly statements, provided by their qualified health plan, help them to be more aware of the cost of health care. Moreover, 89 percent agreed that the amount they pay for their Healthy Michigan Plan seems fair.
- **Barriers kept some members from making contributions.** While competing financial obligations was one reason why members said they were unable to make their contributions, many also said that not having internet access or a bank account were other barriers to making contributions.[19]

Evidence from the Michigan program suggests that many low-income consumers face barriers that are uncommon in the group market.

HSAs in the individual market

When Congress passed the Affordable Care Act (ACA) in 2010, it called for the creation of exchanges for the sale of insurance plans on the individual market. This, in effect, created two marketplaces for plans in the individual market: On-exchange plans and off-exchange plans.

HSAs are not prevalent on the exchanges

Estimates of the proportion of ACA exchange products containing HSA features range from 19 to 25 percent. According to one source, as of 2015, approximately 25 percent of plans offered in the exchanges were HSA-compatible.[20] Another analysis of plans on the exchanges in 2014 found that approximately 19 percent were HSA-compatible plans, but the rate differs by actuarial level. The ACA created four levels of cost-sharing on the exchanges: bronze, silver, gold, and platinum. According to the analysis, 42 percent of bronze-level plans, 15 percent of silver-level plans, and nine percent of gold-level plans are HSA-compatible. HSA-compatible plans, especially bronze-level ones, have lower premiums, on average, than non-HSA-compatible plans.[21]

HSA growth in the exchanges has been hampered somewhat by conflicting regulatory standards. While most plans in the exchanges have deductibles high enough to meet the definition of an HDHP, the IRS has additional requirements that HDHPs must meet to be HSA-compatible:

- **OOP limits in ACA plans can be higher than IRS limits.** The ACA has a different set of requirements for OOP limits than the IRS. Under the ACA, plans may have an OOP maximum as high as $7,150 for individual coverage in 2017, while HSA-compatible plans cannot go above $6,550.[22] Nearly 65 percent of plans offered on the exchanges have OOP maximums set above the IRS's $6,550 limit.[23]
- **HDHPs may not cover services other than preventive care before the deductible is met.** HDHPs may not cover any services, except for preventive services, below the deductible.[24] As one analysis explains, more generous plans that exist on the exchanges and cover benefits such as prescription drugs or specialist visits (with or without a co-pay or co-insurance) cannot qualify as HSA-compatible plans.[25]
- **The ACA's cost-sharing reductions often bring deductibles below the IRS requirement.** People who enroll in silver-level plans and earn below 250 percent of the FPL can be eligible for cost-sharing reductions or help from the federal government with their OOP costs. These payments bring the cost of coverage down for many consumers, but they also can bring an individual's deductible below the IRS requirement to make a plan HSA-compatible.[26]

HSAs' prevalence in off-exchange products can be difficult to analyze

Most research into the prevalence of HSAs on the individual market has focused on the exchanges. According to one estimate, however, approximately 6.9 million individuals purchase coverage in the individual market off of the exchanges.[27] Little research has been done to estimate how many off-exchange plans are HSA-compatible, as it can be a difficult market to analyze. HSA plans may be more prevalent and more popular with consumers in that market given that off-exchange plans attract different types of consumers—namely those who do not need or do not get financial assistance to pay for coverage.

Key questions moving forward

What policies might expand use of HSAs?

The new administration and Republican-controlled Congress view HSAs as a way to reduce costs and put more responsibility for the cost of health care into consumers' hands.[28] The AHCA, which passed the House of Representatives on May 4, 2017, contains several policies to advance the use of HSAs. The AHCA would:

- Increase the maximum annual HSA contribution limit to $6,550 in the case of self-only coverage, and to $13,100 in the case of family coverage, beginning in 2018.
- Reduce the penalty imposed on use of HSA funds for non-medical purposes from 20 to 10 percent.
- Allow HSA funds to be used to purchase over-the-counter medications.
- Allow both spouses to make catch-up contributions to the same HSA.[29]

Other legislative proposals governing HSAs have been introduced in previous sessions of Congress. While several are included in the AHCA, some are not. Many of the following policies could make HSAs a more attractive option for consumers:

Legislation	Policy	Included in AHCA?
Health Savings Act of 2017[30]	Increase the maximum HSA contribution limit to match the amount of the deductible and OOP expenses under an HDHP	Yes
	Expand the definition of an HSA-compatible plan to include bronze, silver, and catastrophic plans on the exchanges	No
	Change the name of "high-deductible health plans" to "HSA-qualified health plans"	No
The Obamacare Replacement Act (S. 222)[31]	Provide a tax credit of up to $5,000 per taxpayer for contributions to an HSA	No
	Remove the maximum annual contribution allowable under the law	No
	Eliminate the requirement that an individual must be enrolled in an HDHP to establish and contribute to an HSA	No
	Allow HSA funds to be used toward the cost of premiums	No
Health Savings Account Expansion Act of 2016[32]	Allow HSA funds to be used toward the cost of premiums and direct primary care expenses	No
	Reduce the penalty imposed on expenditure of HSA funds for non-medical purposes from 20 to 10 percent	Yes
	Allow HSA funds to be used for the purchase of over-the-counter medications	Yes

How much would the average 27-year-old need to have in an HSA to cover a typical health event?

The young adult population has often been a key target for enrollment in the individual market. Greater enrollment of young, healthy individuals could help improve the actuarial risk pool and bring down average premium costs. However, enrollment within this population has been slow to grow over the initial years of the exchanges. In 2017, 27 percent of enrollees in the exchanges are ages 18 to 34, which is slightly lower than 2016 (28 percent).[33]

While the new administration's policies are directed at all insurance markets, they may help to make HSAs a more attractive option in the individual market. Furthermore, other legislation that changes the rules around when health plans can be paired with an HSA could spark additional interest in these plans.

Assuming that many of these policies successfully move forward, we set out to assess how individuals would fare under different rules. Namely, we sought to understand what OOP costs young consumers would face under these new rules and to understand how much money they would need to set aside in an HSA to cover health care costs they might face in a given year.

To do this, we looked at the plan designs of the cheapest silver- and bronze-level plans in five markets operating federal exchanges. (See appendix for more on the methodology.) We calculated the amount an individual would need to have in an HSA to pay for the average outpatient hospital visit. In the five markets we examined, a 27-year-old would need to have between $3,617 and $6,572 in their HSA to cover the cost of an outpatient hospital visit. (See Figure 4.)

Figure 4. The average 27-year-old exchange enrollee would need between $3,617 and $6,572 in their HSA to cover the cost of an average outpatient visit in the five markets examined

Metropolitan statistical area (number of services per 1,000 people)	Amount needed in an HSA to cover average cost of an outpatient visit	
Anchorage, AK (80.6)	Cheapest bronze-level HMO plan	$4,228
	Cheapest silver-level HMO plan	$4,100
Atlanta, GA (61.1)	Cheapest bronze-level HMO plan	$3,905
	Cheapest silver-level HMO plan	$3,905
Dallas, TX (65.3)	Cheapest bronze-level HMO plan	$6,455
	Cheapest silver-level HMO plan	$3,617
Indianapolis, IN (72.4)	Cheapest bronze-level HMO plan	$5,405
	Cheapest silver-level HMO plan	$5,405
Raleigh, NC (45.3)	Cheapest bronze-level HMO plan	$6,572
	Cheapest silver-level HMO plan	$4,411

Source: Deloitte analysis of CMS 2017 QHP Landscape Individual Market Medical data and Truven MarketScan data on costs for the average 27-year-old by metropolitan statistical area

What does this mean for health plans in the individual market?

More regulatory flexibility and a merged individual market may lead to HSA growth

The new administration has made it a priority to enhance the use of HSAs across the different health insurance markets, including the individual market.[34] The AHCA's policies are evidence of some of the ways that the administration and Congress plan to do that. Moreover, the AHCA could remove one of the main reasons why individuals enroll in an on-exchange product versus an off-exchange one: the ability to use premium tax subsidies on either product. These factors combined could create more opportunity for expansion of HSAs in the individual market. However, discrepancies between how the IRS and ACA define and treat HDHPs may need to be resolved first.

Many consumers need education and tools to utilize HSAs properly

Evidence from the group market and Medicaid experiments has shown that enrollees can become educated consumers of health care services if they are exposed to the cost of care and must spend their own money first. However, these programs also have proven how valuable information and tools can be for consumers. Both employers and Medicaid programs have often seen that consumers need high-touch strategies to understand how HSA arrangements work and how to use them once they're enrolled. Health plans interested in expanding HSA enrollment may need to consider reviewing current or adding new strategies to educate and prepare their members.

Evidence suggests that certain segments of the population (e.g., younger consumers and lower-income individuals) have more difficulty putting money into an HSA. Financial services organizations that help administer HSA accounts may be valuable partners to help consumers understand the merits of putting this money aside.

Providers may need better tools to hold conversations with consumers who are responsible for managing the costs of their care

Health care providers may need support from health plans as HSAs increase in popularity. Evidence from Deloitte's *2016 Survey of US Health Care Consumers* shows that many consumers turn first to their physician for advice about treatment and services. Health plans that educate their network physicians about available online tools and cost estimators can aid provider-patient conversations about using these tools to manage the cost of care.

Evidence from Medicaid health accounts suggests that HSAs may be effective in lower-income populations but these individuals face barriers that most employer-sponsored consumers do not face

Medicaid experiments with health accounts have shown that many low-income individuals can effectively use these arrangements. However, many face barriers that are uncommon in the group market. For example, many lower-income individuals lack internet access, making it difficult for them to check account balances or use a portal-based cost estimator. Health plans looking to grow HSA use in the individual market may need to pay more attention to the impact of social determinants of health—not only to understand the different health issues this population faces but also what might deter them from becoming more informed, cost-sensitive health care consumers.

Health plans interested in expanding HSA enrollment may need to consider reviewing current or adding new strategies to educate and prepare their members.

Appendix: Methodology for HSA balance requirements

To determine how much the average 27-year-old would need to have in an HSA to cover the cost of a typical health event, we looked at plan designs across five markets that operate in the federal exchanges. We considered the following to estimate these figures:

- **Premium:** In each market, we focused on the silver- and bronze-level plans with the lowest premiums.
- **Deductible:** We determined the deductible that the health plan requires individuals to meet before paying for services.
- **OOP max:** We identified the maximum amount that consumers must pay (including deductible, copay, and coinsurance spending) before the health plan is responsible for 100 percent of the costs.
- **Average cost of outpatient visit:** Using Truven MarketScan data, we calculated the average cost for an outpatient hospital visit for a 27-year-old in the target markets.
- **Coinsurance:** We determined the coinsurance that each plan charges individuals after they reach their deductible but before they reach the OOP maximum. We only considered plans whose coinsurance amounts were equal for the physician and the facility to simplify the calculation.

The AHCA also includes several policies that could impact individual market consumers' OOP expenses. We assumed the following policy changes would occur:

- **Repealing the cost-sharing reduction payments:** The ACA allows people with incomes up to 250 percent of the FPL to receive help covering their OOP costs. The AHCA would repeal this provision starting in 2020. Approximately seven million people on the exchanges (58 percent of all enrollees) qualify for cost-sharing reductions in 2017.[35]
- **Repealing the actuarial value (AV) requirements:** The ACA requires health plans to sell plans that meet certain cost-sharing requirements. For example, a bronze-level plan with an AV of 60 percent means that the enrollee is responsible for approximately 40 percent of the costs. The AHCA would repeal this requirement, so health plans would be permitted to sell plans with AVs lower than 60 percent or higher than 90 percent (the current platinum-level plan). However, it would keep the maximum OOP limit ($7,150 in 2017) in place, so health plans would not be permitted to sell plans less generous than a catastrophic plan.[36]

		Deductible	Out-of-pocket maximum	Average cost of an outpatient visit	Outpatient coinsurance	Amount needed in an HSA to cover average cost for an outpatient visit
Anchorage,AK	Cheapest bronze-level HMO plan	$5,250	$6,500	$4,228	30%	$4,228
	Cheapest silver-level HMO plan	$3,000	$4,100	$4,228	20%	$4,100
Atlanta, GA	Cheapest bronze-level HMO plan	$6,800	$6,800	$3,905	0%	$3,905
	Cheapest silver-level HMO plan	$7,050	$7,050	$3,905	0%	$3,905
Indianapolis,IN	Cheapest bronze-level HMO plan	$6,650	$7,150	$5,405	50%	$5,405
	Cheapest silver-level HMO plan	$6,150	$7,000	$5,405	15%	$5,405
Raleigh, NC	Cheapest bronze-level HMO plan	$6,400	$7,150	$6,743	50%	$6,572
	Cheapest silver-level HMO plan	$4,000	$7,150	$6,743	15%	$4,411
Dallas, TX	Cheapest bronze-level HMO plan	$6,650	$7,150	$6,455	40%	$6,455
	Cheapest silver-level HMO plan	$2,400	$7,150	$6,455	30%	$3,617

Source: Analysis of CMS 2017 QHP Landscape Individual Market Medical data and 2014 Truven MarketScan data on costs for the average 27 year old by metropolitan statistical area

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