

Medicaid: Creative Improvements from the Field

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“Consumer-Driven Medicaid”
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The Medicaid program provides a much needed health insurance safety net for 52 million of our nation’s poor and medically needy¹; but its price tag threatens the financial stability of states—growing 9.5% in 2004 alone², far in excess of revenues. In South Carolina, for example, in 2004, Medicaid consumed 19% of the General Fund, or \$4 billion.³

Fiscally responsible state Governors and Legislatures who decline to raise taxes and, instead, attempt to control these costs, face three choices: cut Medicaid expenses through reductions in enrollment, benefits, and provider reimbursement; cut other state expenditures, such as those for education roads; or try a new approach. Tennessee’s Governor, for example, proposed to cut 300,000 recipients;⁴ but South Carolina’s Governor, Mark Sanford, opted for the third path. His plan gives Medicaid enrollees a choice: every recipient would obtain catastrophic and preventive coverage and a personal health account (PHA). Enrollees can use their PHA funds to pay for a consumer-driven option of a traditional Medicaid hospital insurance and any doctor they chose; a managed

care policy and its deductibles and copayment; a network group of local physicians; or, if employed, to pay their share of employer-provided insurance.⁵

Because South Carolina's plan is likely to become a national model if adopted, it has drawn the attention of Washington, DC-based policy analysts who question the concept of choice in Medicaid and the consumer-driven option.⁶ In this testimony, I will respond to both criticisms.

Choice of Health Insurance Policies

A wide choice of goods and services is the hallmark of most developed economies. Choice not only fulfills consumers' needs for products with different qualities but also creates that competition which is the key to productivity.

Most Americans want a choice of health insurance plans⁷, but South Carolina's Medicaid recipients currently have virtually no choice: no physician networks organized to treat those with special needs—for example, those with AIDS or sickle cell disease; treatment limited to those physicians who take on Medicaid enrollees; and little managed care.

Although the Governor's plan will give enrollees this kind of choice, some critics view it as wasteful. Because Medicaid's costs are already lower than those of private plans⁸, they ask "What is the point of the transformation?"

But Medicaid's "low costs" come at participants' expense. "Low costs" are achieved primarily by paying service providers only 65% of what they receive for treating the state's employees.⁹ As a result, 30% of all physicians refuse to accept any new Medicaid enrollees and enrollees experienced much more difficulty in scheduling

visits for follow-up care than those with other types of insurance.¹⁰ Medicaid recipients have more unmet needs than similar adults with private insurance.¹¹

A majority of the U.S. public attributes Medicaid's growing costs to poor management.¹² For example, drugs represent the fastest growing component of Medicaid costs (35.4% growth 2000-2003)¹³, in part because Medicaid pays off the "sticker price," which is substantially higher than acquisition costs.¹⁴ Opening the market to managed care insurers and consumer-driven plans may well alter this situation through the pharmaceutical benefit managers, PBMs, employed by managed care plans, and tiered-payment pharmaceutical benefits plans. In a Medicaid context, these plans might charge zero for a generic drug and a \$3 co-pay for a branded one. In the private sector, PBMs and tiered policies have caused generic drugs to represent over 50% of all prescriptions and have become the fastest growing component of the pharmaceutical sector.¹⁵ Managed care can more readily achieve the benefits of the "pay-for-performance" movement too. For example, some plans achieved significant improvement in asthma care and diabetic testing.¹⁶

Critics also note that the planned allowance, based on the *average* cost of a person in a risk category, may not be adequate for the health care needs of the very sick in that category (and they may be excessively generous for those who are less sick than the average). In the consumer-driven Swiss system, this issue is managed by retroactive risk-adjustment of insurers: those who received unduly low payments because they enrolled the sick are compensated by funds removed from those who received unduly high reimbursement. A similar system could be devised in the state.¹⁷

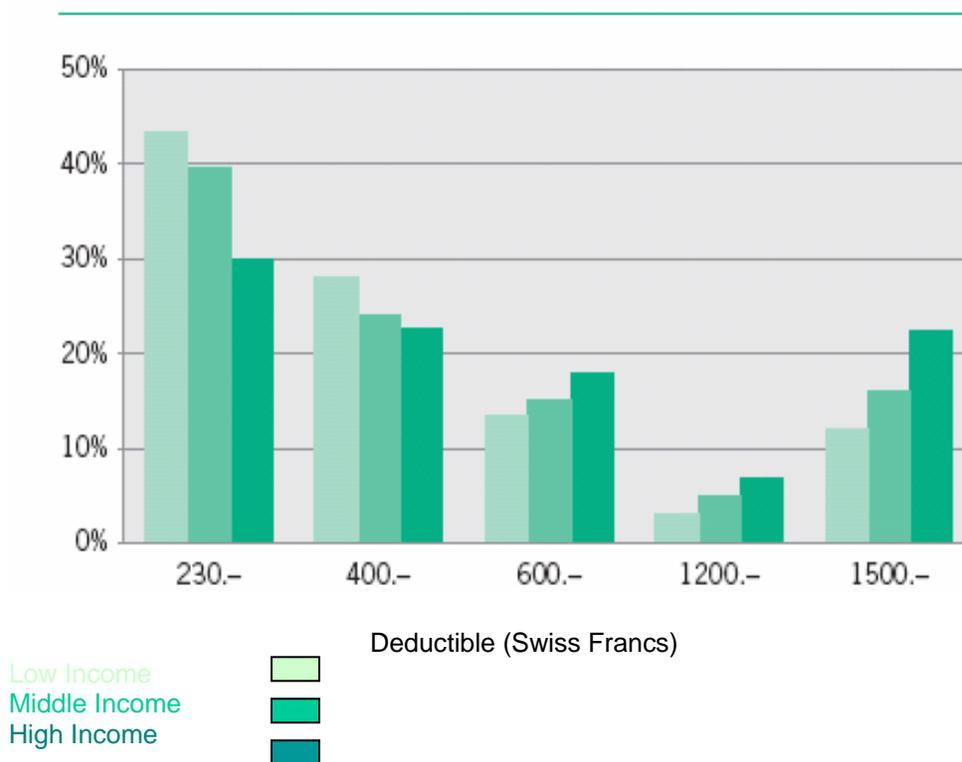
Last, critics of the Governor's plan contend that choice cannot materialize in a South Carolina market characterized by low managed care presence. But when Georgia requested bids for Medicaid managed care, ten firms responded.¹⁸ Similarly, Ohio's conference for potential Medicaid managed care vendors drew nine new managed care firms, including well-established Goliaths such as Aetna, United Health and Anthem.¹⁹

Consumer-Driven Plans

Those who worry about giving Medicaid participants choice are especially concerned about the consumer-driven option. They contend that Medicaid enrollees are too poorly educated and lack access to sources of information like the Internet.²⁰

These critics may well believe that Medicaid recipients will overwhelmingly choose the consumer-driven options; but when consumer-driven plans are offered along with other health insurance choices, they are not necessarily the most popular. A 2005 Kaiser family survey found that when enrollees were offered other insurance plans, only about 7% - 15% chose consumer-driven ones.²¹ Industry experts estimate the percentages at 3% - 16% for HSAs²² and 25% for HRAs, consumer-driven options usually offered by employers.²³ In Switzerland, which has had a century-old consumer-driven system, low-income people typically choose health care plans that offered the lowest deductible (see table below).

Choice of Insurance Policies by Income Categories



Insurance Policies Prices: high-deductible (230.- CHF), low-deductible (1500.- CHF).

Source: Bundesamt für Statistik (BFS), Schweizerische Gesundheitsbefragung 2002, Neuchâtel, Switzerland, 2003.

Nevertheless, can those who are not well-educated use consumer-driven plans to advantage?

The experiences of the disabled who opted for government-based “Cash and Counseling” programs indicate that they derived greatly enhanced satisfaction, while controlling costs, although many of the participants were intellectually impaired.²⁴ (Although the disabled and elderly represent only 25% of Medicaid’s enrollees, they account for 69% of its costs, so their experiences with consumer-driven plans are of considerable importance²⁵). Cash and counseling typically features a monthly allowance, based on the consumer’s needs, that can be used to hire assistants, including family

workers, and to purchase other resources. Enrollees must develop spending plans with the assistance of counselors.

Participants substantially increased their satisfaction and unmet needs and controlled costs.²⁶ In Arkansas, they reduced caregiver neglect by 58% and attained slightly better health outcomes, while costs for long-term care and hospitalization decreased.²⁷ As one program participant noted: “I’m . . . not . . . under anyone’s thumb.”²⁸ (Cash and Counseling enrollees were primarily non-elderly.²⁹ In interviews, African-Americans and Hispanics expressed much more interest in the program than Caucasians presumably because of their strong family and community networks.³⁰)

As for the private sector’s consumer-driven experiences with lower-income populations, Assurant, a leading provider of individual and small group health insurance, found that only 20% of Health Saving Account (HSA—a consumer-driven plan) purchasers had incomes of less than \$40,000 and net worths of less than \$25,000.³¹ Although it is not yet possible to analyze outcomes by income, the experience of Whole Foods, a supermarket chain, are instructive: as of 2004, its employees, primarily blue-collar, have saved \$14 million in health account savings and turnover plummeted; costs increased by only 3.3%.³²

The overall accomplishments of the consumer-driven plans are notable. They not only dramatically controlled cost increases but also improved the health status of those with chronic diseases. Definity Health, a provider of consumer-driven insurance policies, demonstrated a reduction in flare-ups among its diabetic and asthmatic enrollees, due to increased testing and drug utilization, while McKinsey found that consumer-driven

enrollees were more likely to “very carefully follow treatment regimens for chronic conditions.”³³

These plans appeared to have transformed how some enrollees approach their health care. By enabling participants to trade off current expenditures against long-term health status and savings, consumers’ behavior changed from I do it because “my health plan covers it” to I do it because “if I catch an issue early, I will save money in the long-run.”³⁴ Thus, 75% of the enrollees in one consumer-driven group complied with the regimen for their chronic medications as opposed to 63% those enrolled in other insurance plans with virtually no deductible.³⁵

Consumer-driven enrollees used the insurers’ information resources substantially. Although their sources are sometimes depicted as high-tech and Internet-based, much of this kind of support comes from the phone and face-to-face interactions. Large insurers are now enabling price transparency.³⁶

Consumer-driven plans increase enrollee satisfaction with both insurers and providers. A September, 2005 Blue Cross Blue Shield survey found that enrollee satisfaction levels exceeded those achieved by non-consumer-driven plans³⁷ and Swiss patients ranked its consumer-driven hospital care much higher than those in Germany, the U.K. and the U.S.³⁸

Summary

Medicaid enrollees are currently treated like second-class citizens. Some providers choose either not to see them or to treat them only after considerable delay, because of the program’s poor payment, and enrollees have little access to the managed care and no access to the consumer-driven plans available to the rest of the population.

Governor Mark Sanford's plan for the transformation of South Carolina's Medicaid program will give its enrollees the same choices and access to care as the rest of us, and promises to control costs along the way.

Let's make it happen.

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