



Turning Medicaid Beneficiaries into Purchasers of Health Care:

Critical Success Factors for Medicaid
Consumer-Directed Health Purchasing

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Introduction

When health savings accounts (HSAs) were authorized as part of the Medicare Modernization Act of 2003, new interest was sparked in consumer-directed health care purchasing. Central to the notion of an HSA is that a consumer is in control of, and at greater risk for, his or her own health care costs, which may result in more appropriate decision-making by the consumer regarding the selection and timing of health care utilization. In a commercial model, HSAs are tax-deferred accounts that allow covered individuals to purchase health care services from their account, while deferring any funds remaining in the account for future health care costs.

Many state policymakers are interested in applying the concepts of consumer-directed care to the Medicaid program, using the same logic that a more engaged and at-risk Medicaid consumer will more appropriately use health care services. Policymakers interested in this concept expect that it would result in savings in two ways: it would encourage greater use of low-cost preventive services (to avoid later, more expensive care); and it would incentivize consumers to elect lower-cost options for equivalent care (such as generic medications in place of brand-name drugs).¹

Various models are emerging. In what we will refer to in this brief as the direct services model, states would provide Medicaid beneficiaries with health spending accounts to purchase a defined set of health care services. In contrast, the insurance model would give Medicaid beneficiaries a fixed budget to purchase a health insurance product of the consumer's choosing. Some states have proposed Medicaid programs that combine the insurance model with the direct services model. This issue brief will address both approaches.

As states continue to experiment with Medicaid reform efforts and push further into uncharted territory, a continuum of approaches is likely to emerge, ranging from a limited-purpose health spending account coupled with traditional Medicaid benefits delivered through the state, to an insurance model.

Florida, South Carolina, and West Virginia are planning to implement federal Medicaid demonstration waivers that give beneficiaries consumer-directed

health accounts (see Table 1 for a summary of each state's design). These demonstrations would fundamentally alter the relationship between the states and their Medicaid beneficiaries.

Each state varies in its approach to consumer-directed health accounts. In Florida's approved plan, beneficiaries will be allotted a risk-adjusted premium for purchase of a state-approved insurance product of their choosing (an insurance model) offered by a managed care organization (MCO). This will be coupled with rewards for healthy behaviors deposited to an individual's Enhanced Benefits Account, which can be used for certain health-care related expenses (a direct services model). In South Carolina, Medicaid beneficiaries would be given a personal health account with a risk-adjusted amount for purchase of an insurance plan from among state-approved options (an insurance model). In West Virginia, the state would deposit credits to a beneficiary's Healthy Rewards Account (a direct services model) for purchase of services not included in the standard Medicaid benefit package; the state would add or deduct credits based on healthy behaviors and appropriate use of health care resources.

The appeal of Medicaid consumer-directed health accounts has moved beyond state capitals to Congress. In October 2005, Representative Mike Rogers (R-Mich.) and Senator Mike Crapo (R-Idaho) introduced a bill that would allow 10 volunteer states to pilot Medicaid Health Opportunity Accounts, which are similar to consumer-directed health accounts in that they provide Medicaid beneficiaries with a personal account to pay for health care services directly. If enacted, this legislation would simplify the federal approval process for the pilot states to test Medicaid Health Opportunity Accounts.

While Medicaid consumer-directed health accounts increasingly are viewed as a tool that might incentivize preventive care and slow the growth in state Medicaid spending, they remain untested. This issue brief will provide background on this concept and outline critical success factors that any state should consider in developing a Medicaid consumer-directed health spending account program.

Table 1: Medicaid Reforms that Include Consumer-Directed Health Purchasing

<p>Florida</p>	<p>Florida’s Section 1115 Medicaid demonstration waiver was approved by the U.S. Department of Health and Human Services (HHS) on October 19, 2005. In this demonstration, which was approved by the Florida Legislature and is now to be implemented, Medicaid beneficiaries will be assigned a risk-adjusted premium, based on their health status and historic use of services. With this premium, the beneficiaries will purchase coverage from state-approved managed care plans. The state will regulate plans to ensure actuarial equivalency among the plans and sufficiency of benefits; many different benefit and cost-sharing arrangements may emerge in the different products offered to Medicaid beneficiaries by the insurance plans.</p> <p>A “Choice Counselor” will advise beneficiaries in choosing a plan. In each plan, there will be a comprehensive care component, in which the insurer assumes the risk, and a catastrophic care component, in which the insurer may choose whether or not to assume the risk in accordance with criteria established by the state. The state will establish an overall maximum benefit for all recipients except children under age 21 and pregnant women. Beneficiaries may “opt out” of a Medicaid-approved plan and use their allocation to purchase insurance through their employer. Beneficiaries will also be given an Enhanced Benefits Account, in which the state will deposit funds to reward healthy behaviors, such as weight management, smoking cessation, and diabetes management. These funds could be used for health care related expenses.</p> <p>Initially, the program will be mandatory for Temporary Assistance for Needy Families (TANF) and Aged and Disabled eligibility groups. Current income and asset limits for enrollment will apply. The program will be phased in by county, beginning with Broward (Ft. Lauderdale) and Duval (Jacksonville). The state will establish a low-income pool to provide direct payments to safety-net providers to subsidize care to the uninsured. Growth in state Medicaid expenditures will be tied to growth in state revenues rather than historic growth in Medicaid, thereby both constraining the growth of the Medicaid budget and making it more predictable.^a</p>
<p>South Carolina</p>	<p>South Carolina has also submitted an application to HHS for a Section 1115 research and demonstration waiver. Under South Carolina Medicaid Choice, beneficiaries would be given a Personal Health Account (PHA) funded with a risk-adjusted, actuarially determined amount for purchase of an insurance plan from among options approved by the state. Enrollment counselors would assist beneficiaries in choosing a plan. Choices would include: 1) self-directed care, in which the beneficiary purchases a limited major medical benefits plan and uses the balance of funds for fee-for-service purchases; 2) private insurance, in which the beneficiary purchases a more comprehensive health insurance plan; and 3) medical home networks (MHNs), where, in exchange for the entire premium, the beneficiary chooses a primary care physician and receives standard Medicaid services for which participating providers are paid Medicaid rates. Beneficiaries may also “opt out” and use their premium to purchase employer-sponsored insurance.^b</p>
<p>West Virginia</p>	<p>West Virginia’s Medicaid Redesign proposal was submitted to HHS on November 7, 2005. Healthy Rewards Accounts are a key component of this reform plan. These accounts would provide incentives for Medicaid beneficiaries to make healthy decisions and use health care services appropriately. The state has modeled the Healthy Rewards Accounts after consumer-directed health plans in the private sector, but without the high-deductible health plans, which the state acknowledges would not be appropriate for the Medicaid population. The state would deposit credits to beneficiaries’ Healthy Rewards Accounts which could be used for copayments or the purchase of services not included in the standard Medicaid benefit package. The state would add credits to an individual’s account based on the individual’s healthy behaviors (e.g., prenatal care; well-child checkups and vaccinations; cardiovascular, asthma, and diabetes care) and deduct credits based on inappropriate use of services (e.g., non-emergent use of emergency services, missed medical appointments, non-compliance with the preferred drug list, smoking). Credits may be used by the beneficiary to pay the higher copayments included in the reform design, as well as purchase other services not typically covered by Medicaid, such as enrollment in weight loss and smoking cessation programs. West Virginia would establish Healthy Rewards Accounts for “all Medicaid members who have the ability and capability to partner in their personal health decisions.”^c</p>

Note: Current as of December 15, 2005.

a State of Florida, Agency for Health Care Administration, “Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver.” October 19, 2005.

b South Carolina Department of Health & Human Services, “South Carolina Medicaid Choice: An 1115 Demonstration Waiver Proposal,” July 15, 2005.

c West Virginia Department of Health and Human Resources, “Medicaid Redesign Proposal: Joe Manchin III, Governor,” November 7, 2005.

Background: The Concept

Defining the Concept: Medicaid Consumer-Directed Health Purchasing

In states presently considering Medicaid consumer-directed health purchasing, these Medicaid reforms are seen as a natural extension of three movements: 1) Medicaid reforms aimed at containing the growth in Medicaid expenditures by adopting a budget model with a predictable monthly allocation per beneficiary; 2) an incentive system designed to encourage beneficiaries to use preventive services (for fear of incurring significant out-of-pocket costs for otherwise avoidable health problems); and 3) a philosophical shift toward a form of “personal responsibility” related to the rise of the “ownership society.”² Moreover, these Medicaid reforms mirror developments in the private health insurance market where, faced with health insurance premiums rising at more than two-and-a-half times inflation,³ more and more U.S. companies are offering defined-contribution health insurance products.⁴

In a defined-contribution health plan, the third-party payer (the employer or Medicaid) contributes a specified dollar amount to an account for each covered individual, and the individual assumes responsibility for purchasing health insurance or paying for health care services directly. This contrasts with a defined-benefit health plan, in which a third-party payer (the employer or Medicaid) agrees to pay for specific health care benefits. Traditional Medicaid is a defined-benefit plan.

Consumer-directed health plans are a form of defined-contribution plan that often combines a high-deductible health insurance plan with a tax-advantaged account that can be used to pay for eligible medical expenses. HSAs, authorized by the Medicare Modernization Act of 2003, can be established either by an individual or an employer and must be coupled with a high-deductible health plan (an annual deductible of at least \$1,000 for an individual or \$2,000 for a family). The individual owns and controls the funds in the account.⁵ The Medicaid consumer-directed benefit designs build on the same concepts as the HSA, but because they serve a low-income population they do not have the same tax incentives and limit cost-sharing requirements.

As currently conceived, Medicaid consumer-directed health accounts can be classified into two basic approaches: the direct services model and the insurance model. But these approaches could be combined in a state’s Medicaid reform plan (as they are in Florida), and the basic models will evolve further as states experiment with new designs.

- ◆ **Direct services model:** The state would fund a health spending account for each Medicaid beneficiary. The funds could be spent by the beneficiary for purposes established by the state. In more targeted models, the funds would be set aside to encourage beneficiaries to pursue healthy behaviors, such as completion of smoking cessation, weight loss, and other programs. In more comprehensive models, the funds would be intended for direct payment of deductibles, copayments, and/or purchase of health care services. Expenditures from the account would be controlled by the beneficiary and, in some cases, the beneficiary could access remaining funds for a specified period of time after loss of Medicaid eligibility.
- ◆ **Insurance model:** The state would allot each Medicaid beneficiary a premium amount to purchase a state-approved insurance product or insurance available through the beneficiary’s employer. The premium may be risk-adjusted to account for the different utilization of high-cost enrollees. The beneficiary would exercise control over the choice of the insurance plan, weighing the advantages and disadvantages of different products with varying benefits, cost sharing, and provider network designs. Unlike the direct services model, the beneficiary would not purchase individual services directly from the providers of those services, but would join an insurance pool where the insurance company acts as a risk-bearing entity and intermediary with providers on behalf of many beneficiaries. The insurance model could possibly differ from current Medicaid managed care models in two important ways: beneficiaries may not be guaranteed access to a specified benefit package, or benefits could be capped as in some commercial products.

Medicaid Typically Operates as a Traditional Third-Party Payer

Absent a Section 1115 demonstration waiver, a state must operate its Medicaid program under a traditional third-party payer insurance model. In this defined-benefit model, three parties are involved: 1) the beneficiary/patient, who receives the service; 2) the provider, who delivers the service; and 3) Medicaid, which pays for the service.

Related Medicaid Reform: Cash & Counseling Demonstrations

The concept of consumer direction is not completely new to Medicaid. The Cash & Counseling demonstrations in Medicaid long-term care provided consumers a cash account to manage their use of attendant care services. While the demonstrations serve as a model for consumer-directed Medicaid benefit designs, there are important differences to the models currently being proposed.

Initially funded as pilots by The Robert Wood Johnson Foundation, Cash & Counseling programs began operating in Arkansas in 1998, in New Jersey in 1999, and in Florida in 2000. These programs, which required federal Section 1115 waivers to proceed, resemble consumer-directed health accounts. In the Cash & Counseling demonstrations, a person who is both eligible for Medicaid and in need of nursing facility-level services is able to receive a monthly cash allocation from the state Medicaid agency. This cash allocation is calculated by determining how many hours of attendant care the person would need to safely remain in a community-based setting, and then multiplying the number of hours by the hourly rate the state would have paid for attendant care services, were the state to have paid a provider directly. The beneficiary receives this cash, along with counseling arranged by the state on how to hire, fire, schedule, and manage his/her own caregivers, and the beneficiary then is free to use the budget and arrange for his/her own care. All Medicaid services other than attendant care remain in a traditional third-party payer model. Evaluations of the Cash & Counseling demonstrations have shown positive results.^a

These demonstrations are analogous to Medicaid consumer-directed health accounts. They provide the beneficiary with control of the funds to manage his/her own care and to select and pay providers without any role in the beneficiary-provider relationship for the state. However, in at least one crucial way, Cash & Counseling demonstrations are more modest than the consumer-directed health account proposals now being considered. Because the budgets in Cash & Counseling models are developed for only one benefit (attendant care) based on a fairly predictable number of hours that the beneficiary will require that service (according to an approved care plan), the degree of financial risk to the state and the beneficiary in setting an individual's budget is reduced. That is, on a purely actuarial basis, there are fewer moving parts in a Cash & Counseling model to take into account in developing an individual's budget, and it reduces the risk to the state that the individual's budget will be excessive or the risk to the individual that the budget will be insufficient.

In traditional Medicaid, once beneficiaries become eligible for the program, they are entitled to all of the medically necessary benefits covered under the state's approved Medicaid plan, many of which are required by federal law. With certain important exceptions, a state may define the amount, duration, and scope of a benefit—limiting prescriptions to five a month for adults, for example—but a state then must deliver all of the covered benefits to the Medicaid beneficiaries who need them, without regard to any pre-established budget.

Under this traditional third-party payer model, the state Medicaid agency contracts with eligible providers who are willing to serve beneficiaries under the state's Medicaid fee schedule, and the state Medicaid agency exercises direct oversight with respect to provider performance measures (quality assurance, fraud and abuse prevention, and many others). The state Medicaid agency receives provider claims for payment, reviews those claims to determine whether they are appropriate, and pays the claims. Beneficiaries do not manage any of the funding associated with their care, other than occasional (and nominal) cost sharing that may be imposed by a given state. For example, some states require adults to pay \$3 for prescriptions, which is the maximum copayment allowed under federal law.⁶

Even when a state implements a Medicaid managed care program, it adheres to the structure of a traditional defined benefit third-party payer model. For example, the state contracts with MCOs to deliver covered benefits to a covered population for a capitated payment. The MCOs then are obligated to deliver all of the covered benefits (where medically necessary) without regard to the capitation amount the MCO receives for the beneficiary. In this instance, the MCOs bear the financial risk associated with the beneficiaries' utilization levels, and they must deliver the defined benefits covered within the scope of their contracts. The MCOs then contract with and pay providers, and the beneficiary again does not manage any of the costs associated with his/her care. Thus the fundamental structure of a defined-benefit third-party payer model remains.

^a Phillips, B. et al. "Moving to Independent Choices: The Implementation of the Cash & Counseling Demonstration in Arkansas," Mathematica Policy Research Inc., May 2002; Phillips, B. et al. "Lessons from the Implementation of Cash & Counseling in Arkansas, Florida, and New Jersey," Mathematica Policy Research, June 2003; Phillips B. et al. "Enabling Personal Preference: The Implementation of the Cash & Counseling Demonstration in New Jersey," Mathematica Policy Research, March 2003; Phillips, B. et al. "Changing to Consumer-Directed Care: The Implementation of the Cash & Counseling Demonstration in Florida," Mathematica Policy Research Inc., July 2004.

Critical Success Factors for States

States continue to be innovators and some are likely to move ahead with these new benefit designs. In planning and implementing Medicaid consumer-directed health purchasing programs, states should take four critical success factors into account. Table 2 summarizes the critical success factors and indicates the relevance of each one to the insurance model and the direct services model for Medicaid consumer-directed health accounts.

Critical Success Factor 1: Protect Access to Care

For any of these reforms to be successful, a state must protect access to care. As discussed below, this involves a number of issues. States should consider risk-adjusting individual accounts, carving out certain Medicaid benefits, and monitoring the impact of out-of-pocket expenditures on utilization of care. States should also provide beneficiaries with clear guidelines for use of individual accounts, develop ways to ensure the viability of safety-net providers, and protect individuals against eroding purchasing power.

Risk Adjustment in Setting Level of Accounts

Medicaid beneficiaries are not a homogeneous group; certain distinctions among them may help to predict whether a given beneficiary will use more or less than the average amount of health care services. These variables may include the person's category of eligibility, age, gender, diagnoses, region in the state, and/or other variables.

In developing an insurance model Medicaid consumer-directed health program, or a comprehensive direct services model that includes extensive health care benefits, a state should carefully analyze the use and expenditure patterns among the Medicaid beneficiaries who would be enrolled in such a program, and should risk-adjust the allocations to reflect the individual's level of need. As a result, a person who is likely to need twice the average amount of services should receive a monthly allocation that is twice the average amount. In its approved waiver, for example, Florida has committed to consider-

ing health status and historic use of health care services in assigning premium amounts to Medicaid beneficiaries.

This is not an easy task. The risk-adjustment methodologies developed to date are designed to account for the different enrollment experiences of MCOs, paying them more when they enroll people who are likely to be more costly than others. The MCO is able to pool the risk across all of its beneficiaries. The vast majority of Medicaid managed care programs still use fairly crude forms of risk adjustment in setting capitation rates for MCOs because of a lack of data and analytic resources. The most sophisticated methodologies still explain only about 20 percent of the variability of cost within a rating category. The current methodologies, therefore, are not sufficient to assign individual-level risk scores to individually tailor the allocations to a consumer-directed health account.

For instance, a state capitated managed care program is likely to have a single rating category such as one rate cell for men who are in a disability category of eligibility and are between the ages of 21–39. In this rate cell the state may pay \$600 per member per month (PMPM). Two men may be covered within this category yet have far different predicted needs for health care. One might have diabetes that is being managed, and the cost of his care might be less than \$200 per month. Another might have severe disabilities, and his care might cost \$1,000 per month. In a capitated managed care model, the fact that an MCO is receiving the same \$600 PMPM for these two men is not necessarily a problem; they are members of the same risk pool, and the MCO can shift funds within the risk pool to address their varying needs.

The current risk adjustment systems are better adapted to the insurance model of consumer-directed health program than they are to a comprehensive direct services model, due to the insurance pooling of risk within groups. Yet even in the insurance model there is a risk that, if allowed to do so, MCOs will

Table 2: Medicaid Consumer-Directed Health Accounts: Critical Success Factors for the Insurance Model vs. the Direct Services Model

	Insurance Model	Direct Services Model
Critical Success Factor 1: Protect Access to Care		
Risk Adjustment in Setting Level of Accounts	√	√
Identification of Carve-Outs	√	√
Access in the Event of a Possible Erosion in Purchasing Power	√	√
Monitor Out-of-Pocket Expenditures and Changes in Utilization Patterns		√
Use of Account Funds		√
Safety-Net Providers: Effect on Access for the Uninsured	√	√
Critical Success Factor 2: Develop Policies that Anticipate How Consumer-Directed Health Accounts Will Affect the Behavior of Insurers, Providers, and Employers		
Insurers	√	
Providers	√	√
Employers	√	√
Critical Success Factor 3: Reformulate the Roles of State Agencies		
Insurance Superintendent and Provider Boards	√	√
Medicaid Agency	√	√
State Budget Agency	√	√
Critical Success Factor 4: Develop and Implement New “Risk Management” Approaches	√	√

“cherry pick” enrollees whose monthly allocation exceeds his/her expected utilization, such as the adult male with diabetes in the example above. This form of cherry picking could create access problems for people whose predicted needs (at an individual level) exceed the allocations set for him/her under current risk-adjustment models. The potential for this form of cherry-picking distinguishes the

insurance model from traditional Medicaid managed care. Unlike traditional Medicaid managed care where an MCO must accept all enrollees who choose or are assigned to it, the insurance model may allow underwriting practices that permit an MCO to exclude a potential enrollee whose capitation is inadequate given his/her individual-level risk.

Therefore, to adequately risk adjust Medicaid consumer-directed health accounts, better forms of risk adjustment will be necessary to “size” the accounts of different individuals, and the risk profile of beneficiaries should be updated on a frequent basis to ensure that the individual’s account is adjusted as his/her risk characteristics and diagnoses change. Even then, consideration of a stop-loss arrangement may be appropriate to protect high-cost beneficiaries whose needs are unpredictable. Otherwise, a Medicaid consumer-directed health program might allocate \$600 to each man in the example above, mirroring the managed care model, and this method might deny crucial access to the high-cost man. However, stop-loss will not protect against an unexpected windfall for the low-cost man.

Identification of Carve-Outs

States should consider carving certain benefits out of the Medicaid consumer-directed health purchasing program—that is, leaving these benefits in a traditional Medicaid third-party payer model. Benefit carve-outs should be considered under both the insurance model and the direct services model. (The more-limited forms of direct services accounts essentially “carve out” most health care services from inclusion in the accounts.) In general, whether a benefit should be carved out depends on two issues.

First, benefits for which it is especially difficult to predict a given person’s utilization may be appropriate for a carve-out. These benefits may include certain specialty benefits in Medicaid, such as services for children with special health care needs or adults with serious mental illness. For example, in the Cash & Counseling demonstrations, only the financial value of the attendant care benefit is included in the allocation, while the beneficiary’s other Medicaid benefits remain in a traditional Medicaid third-party payer model. This distinction exists in Cash & Counseling because personal attendant services are predictable and the separation ensures that beneficiaries are not at risk of being inadequately funded for other Medicaid services for which utilization levels are difficult to predict.

Second, some benefits in the Medicaid program are not generally offered in commercial insurance products and may be good candidates for

a carve-out.⁷ These benefits include long-term nursing facility care, special education services for children, certain case management and other services for children in foster care, and many others. Without a competitive market where providers’ prices are constrained by the presence of other powerful purchasers, a Medicaid beneficiary may not have a market reference price to enable him/her to buy these services at competitive rates.

Access in the Event of a Possible Erosion in Purchasing Power

In order to protect access to needed services, states must ensure that a beneficiary’s purchasing power does not erode too much over time. To do so, a state must calculate the appropriate trend (or inflation rate) to be applied to Medicaid consumer-directed health accounts each year. To protect access, this trend should be tied to appropriate health care indices, rather than inflation factors that fail to reflect the increasing cost of health care (such as the consumer price index [CPI] or the growth in state revenue). Should the trend be keyed to factors that are consistently below the rate of health inflation such as CPI, a beneficiary’s purchasing value would erode over time, which would jeopardize his/her access to care. The dilemma for state policymakers is that one of the goals of the Medicaid consumer-directed program may be to contain Medicaid cost growth to a level lower than health care inflation; this may mean that a beneficiary will be able to buy less over time.

Another way that a Medicaid beneficiary’s purchasing power would erode is if the amount the state provides to the individual’s Medicaid consumer-directed health account is based on the person’s historic Medicaid costs, which in turn are based on services purchased under the Medicaid fee schedule. The Medicaid fee schedule is set by individual states, but typically is much lower than either the Medicare or commercial fee schedules. Under a version of the direct services model that includes health care services in the account, a beneficiary may have to purchase in the private market those services included in his/her account at the generally higher fee schedules in the private market. In the insurance model, individuals may have to purchase commercial insurance

products at market-rate premiums that are premised on an underlying higher commercial fee schedule between the MCO and its provider network.

Monitor Out-of-Pocket Expenditures and Changes in Utilization Patterns

Under the direct services model, beneficiaries may be expected to pay out-of-pocket for covered services that exceed the amount of the person's allocation. This is intended to motivate beneficiaries to pursue less expensive preventive services, rather than risk high-cost services later. Some states are considering ways to enhance consumer purchasing power to reward healthy behaviors.

There is a delicate balance between cost sharing and access to care. The RAND Health Insurance Experiment, considered by many to be the definitive study in this area, demonstrated the relationship between increased cost sharing and reduced utilization.⁸

One of the fundamental unknowns regarding Medicaid consumer-directed health accounts and particularly the direct services model is how the new financial incentives will drive beneficiaries' utilization decisions. The incentives may have positive effects on utilization if they motivate beneficiaries to pursue lower-cost preventive care and healthy lifestyles, or they may have negative effects if Medicaid beneficiaries forgo necessary and appropriate services for fear of exhausting their accounts. Either way, establishing timely mechanisms to monitor changes in utilization will be critical to ensure that access is being preserved.

Use of Account Funds

Under the direct services model, states must consider what services an individual will be permitted to purchase from his/her consumer-directed health account, which may be affected by how the account is funded. For example, West Virginia is considering, but has not committed to, allowing the use of funds for a health club membership. Many states are promoting prevention and link consumer-directed

accounts to policies designed to encourage healthy lifestyles, such as smoking cessation, weight loss, and regular exercise. Some are considering rewarding people for their use of preventive services by contributing to the fund. States must consider whether use of consumer-directed health accounts is permitted to purchase non-traditional health care services as a substitute for Medicaid health care services (e.g., in a state where acupuncture is not typically covered, could a person use his/her health care budget to purchase acupuncture?). In addition, the state needs to determine whether an individual will be able to keep the funds in his/her account in the event the individual is no longer Medicaid-eligible. States will need to establish the constraints on a beneficiary's use of his/her funds, and then must determine how they will enforce these limitations.

If contributions to the accounts are based on historic Medicaid spending, they will reflect historic average utilization. For example, some beneficiaries may not have used preventive services historically; as a result, the average payment may be insufficient for some under the new plan. If contributions are based on the full range of recommended preventive care and a beneficiary is allowed to keep unexpended funds in his/her account, the state's costs will exceed historic costs.

Safety-Net Providers: Effect on Access for the Uninsured

Medicaid dollars often comprise one-third to one-half of patient care revenues in public hospitals and clinics, Federally Qualified Health Centers (FQHCs), and teaching hospitals. Medicaid's rate structure provides direct subsidies to these safety-net providers by paying them more per visit than comparable non-safety-net providers, such as private hospitals and physicians. These subsidies take several forms, such as the prospective payment system (PPS) payment structure for FQHCs, and various subsidies to public and teaching hospitals in the form of upper payment limit (UPL) payments, graduate medical education (GME), and indirect medical education (IME). The safety-net providers

use these subsidies to fulfill other parts of their missions, such as providing care for the uninsured who use these providers and delivering training to future physicians.

What is common to all these subsidies, however, is that the amount of the subsidy depends on the volume of utilization by Medicaid beneficiaries. It is possible that Medicaid consumer-directed health purchasing programs could change the utilization patterns of Medicaid beneficiaries in two important ways that may affect the financial solvency of some safety-net providers and therefore diminish access to care for the uninsured.

First, Medicaid consumer-directed health programs may move “paid” utilization away from safety-net providers such as public hospitals and FQHCs toward other hospitals and private physicians. One of the positive features of consumer-directed health accounts is the choice that will be given to Medicaid consumers, and these consumers may use their funds to secure services from non-safety-net providers. States should consider this issue and decide whether and how to address the potential loss of Medicaid funding to these providers.

With the advent of Medicaid consumer-directed programs, Medicaid beneficiaries will have the option of purchasing private insurance (the insurance model) or medical services (under a comprehensive direct services model) from private providers. Often, these private insurers and providers are less expensive than safety-net providers, because their rates do not include the subsidies used to help serve the uninsured. Therefore, a Medicaid beneficiary may shift his/her care away from safety-net providers toward lower-cost private providers. Consequently, safety-net providers are likely to experience disruptions in utilization and revenue streams. The ability to subsidize care for the under- and uninsured through cost shifting and cross-sub-

sidization of revenues from private payers probably would be compromised under a Medicaid consumer-directed health purchasing program.

To minimize these effects on safety-net providers under either the insurance model or the direct services model, states should consider developing new methods to subsidize safety-net providers. In the approved Florida waiver, for example, the Centers for Medicare and Medicaid Services (CMS) agreed to the creation of a \$1 billion annual fund (in combined state and federal dollars) to replace the UPL funds that public hospitals in Florida are projected to lose in the shift to Florida’s new program.⁹ This new indigent care fund will help to fund the missions of safety-net institutions without keying the subsidy to the volume of utilization at the safety-net hospitals, as is now the case under the upper payment limit financing system. In its waiver application, South Carolina proposes that direct subsidies to its safety-net providers be continued as well.

Safety-net providers also will need to develop new strategies to protect their institutions. In some states, safety-net institutions such as community health centers and teaching hospitals already offer MCOs of their own through affiliated provider-sponsored companies.¹⁰

Second, Medicaid consumer-directed health programs ironically may hurt safety-net providers in another way. If a Medicaid beneficiary exhausts his/her account (under the direct services model), or obtains a “thin” insurance product with limited inpatient or outpatient benefits (under the insurance model), the Medicaid beneficiary may turn to the safety-net providers for care once he/she lacks resources or coverage. In this scenario, the Medicaid beneficiary would be presenting at these providers as an uninsured person, thereby exacerbating the financial stress on these providers.

Critical Success Factor 2: Develop Policies that Anticipate How Consumer-Directed Health Accounts Will Affect the Behavior of Insurers, Providers, and Employers

Insurers

Under the insurance model, a Medicaid beneficiary uses his/her consumer-directed health account to buy insurance. Insurers may respond by developing new products specifically aimed at Medicaid beneficiaries moving into the private insurance market. They may develop new segmented plan designs with varying benefit levels, provider networks, and cost-sharing rules to target beneficiaries with varying needs, such as younger, healthier beneficiaries, persons with disabilities, HIV/AIDS patients, and elderly people with multiple chronic diseases. States like Florida that are pursuing the insurance model intend to encourage insurers to enter the market; MCOs must be prepared to offer plan designs that meet the needs of Medicaid beneficiaries whose needs vary across various subpopulations.

To accomplish this, states should:

- ◆ **Develop policies that offer insurers sufficient “covered lives” and stable medicaid enrollment**

When considering market entry and plan design, insurers/MCOs will assess the size of the market and the competitive environment, such as:

- expected enrollment;
- whether enrollment is mandatory or optional, and for what populations;
- whether the required benefit package encourages adverse selection;
- the extent to which “churning” in enrollment is expected, with its attendant administrative costs;
- how the market can be segmented to best leverage the insurer’s business strengths, the state’s rate-setting methodology, and potential economies of scale; and
- potential competitors and expected market share.

States should develop plans designed to promote stable and predictable enrollment. For example, Florida’s program will be mandatory for the TANF and Aged and Disabled eligibility groups, with other groups to be phased in over time. South Carolina would require mandatory enrollment for all Medicaid beneficiaries except those dually eligible for Medicare and Medicaid. Both designs suggest large enough pools of potential enrollees that insurers and MCOs may develop products targeted specifically at meeting the needs of Medicaid beneficiaries who would be purchasing these products.

- ◆ **Protect insurers against unpredictable risks**

An essential part of making this model work is having willing participation by insurance carriers. To make a long-term investment in a Medicaid plan design, insurers also are likely to seek a commitment that the state’s contributions to the consumer-directed health accounts will be trended annually to the cost of medical care inflation and that there is some level of risk sharing with the state in the form of a stop-loss, a state reinsurance plan, and/or a risk pool. This is especially true in the early stages of a program, where insurers/MCOs have limited experience. For example, Florida proposes that insurers assume risk for comprehensive care coverage; for catastrophic coverage, insurers may choose whether or not to assume the risk in accordance with criteria established by the state. Insurers will also want to know whether the state intends to exclude (carve out) certain populations or services, such as behavioral health or prescription drugs, that are either high-cost services or services that may affect the insurers’ ability to manage care.

In designing Medicaid consumer-directed programs and working to promote a competitive marketplace, states also should heed the lessons learned from Medicaid managed care. Since the latter half of the 1990s, multi-payer commercial MCOs have been exiting Medicaid managed care, citing inadequately funded contracts and payment rates that have not kept up with medical care cost inflation. The majority of plans remaining are Medicaid-focused—either national companies like Amerigroup, Molina, and Centene,

companies with Medicaid-focused subsidiaries like United Healthcare, or MCOs owned by safety-net hospitals and clinics.^{11,12}

◆ **Address the fact that insurers may want to leverage products across customers (Medicaid and commercial market)**

Medicaid consumer-directed programs are likely to encourage the development of new insurance products and plan designs, which may be desirable to non-Medicaid purchasers as well. For example, a low-cost basic benefit package that offers first-dollar coverage, or a form of high-deductible plan with catastrophic coverage, may appeal to self-employed individuals or small employers who cannot afford to offer employees more extensive coverage. More specifically, moving Medicaid beneficiaries into the private insurance marketplace with consumer-directed health accounts not only may have a tremendous impact on the companies and products that are available to Medicaid beneficiaries, but it also may have a large impact on others buying insurance in that market, such as individuals in high-risk pools and those who purchase individual-issue insurance products.

Moreover, employers of Medicaid-eligible, low-wage earners may choose to supplement Medicaid consumer-directed health accounts for their Medicaid-eligible employees by offering dental insurance or some other type of “wrap-around” coverage, instead of offering more expansive health insurance. Under Florida’s plan, beneficiaries can use their premium allocations to subsidize premiums for employer-sponsored insurance, so employers may seek insurance products that would meet the needs of Medicaid beneficiaries outside the Medicaid product. Customized benefit packages targeted at specialized and high-risk populations, such as HIV/AIDS patients, individuals with multiple chronic conditions, and people with physical and cognitive disabilities, may be offered by insurers/MCOs that would appeal to public and private employers. These products may be expensive, but they may be affordable if the state adopts risk-adjustment methods that result in large monthly allocations to people with disabilities.

Moving Medicaid beneficiaries with disabilities into the private insurance market, with its large, risk-adjusted allocations, also may have an effect on existing high-risk pools operated by states. The extent to which insurers can develop viable products that cut across public/private market boundaries and meet the needs of populations beyond Medicaid to amass more “covered lives” will influence their decision to enter the market.

Some insurers may integrate products for Medicaid beneficiaries with their mainstream products, and others may choose to become Medicaid-focused insurers. As states seek to maximize offerings to Medicaid beneficiaries and others, they should be cognizant of the fact that further segmentation of the broader health insurance market is likely as publicly traded corporations, local provider-sponsored companies, and Blue Cross Blue Shield organizations seek a competitive advantage and carve out their niche in the marketplace.

Over time, consolidation in local markets may occur, as plans “shake down” and one or two plans come to dominate the market. This has occurred with Medicaid managed care in many states. Market shake-down is particularly likely if the state does not adequately finance the program. As in any market environment with few sellers, this could inhibit the development of new products, service provision, pricing, and consumer satisfaction.

Finally, states must take measures to preserve “the social redistributive element of insurance” when developing Medicaid programs that empower beneficiaries to choose from among a variety of insurance products. Medicaid beneficiaries who expect to have extensive health care needs will choose more comprehensive plans with higher premiums, while individuals who expect to use less care will choose less comprehensive plans with lower premiums. Over time, beneficiaries are likely to “cluster” in one group or the other, resulting in widely disparate premiums as plans adjust premiums to account for risk.^{13,14}

Providers

A Medicaid consumer-directed health purchasing program will affect provider behavior. First, under either the insurance model or the direct services model, the movement away from a Medicaid fee-for-service fee schedule may be greeted favorably by providers, who may seek higher “commercial” fees when serving Medicaid beneficiaries who are paying for coverage or services from consumer-directed accounts. Should this occur, however, it may substantially undercut the purchasing power of a consumer-directed account that is based on the lower historic Medicaid fee schedule. Medicaid costs really have three components: 1) the benefits covered, 2) the utilization of services, and 3) the amount paid to providers. If the amount paid to providers increases, Medicaid beneficiaries will be able to buy less in benefits or use fewer services.

Second, it is likely that the pool of potential providers will be larger if more providers are willing to serve Medicaid beneficiaries based on a more commercial-like fee structure. As Medicaid develops new benefits and new benefit designs, new and different providers, previously unavailable to Medicaid beneficiaries, may emerge.

Finally, the change in revenue mix in provider offices may accrue to the benefit of other payers. One reason that commercial insurance premiums have risen steeply in recent years is that providers have demanded higher rates from commercial insurers to compensate for a growing number of Medicaid patients whose care is paid on a relatively low Medicaid fee-for-service fee schedule. Should these providers be permitted to charge Medicaid beneficiaries higher commercial rates under either the insurance model or the direct services model, there may be less cost shifting because providers may be less pressured to negotiate higher rates for employer-sponsored insurance and other commercial products.

Employers

The market is already witnessing substitution of coverage in which Medicaid-eligible, low-wage employees are turning to Medicaid for coverage because their employer either ceases to offer health insurance or the employee’s share of the premium has become prohibitively expensive. Between 2001 and 2003, a significant increase in the uninsured was forestalled by movement of the under-65 population (particularly children) to Medicaid, the State Children’s Health Insurance Program (SCHIP), and other state coverage. Enrollment in these state programs increased from 8.9 percent of the population in 2001 to 11.9 percent in 2003.¹⁵

States must develop Medicaid consumer-directed health purchasing programs that discourage employers from actively pursuing substitution of coverage by referring their employees to the state Medicaid program, as this trend is likely to continue as long as the supply of low-wage labor is abundant and companies do not have an incentive to offer workers a more comprehensive insurance package in order to retain them.

Enrollment in Medicaid consumer-directed programs will be unpredictable. On the one hand, individuals may choose not to enroll if they perceive the new program to be too complicated or the coverage too “thin.” On the other hand, Medicaid-eligible individuals and families not previously enrolled in Medicaid may “come out of the woodwork” to participate in the new benefits. This issue, described in more detail below, is one risk in Florida, with its option of allowing Medicaid beneficiaries to “opt-out” of Medicaid and buy insurance through their employers. Working-poor families who have not previously pursued public assistance may welcome the opportunity to purchase an insurance plan of their own choosing and obtain health care services from their employer without having to show a Medicaid card. States must devise policies and models to address this potential woodwork or substitution effect, especially for the insurance model.

Critical Success Factor 3: Reformulate the Role of State Agencies

Providing Medicaid clients with consumer-directed health accounts would radically transform the roles of state agencies. As states consider these programs, they should evaluate whether and how to alter the mission, staffing, and authority of various state agencies.

Insurance Superintendent and Provider Boards

In the direct services model, Medicaid beneficiaries will have new and more direct relationships with health care providers. With the insurance model, beneficiaries will be entering the commercial insurance market. States should develop policies to address issues such as:

- ◆ **Direct services model:** In a comprehensive direct services model, which has not yet been proposed in any state, health care services would be purchased from the consumer-directed account (operating like an HSA). In this model, Medicaid beneficiaries would be purchasing services directly from providers. What would constitute price gouging by providers? Who would be responsible for monitoring and enforcing proper provider behavior? Already many states are taking steps to intervene when hospitals try to collect high-priced, full-billed charges from people who are uninsured. Presumably some enforcement agency at the state would need to be empowered to address potential price gouging.

Some state agency, perhaps Medicaid, presumably would become the appropriate locus for monitoring the direct interactions between Medicaid beneficiaries and providers from whom the beneficiaries may purchase services. This role may include monitoring provider price schedules to prevent gouging, monitoring provider behavior to prevent discrimination, and responding to complaints about quality or other issues. At a minimum, states may want to consider

providing information to consumers on the price of health care services and other factors they may want to consider in selecting a provider, such as their performance on certain quality measures.

- ◆ **Insurance model:** Moving the Medicaid population into the commercial insurance world may require changes in the staffing, role, and authority of a state insurance superintendent. This is unlike the current Medicaid managed care models where the Medicaid agency directly contracts with an MCO and oversees MCO behavior through contracting and regulation. In the new emerging models, the individual beneficiary would have a direct relationship with the MCO rather than the Medicaid agency. Basic consumer protections will need to be established. For example, the state insurance superintendent will need to monitor the solvency and reserves of this new insurer and its product. The insurance superintendent also may need to provide additional ombudsman and other supports to protect beneficiaries who believe they have wrongly been denied a service and address consumer complaints. This may greatly expand the insurance superintendent's role.

The state insurance superintendent also may have other expanded roles. These roles may include approving insurance policies and rates; monitoring market performance; ensuring compliance of insurance products with state regulations (e.g., minimum benefit requirements, network adequacy, deductibles, and copayments); conducting oversight of marketing and enrollment; conducting oversight of provider relations (e.g., oversight of contractual arrangements, financial and encounter data collection, claims payment, grievances, and appeals); and monitoring access and quality of care.

Medicaid Agency

The role of the Medicaid agency also would change. This agency might retain responsibility for eligibility determinations and enrollment in Medicaid, and probably would need to retain the role of developing the risk-adjustment system to set consumer-directed health accounts amounts, and subsequently issue those allocations. In addition, the Medicaid agency would continue to be responsible for all the carve-outs and other Medicaid programs that are not bundled into the consumer-directed program, such as long-term care and programs for special populations. The Medicaid agency also might have a role in selecting the participating insurance plans and providers and approving their rates.

Also, it will be important for state Medicaid agencies to implement effective outreach and education programs to inform Medicaid beneficiaries about the state's consumer-directed program and to provide guidance on being an educated purchaser of health care insurance and services. Many beneficiaries will have limited experience in managing cash accounts. For example, a survey of Hurricane Katrina evacuees—who were predominately poor and either uninsured or enrolled in Medicaid—found that 68 percent had no bank account and 72 percent had no credit cards.¹⁶ Medicaid clients are also likely to have limited or no experience with employer-sponsored health insurance. In Oregon, parents with more education and those experienced in paying premiums for private coverage were more likely to choose to participate in the Family Health Insurance Assistance Program (FHIAP), that state's premium assistance program, which provides beneficiaries with subsidies to purchase employer-sponsored insurance or insurance available in the individual insurance market.¹⁷ This suggests that inexperience in the private market may impede participation, decision-making, and ultimately satisfaction among consumers.

State Budget Agency

On the one hand, either a direct services model or an insurance model consumer-directed health purchasing program greatly simplifies the state budgeting process by con-

verting Medicaid into a predictable defined-contribution program with known monthly allocations. On the other hand, Medicaid consumer-directed programs will complicate state budgeting in several ways, which may require state budget agencies to develop new skills and budget forecasting models.

First, depending on the design of a state's consumer-directed program, the program itself may have a large influence on how many people apply for Medicaid. For example, a generous program may induce people to apply for Medicaid when they otherwise might not. This is especially true if the beneficiaries believe they can use these resources to secure services they need that may be difficult to secure in traditional Medicaid, such as dental care.

In addition, a generous program may induce greater substitution of Medicaid for private coverage if beneficiaries believe they will have access to their existing employer-sponsored insurance or the same benefits and providers at a lower out-of-pocket cost.

This woodwork effect may influence not only potential beneficiaries but also employers. If employers perceive the Medicaid consumer-directed health accounts program as an option for low-wage employees, either as a substitute for employer-sponsored insurance or as a means for augmenting the employer's benefits, employers are likely to provide incentives for employees to enroll in Medicaid.

Of course, it might go the other way as well—consumer-directed health programs may lead to lower enrollment in Medicaid. Lower enrollment could occur if people perceive the program (and its choices) as complex, or if they believe that the individual monthly allocation is insufficient to justify the effort of applying for (or reapplying for) Medicaid. Lower enrollment also could result if Medicaid beneficiaries do not use their consumer-directed benefits and decide it is not worth the effort to reapply.

Clearly, implementing a Medicaid consumer-directed health accounts program may, by itself, affect enrollment levels in ways that the state budget office needs to predict.

Second, Medicaid consumer-directed programs may alter the mix of the Medicaid enrollment. In other words, the Medicaid program may stay at the same overall enrollment level, but skew toward healthier or sicker beneficiaries, depending on the design of the new program. Assuming the consumer-directed health accounts are risk-adjusted, this change in the mix of the Medicaid enrollment will affect the Medicaid budget. That is, to develop the annual Medicaid budget, the state must project overall enrollment as well as the risk composition of the enrolled population. These projections must be developed in the context of a potentially fluctuating change in the mix of the enrollment, which would be influenced by the perceived richness or leanness of the individual budget, the extent to which program requirements are seen as cumbersome and intrusive, and product substitution occurring with employer-sponsored insurance.

Third, the health care inflation trend developed for Medicaid consumer-directed programs may need to account for more variables than traditional Medicaid. For example, Medicaid rarely raises most provider rates; in many states, the amounts paid for physician billing codes remain unchanged for years. This may be more variable in the commercial world, where Medicaid beneficiaries would be purchasing insurance coverage or services directly from providers. Thus, added to the factors described above is the need for the state to develop reasonable yet affordable trend rates to account for premium increases, which in turn reflect provider rates, utilization, and intensity. The result is a highly complex state budgeting process with far more moving parts than states currently confront with their traditional Medicaid programs.

Finally, should a state continue to carve-out certain benefits, such as long-term care or specialty mental health, states will need to monitor whether cost shifting occurs. For example, if a Medicaid beneficiary purchases a “thin” mental health benefit package inside

an insurance product, the insurer may deny even appropriate and covered mental health services, expecting the state Medicaid agency to cover these services in a specialty mental health carve-out.

Critical Success Factor 4: Develop and Implement New “Risk Management” Approaches

The Cash & Counseling demonstrations described earlier blazed a trail to help identify some of the new liabilities states may face when they move to consumer-directed models that place more decision-making authority in the hands of Medicaid beneficiaries. The potential liabilities described below would apply in either the direct services model or the insurance model.

To mitigate their risks under a Medicaid consumer-directed health accounts program, states should develop policies that set forth the expectations of the program, and make it clear that beneficiaries are assuming certain risks based on the beneficiaries’ choices. For example, states may wish to consider developing policies to address the following situations:

- ◆ The beneficiary selects inappropriate or insufficient providers to treat his/her health care conditions (such as purchasing services from a non-accredited or “alternative” provider) and subsequently claims inadequate or substandard care;
- ◆ The beneficiary is victimized financially by fraud perpetrated by an insurer or provider on the beneficiary and wishes to be made whole by the state;
- ◆ The beneficiary mismanages his/her account, resulting in overspending his/her budget prior to release of the next monthly allocation, and wishes to have a supplemental payment made; or
- ◆ The beneficiary is sued by a provider for nonpayment and wishes to be indemnified by the state.

Conclusion

Momentum appears to be gathering to pilot various forms of consumer-directed models in Medicaid. These reforms fundamentally would alter the role of the state, the state's expectations of Medicaid beneficiaries, and the behavior of every participant in the system. Depending on their design, consumer-directed health purchasing programs would create new opportunities and risks for Medicaid beneficiaries.

Although these models are emerging from a significant philosophical shift in the agreement between a state and its Medicaid beneficiaries, the operational success of a consumer-directed program will depend on how well a state executes its plans. This, in turn, is dependent on how well a state identifies and meets the critical success factors of protecting access to care; anticipating the behavioral changes of insurers, providers, and employers; reformulating the roles of multiple state agencies; and developing new approaches to state risk management.

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