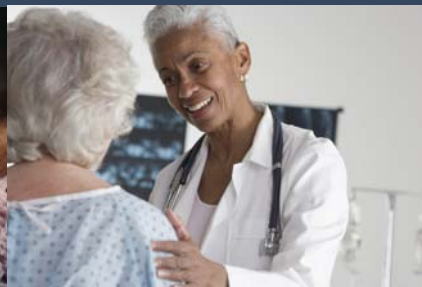


# Changing Policies to Engage Medicaid Beneficiaries in Health Care Decisions: A Review of Strategies and State Activity

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# Executive Summary

Policymakers in many states have expressed interest in changing the incentives facing Medicaid enrollees as they make decisions regarding their health care. These consumer-focused changes are motivated by dissatisfaction with the low level of patient autonomy and responsibility in the system; increased knowledge about the importance on personal behavior in determining health; and, most notably, the quest for new approaches to control rising costs. In this report, we review the use of consumer-focused initiatives in Medicaid.

- There are several reasons to engage individuals in their health and healthcare. A central reason is to reduce the likelihood of an individual over-using highly-subsidized care; this is typically addressed by imposing a cost to the patient at the point of care. Another motivation is to change habits that contribute to poor health by providing information or financial incentives to engage consumers in their health care. Last, many believe that increasing individual choices and making people more financially responsible for their decisions can stimulate competition and, in turn, improve quality and contain cost.
- The literature indicates that individuals are sensitive to the price of health services, and programs using financial incentives to engage consumers have some impact. However, responses vary by the structure of the incentive, services targeted, and characteristics of the consumer. The effects of efforts that rely on non-financial strategies—such as the provision of information—are mixed. Importantly, consumer-focused strategies may have differential impacts among low-income populations. For example, those with low incomes are more price-sensitive than others, and increased cost-sharing for poor populations is associated with higher incidence of adverse events, emergency room use, or financial hardship. Lower income individuals are less likely to be “activated” (that is, able to manage their health and health care) and also face socio-economic barriers to “activation.”
- Historically, the Medicaid program did not use consumer-focused approaches to deliver health services to enrollees. This practice reflects the significant needs and limited resources of the population covered by the program, as well as limited provider participation. Initially, policymakers needed a federal waiver to incorporate consumer incentives into Medicaid, but recent legislation has eased states’ ability to rely on these strategies.
- States vary widely in the degree to which they draw on consumer incentives in Medicaid.
  - At one end of the spectrum, most states use non-financial incentives to engage consumers. Many states are focused on enrollee education—e.g., promoting health literacy— to engage and activate Medicaid beneficiaries. Nearly all states draw on consumer choice by having beneficiaries to select from a list of managed care plans.
  - A common strategy for incorporating consumer incentives into Medicaid is to expand beneficiaries’ financial liability for service use through cost sharing. As of 2008, all but six states imposed co-payments on at least some Medicaid services, and 35 states were collecting premiums for some enrollees in Medicaid programs.
  - To provide incentives for healthy behaviors, states are testing the use of incentive programs that make the receipt of certain benefits contingent on adherence to specific actions (e.g., keeping appointments or engaging in healthy behaviors). Currently, Florida, Idaho, Kentucky, and West Virginia operate such programs.

- Some states use strategies that shift Medicaid from a defined benefit plan to one in which states contribute a set dollar amount towards enrollees' health coverage and give individuals control over spending those dollars. Several (15) states do so through Cash and Counseling programs, which provide enrollees with a healthcare budget to allocate as they see fit but supports their decision-making with wrap-around benefits and program counselors. Two states (South Carolina and Indiana) have developed programs modeled after health savings accounts, which provide enrollees control over where and how to spend a dedicated fund and are coupled with a high-deductible health plan to cover health expenses beyond the fund total. Florida has used a voucher model in a pilot program; under this program, the state provides a capped amount toward enrollees' coverage; enrollees are responsible for selecting a plan whose benefits and cost sharing rules best meets their needs.
  
- While several states are moving forward to incorporate consumer-focused approaches into their Medicaid programs, the impact of these initiatives is largely unknown. Information available to date questions whether these efforts will achieve the goals of decreased costs, improved health, and alignment with the private market. Early lessons from state experiences suggest the need for extensive enrollee education, careful calculation of provider payment or voucher amounts, and consideration of indirect inputs and effects of consumer-focused strategies.

# Changing Policies to Engage Medicaid Beneficiaries in Health Care Decisions: A Review of Strategies and State Activity

## Introduction

In recent years, there has been growing interest in changing the incentives facing Medicaid enrollees as they make decisions regarding their health care. The focus on incentives—sometimes called “consumerism”—encompasses a range of initiatives, from increasing patients’ financial responsibility for medical care to providing incentives to encourage individuals to lose weight. Consumerism has been a recurring theme in efforts to improve health coverage in the United States for decades<sup>1</sup> but has gained traction due to dissatisfaction with the low level of patient autonomy and responsibility in the system, increased knowledge about the importance of personal behavior in determining health, and, most notably, the quest for new approaches to control rising costs.

The push for increased consumer involvement has also affected Medicaid, the federal-state program that finances health services for certain low-income populations. Because it serves low-income, vulnerable populations, Medicaid has traditionally limited enrollees’ financial responsibility for services. Further, rules regarding Medicaid administration have limited the program’s use of other consumer-focused incentives. However, recent policy changes have allowed for greater use of consumer initiatives in Medicaid, and both federal and state policymakers have expressed interest in expanding these efforts. As with health insurance more broadly, a primary motivation behind consumer incentives in Medicaid is to control rising program costs. Some policy makers advocate consumerism because they believe that Medicaid should be structured similarly to private coverage in order to prepare Medicaid recipients (who move back and forth between private and public coverage) for the changes taking place in private coverage.<sup>2</sup>

A large and growing body of research has examined the prevalence and impact of consumer-focused initiatives in the private market. Because Medicaid serves a predominantly vulnerable population, it is important to understand the implications of a consumer-focused approach to this unique program. Medicaid enrollees have lower incomes than those in private insurance plans; they also have poorer health status than their counterparts in private plans and may face more socioeconomic or environmental barriers to health and healthcare.<sup>3</sup> In addition, Medicaid coverage functions differently than private coverage: the program covers some services generally excluded from private insurance plans; enrollees may lose and gain eligibility as their personal situation changes; and provider participation is often low. Thus, consumer-focused initiatives that are tested in the private market may not operate the same way in Medicaid programs.

Pennsylvania can learn from other states’ experiences with consumer-focused strategies as it debates the future of its Medicaid program. In this report, we review the use of consumer-focused initiatives in Medicaid. We begin with a brief overview of policies to engage individuals in health care decisions and then review how such initiatives are applied currently in the Medicaid program. We discuss how states may use strategies of information, choice, cost sharing, benefits incentives, and cash transfers or vouchers under current federal rules and we then summarize current state activity in each area. We conclude by analyzing the likely impact of these efforts on (between private and public coverage) for the changes taking place in private coverage.

## Background: Consumer Incentives and Health Insurance

The concept of “consumerism” in health care is premised in the idea that health services are purchased in a market in which patients are the buyers. In a traditional model of a competitive market, consumers maximize their utility by selecting goods and services from competing suppliers based on their income, personal preferences and the prices of

those goods and services. Consumers' demand for particular goods and services at alternative prices drives what and how much is produced and consumed. Many have observed that the "market" in health, particularly given the presence of insurance, is highly imperfect and does not operate as a traditional competitive market<sup>4</sup> — leading a great deal of medical care to be directed by providers and payers rather than patients. Market failure in health can also lead to the provision of high-cost but low-benefit care.

The role of individuals in healthcare, however, should not be underestimated.<sup>5</sup> Individuals may make decisions related to, among other things, what type and how much insurance to purchase; when and whether to seek care; what type of setting to use for care; and what type of provider to use.<sup>6</sup> The extent to which consumers have discretion in each of these decisions varies with the structure and type of insurance coverage they have and the conditions under which they obtain it. Below, we briefly summarize reasons for increasing consumer involvement in medical care and review the literature on what is known about strategies to do so, with a particular focus on their impact on populations targeted by Medicaid programs.

### WHY INVOLVE CONSUMERS?

A central motivation for changing the role of consumers in health insurance is related to cost control. This motivation stems from the presence of *moral hazard*, or the fact that people's behavior changes as insurance coverage alters the financial implications of their actions. When people have insurance coverage, the effective price they pay for care is lower (as the cost of their care is partially or fully paid for by others), so they consume more than they would without health coverage. They also have less incentive to seek out lower cost providers. The more insurance coverage a person has (i.e., greater protection from risk), the higher the incentives for people to seek care (i.e., greater moral hazard). Moral hazard also may lead to under-use of some services, particularly preventive health services that may forestall higher cost services in the future, or reliance on more costly services when cheaper alternatives are available. To alleviate moral hazard, insurers frequently rely on patient cost sharing to impose a cost to the consumer at the point of care. These *demand-side* strategies include deductibles, coinsurance, and, more recently, flat-dollar tiered copayments across given services (i.e. pharmacy benefits) and are premised in the theory that out-of-pocket expenditures will reduce the likelihood of a consumer over-using care. Consumer-focused strategies to control moral hazard are in contrast to those that focus on using provider-focused incentives (or *supply-side* strategies) to control utilization, such as utilization review, preauthorization requirements, or capitated payments. [In practice, most private insurers today rely on a combination of consumer and provider focused efforts.]

A second motivation for including consumer incentives in health insurance is to change habits that contribute to poor health. For a variety of reasons—i.e., affordability, convenience, knowledge, social norms, or access—individuals may neglect healthy behaviors or engage in risky behaviors that ultimately contribute to poor health.<sup>7</sup> Factors such as smoking, diet, lack of exercise, substance abuse, and risky sexual behavior are estimated to account for nearly half of deaths in the United States.<sup>8</sup> Further, studies have found that Americans receive only about half the amount of recommended preventive care services<sup>9</sup> and that, even when free, preventive care is under-utilized.<sup>10</sup> Payers are exploring strategies to engage consumers in their health care, with the idea that more "activated" patients will engage in healthier behaviors.<sup>11</sup> One strategy to engage patients relies on providing information—such as public awareness campaigns, appointment reminders, or individual counseling—in hope that it will motivate consumers to change behavior. Policymakers also have explored financial incentives as a way to encourage healthy lifestyles and use of preventive care (e.g., immunizations). Most private insurers already do this to some extent by excluding preventive services from cost sharing requirements, and a few insurers offer cash or gifts as rewards for engaging in healthy behavior.

Last, consumer incentives in health insurance may be motivated by the belief that patients are the best people to decide how to value and direct health care. Many feel that the current insurance system has diminished

choice and competition at the individual level, which in turn has led to poor matching of coverage with individual preferences. Nearly half (49 percent) of individuals who receive their coverage through their employer have no choice of plan type, and another third (34%) have a choice between just two plan types.<sup>12</sup> The characteristics of these plans are selected by the employer. Once enrolled, plan enrollees often must utilize services from a restricted panel of participating providers. Further, many consumers have limited knowledge about how their insurance coverage operates.<sup>13</sup> By increasing consumer choice, understanding, and control of health care spending, some researchers predict that competition for patients will lead to lower costs and better matching of individual preferences to market options.<sup>14</sup>

Strategies to introduce choice and competition into insurance take several forms. At one end of the spectrum, policymakers seek to equip consumers with information on treatment, health plans, or providers, with the hope that information will empower consumers to demand high-quality, efficient care.<sup>15</sup> This information may be a simple description of the basic facts on the structure and out-of-pocket costs for a plan; decision-making tools that consumers can use to make choices among treatment options, or “report cards” that provide comparative quality information on health plans or providers. At the other end, strategies give consumers direct control over a range of options and hold them financially liable for their choice. Common models include providing consumers a voucher for their health insurance premium and having them “shop around” for coverage (often within a limited set of options) or, more recently, creating personal spending accounts that they can use to purchase services directly from providers (coupled with high-deductible insurance coverage). Many analyses note the importance of combining both information and control to fully empower consumers to make informed, effective decisions.<sup>16</sup>

#### **WHAT DO WE KNOW ABOUT THE EFFECT OF POLICIES TO CHANGE CONSUMER INCENTIVES?**

A significant body of research has investigated the impact of various strategies to involve consumers in their care. Overall, this literature indicates that individuals are sensitive to the price of health services and programs using financial incentives to engage consumers have some impact. However, responses vary by the structure of the incentive, services targeted, and characteristics of the consumer. The effects of efforts that rely on non-financial strategies—such as the provision of information—are mixed.

The use of cost-sharing in health insurance is perhaps the most widely studied of efforts to involve consumers in health care. The findings from the 1970s RAND Health Insurance Experiment (HIE), considered the definitive study of the impact of cost-sharing, concluded that cost sharing has a sizeable effect on both the cost and use of health services; more recent studies have confirmed this relationship.<sup>17</sup> Consumers randomly assigned to health insurance plans with higher cost sharing requirements had a lower likelihood of using medical care, a pattern that was consistent across different types of health services. Importantly, the HIE found that higher cost sharing led to reductions in both “highly effective” and “rarely effective” medical care. That is, patients did not just decrease their utilization of “extraneous” or elective care, but also cut back on services that were medically necessary and appropriate. The study also found that, despite the decline in both effective and ineffective care, higher cost-sharing did not lead to adverse health outcomes for most people.

Fewer studies have investigated the impact of paying individuals to take up healthy behaviors, and the findings in this area are mixed. A 2004 review of the literature found that the majority (73 percent) of studies of financial incentives for one-time preventive care (e.g., receiving coupons in exchange for getting an immunization) showed a positive result, while interventions that paid (or gave other rewards) for more complex behavior changes (e.g., changing one’s diet) had lower rates of success.<sup>18</sup> Across studies, there was wide variation in both the details of the intervention (e.g., behavior targeted, type of incentive used, population studied) and the level of success, leading the analysts to conclude that the mechanisms whereby financial incentives work are not well understood. Further, all of the studies that examined long-term results after the incentive program ended found that improvements disappeared over time and measures returned to their pre-intervention level.

Other strategies for engaging consumers in their care also show mixed results. Many have looked to the approach of giving consumers information about health care providers as a way to empower them to make appropriate choices. Reviews show that a minority of consumers is aware of publicly-reported information about providers. Even among those who know of the information, few use it to make decisions.<sup>19</sup> Some studies do show that report cards have a small, measurable impact, but research indicates that this result is largely due to changes in provider (rather than consumer) behavior.

Researchers recently have begun to report outcomes for consumer-directed health coverage that transfers the responsibility of paying for much of the care to individuals. Under most of the programs studied, consumers were enrolled in a high-deductible plan, often accompanied by a personal health account. Many studies of these plans find lower average health care spending, though there is some indication that the plans attract healthier than average enrollees.<sup>20</sup> Surveys find that enrollees in consumer-directed plans show more “cost-conscious” behaviors, such as considering costs in their decisions about health care, requesting a generic over brand name prescription drug, or checking whether their plan would cover care.<sup>21</sup> However, it appears that the plans did not stimulate consumer activation but instead supported behaviors of individuals who were already highly engaged in their health care.<sup>22</sup> It is also unclear whether expanded choice and control leads to better matching of insurance to individual preferences: surveys of enrollee satisfaction suggest that patients in consumer-directed plans are less satisfied with their health coverage than those in traditional plans.<sup>23</sup>

#### **INCOME, HEALTH STATUS AND CONSUMER INCENTIVES**

Consumer-focused approaches may have differential effects for low-income or unhealthy populations. For example, the RAND HIE found that the use of health care among low-income individuals was more price-sensitive than that among higher income people for some services, namely dental services and some services for children. Further, the study concluded that people in poor health who faced higher cost sharing fared worse on health outcomes than those with lower cost sharing, with the largest effect seen among those who were both poor and sick.<sup>24</sup> More recent studies of the impact of cost-sharing among the poor have shown that increases in co-payments are associated with higher incidence of adverse events, emergency room use, or financial hardship.<sup>25</sup>

Initiatives to pay consumers for behavior change are largely targeted to low socioeconomic-status groups, and reviews do not indicate how outcomes are affected by consumer income or health status. Studies do indicate that, even among low-income groups, economic need does not necessarily translate to compliance with incentive programs: larger rewards do not always lead to higher participation in these programs. Moreover, many studies found positive results even though the incentives offered were never redeemed.<sup>26</sup> Research also shows that lower income individuals are less likely to be “activated” (that is, able to manage their health and health care),<sup>27</sup> primarily due to the association between low income and low educational attainment. Indeed, early evaluations of consumer-driven health care in the private market show that these plans attract healthier and higher-income enrollees than do traditional plans.<sup>28</sup>

#### **Consumer Incentives in Medicaid**

Historically, the Medicaid program has not relied on consumer-focused approaches in delivering health services to enrollees. This practice largely reflects the needs and resources of the population covered by the program.<sup>29</sup> Medicaid was initially designed to meet the basic health needs of the poorest Americans. The focus was on facilitating access for individuals who encountered difficulties in obtaining or paying for health services. Over time, the program has evolved to cover more populations and services, but it retains its goal of facilitating access to services for those who would otherwise not be able to access or afford insurance. Medicaid beneficiaries have very limited financial resources: all enrollees must meet financial eligibility requirements, which generally limit coverage to those with very low incomes and limited or no assets. Further, Medicaid enrollees must fall into a categorical

eligibility group, such as children, parents or pregnant women, individuals with disabilities, or elderly. Many individuals in these categories have substantial health needs and face challenges in navigating the health system or coordinating complex systems of care.

Medicaid also faces market challenges that make the use of such approaches difficult. In particular, relatively low reimbursement rates, administrative burdens, and uneven geographic distribution of providers have led to limited participation by providers in the Medicaid program. Only about half of physicians accept all new Medicaid patients into their practice, and in some areas there is a severe shortage of specialists who accept Medicaid patients.<sup>30</sup> As a result, rather than choosing from a broad array of providers within the market, Medicaid beneficiaries often have limited choice of providers. For example, children in Medicaid are disproportionately served by safety net providers (such as public clinics and county health departments) rather than providers in private practice.<sup>31</sup> The low rate of provider participation has been an ongoing concern for the Medicaid program, as it potentially inhibits access for enrollees, particularly access to specialists. Thus, policymakers paid more attention to mechanisms that would encourage provider participation rather than strategies to foster competition for enrollees.

As Medicaid has expanded to cover more populations, and as states struggle to meet program costs, federal and state policymakers have begun to incorporate consumer-focused strategies into Medicaid. While these strategies are premised on those used in the private market, they are sometimes (but not always) adapted to accommodate the particular population served by Medicaid.

#### **DEVELOPMENT OF CONSUMER INCENTIVES IN MEDICAID**

Policymakers have incorporated consumer incentives into Medicaid over time. Some efforts (such as education and information to engage consumers) are largely left to states to design, while others (such as the use of choice) are carefully regulated by federal law. Strategies that involve financial incentives or risk, whether by cost-sharing or reducing benefits, have been slowly incorporated into Medicaid as federal rules have changed over time (see Table 1).

Initially, the states could place enrollees at some financial risk only through the use of waivers of federal Medicaid rules. A waiver is special permission granted by the Secretary of Health and Human Services for a state to modify its Medicaid program (and still receive federal matching payments) in ways that federal regulations would not normally allow. Waivers are approved for a limited time period, must be cost-neutral to the federal government, and can fall under different statutory authority, depending on their scope and purpose.<sup>32</sup> The broadest waiver authority is section 1115 (Research and Demonstration Projects), which gives the Secretary wide-ranging ability to approve projects testing policy innovations likely to further the objectives of the Medicaid program.<sup>33</sup>

One strategy implemented through a waiver is the Cash and Counseling Program, which was first approved in 1998. Cash and Counseling is a section 1115 waiver demonstration program established through a public/private partnership between the U.S. Department of Health and Human Services, the Administration on Aging, and the Robert Wood Johnson Foundation. Under this program, disabled and elderly Medicaid enrollees are given a monthly cash allowance to purchase the mix of goods and services that they feel best fit their needs. Recipients are allowed to select their own providers without regard to their participation in Medicaid, independently allocate their budget among goods and services (e.g., purchasing a voice-recognition microwave instead of hiring an aide to prepare meals), and even hire certain family members to serve as caregivers. Enrollees receive administrative assistance for tasks such as planning budgets, keeping up with the paperwork required to pay an employee's wages and withhold taxes, and accounting for expenditures. Initially, Cash and Counseling demonstration programs were approved for three states;<sup>34</sup> in 2004, three-year federal grants were awarded to eleven additional states (including Pennsylvania) under the Independence Plus waiver initiative (based on either Section 1115 and 1915(c) waiver authority).<sup>35</sup>

**Table 1: Development of Financial Incentives for Consumers in Medicaid**

<b>Strategy</b>	<b>Traditional Medicaid</b>	<b>Medicaid Waivers</b>	<b>SCHIP (1997)/CHIP (2009)</b>	<b>HIFA Waivers (2000)</b>	<b>DRA (2005)</b>
<b>Cost sharing</b>	“Nominal” (generally \$0.50-3.00 per service/visit) levels allowed for some services and some enrollees. Premiums not allowed for most enrollees. Cost-sharing not enforceable.	Secretary may approve higher cost sharing	Allowed at Medicaid nominal levels for children up to 150% FPL and higher levels for children $\geq$ 150% FPL. Premiums allowed on income-related sliding scale. Capped at 5% of family income for all enrollees.	Allowed for optional and expansion populations. For children, capped at 5% of family income (no limit for other groups)	Allowed for most enrollees above poverty but capped at 5% of family income and 10% (100-150%FPL) or 20% (>150%FPL) of cost of service. Premiums allowed for those >150%FPL. Cost sharing enforceable.
<b>Benefits incentive programs</b>	Not allowed; must cover all services defined in state plan for all enrollees	Secretary may approve use of incentives programs	Not specified	Not specified	May use incentive programs as part of allowable “benchmark” coverage *
<b>Cash transfers and vouchers</b>	Generally, not allowed, with exception of premium assistance for coverage that meets Medicaid benefits and cost-sharing requirements	Secretary may approve use of cash transfers or vouchers in lieu of defined benefits	Generally, not allowed, with exception of premium assistance for coverage that meets SCHIP benefits and cost-sharing requirements	Generally, not allowed, but use of premium assistance to subsidize purchase of private coverage is encouraged	10-state demonstration program to set up health savings accounts for families;** Extension of “cash and counseling” program to establish individual budget model

\* Healthy children and parents already covered by state plan may be *required* to enroll in benchmark or benchmark equivalent plans, without choice of plan; other groups can only be offered the *option* to choose benchmark or benchmark equivalent plans over traditional Medicaid coverage. As the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) clarified, children enrolled in benchmark coverage continue to be eligible for EPSDT benefits.

\*\* CHIPRA (Sec. 613) prohibits the Secretary from approving any new health opportunity account demonstration programs.

In 1997, the State Children’s Health Insurance Program (SCHIP, now called CHIP) was established to provide publicly-financed health coverage to uninsured low-income children not eligible for Medicaid coverage. Under CHIP (which was re-authorized in 2009), states can extend their Medicaid programs to cover CHIP-eligible children or administer CHIP through a separate program (states can also use a combination of Medicaid expansion and a separate program). States using Medicaid expansions must follow Medicaid rules. Those using separate programs must offer benefits packages at least equal to either one of three “benchmark” private plans or the actuarial equivalent of one of those three plans.<sup>36</sup> Because CHIP allows states to model coverage after private coverage, it incorporates several practices found in the private market. Most notably, states can impose higher cost sharing requirements under CHIP than under Medicaid, though there was still a limit to the costs families could face.

The Health Insurance Flexibility and Accountability (HIFA) waiver initiative established by the Bush Administration in 2001 provided states with flexibility in designing benefits and cost sharing in their Medicaid programs that was not previously allowed. In exchange, states were expected to expand coverage to uninsured

populations by relying on private market approaches.<sup>37</sup>

The Deficit Reduction Act (DRA) of 2005, among other changes to Medicaid, establishes a number of provisions specifically related to changing consumer behavior or increasing consumer involvement in purchasing decisions.<sup>38</sup> For example, states can impose cost sharing above “nominal” levels for some Medicaid enrollees or provide tiered benefits packages to different groups in Medicaid. States can also implement Cash and Counseling programs as a state option (rather than through a waiver). Many of these provisions allow initiatives that had previously been allowed only under waiver authority; under the DRA, states can implement these strategies without receiving permission or renewal from the federal government and are not subject to budget neutrality tests.

#### **CURRENT CONSUMER-FOCUSED INITIATIVES IN MEDICAID**

States vary widely in the degree to which they draw on consumer incentives in Medicaid (see Appendix Table A). At one end of the spectrum, some states involve consumers by allowing beneficiaries to select from a list of managed care plans. This approach creates a low level of consumer choice with limited repercussions for consumers: consumers do not face different financial implications based on their choices; in most states, the decision is not fixed since Medicaid beneficiaries can change plans at will. A small number of states support a moderate level of consumer-directed care through cash and counseling programs, which give beneficiaries control over spending but include supports such as wrap-around benefits and program counselors.<sup>39</sup> A few states choose to provide consumers with almost total control over their Medicaid spending. In some cases, enrollees are provided with a budget and may allocate it as they see fit for the purchase of their chosen healthcare goods and services.

#### **Education and Information**

The need for enrollee education to engage and activate beneficiaries is frequently invoked in discussions regarding improving Medicaid beneficiaries’ access to care and health outcomes. States take a variety of approaches to how they provide information to beneficiaries, the scope of information they provide, and the goals of their education campaigns. Since many efforts are implemented at the local or plan (rather than statewide) level, a comprehensive assessment of strategies in this area is difficult. Some general trends do emerge from a review of the literature.

Many states are addressing low levels of health literacy among Medicaid beneficiaries,<sup>40</sup> based on the premise that a basic step in providing information involves developing materials appropriate for the target audience. A recent survey found that most (88 percent) of states had developed guidelines stipulating that printed and web-posted Medicaid materials be written at a reading level of 6<sup>th</sup> grade or below.<sup>41</sup> Some states are experimenting with new ways to reach Medicaid beneficiaries, as Medicaid enrollees are often difficult to reach by mail or phone. For example, in 2003, 4 Denver area NICUs experimented with hospital-based terminals to allow enrollees to access information via the internet.<sup>42</sup> The most common enrollee education campaigns are focused on facilitating enrollment, with state materials educating beneficiaries regarding how to enroll and use services once in the Medicaid program.<sup>43</sup>

#### **Choice**

Historically, choice in Medicaid existed at the provider level: Medicaid services were directly purchased by the state and delivered to beneficiaries on a fee-for-service basis, and beneficiaries could receive health services from any willing provider in the state. As described earlier, actual choice was frequently limited, since many providers chose not to participate in Medicaid or limited the number of Medicaid recipients they served.

Over time, states shifted to contracting with managed care organizations (MCOs) to deliver services to many beneficiaries, particularly low-income children and adults. In some cases—e.g., when beneficiaries are required to enroll in managed care plans that contract with a restricted panel of providers—this development has

restricted consumer choice. On the other hand, the use of Medicaid managed care can also promote choice, since Medicaid regulations require states to offer most enrollees a choice between at least two plans and provide information to support that decision.<sup>44</sup> Under the DRA, states may expand the choices available to beneficiaries by offering them different plan types with varying benefits. Provision of choice among plans— even if there are no financial implications to the beneficiary—may draw on consumerism in that beneficiaries are required to compare plan options and select the MCO whose provider network, service delivery model, or quality outcomes they feel best meets their needs. Ultimately, consumer choice could foster competition as plans strive to attract beneficiaries. Medicaid beneficiaries in managed care continue to be eligible for the full range of Medicaid services, but plans may offer additional benefits to create tailored benefit packages.

As of 2006, all states except Alaska, Mississippi, and Wyoming enrolled at least some of their Medicaid population in managed care and thus offer some enrollees a choice of plans.<sup>45</sup> In some cases, states support these decisions through report cards on plan quality or decision support: a recent survey found that 24 states indicated they will provide report cards to give Medicaid beneficiaries comparative quality information on their health plan options.<sup>46</sup> One study of 12 states found that the majority of counties with Medicaid managed care offered beneficiaries a choice between a Medicaid-dominated (primarily composed of Medicaid beneficiaries) and commercial (made up primarily of privately-insured individuals) health plan.<sup>47</sup>

In Pennsylvania, Medicaid beneficiaries in counties where managed care is required (25 counties in the Southeast, Southwest, and Lehigh/Capital areas of the state) choose from among three managed care plans for their physical health care. Beneficiaries in the 27 counties where managed care is optional choose between managed care and primary care case management (PCCM)-delivered services. In 2009, approximately 900,000 beneficiaries were enrolled in managed care for their physical health care.

## Financial Incentives

### *Out-of-pocket Costs*

A common strategy for incorporating consumer incentives into Medicaid is to expand beneficiaries’ financial liability for service use. Prior to the enactment of the DRA, Medicaid cost sharing was very limited. States could not impose any cost sharing on children, pregnant women (for pregnancy-related services), individuals in hospice care, or individuals who spend-down to gain Medicaid eligibility. Further, cost sharing was prohibited for emergency services and family planning services. Co-payments for other populations were generally capped at less than \$3.00 per service or prescription (referred to as the “nominal” co-payment); deductibles could be no higher than \$2 per month per family; and premiums were generally prohibited (except in the case of certain waiver-based expansion programs). Cost sharing was not enforceable, which means that providers were required to provide services regardless of whether the beneficiary paid the cost sharing.

**Table 2: Allowable Cost Sharing Under Current Medicaid Law**

	<b>Exempt Groups*</b>	<b>Income &lt;100% FPL</b>	<b>Income 100-150% FPL</b>	<b>Income &gt;150% FPL</b>
Non-exempt services**	Not allowed	Nominal levels	Up to 10% of cost of service	Up to 20% of cost of service
Non-preferred prescription drugs	Nominal levels	Nominal levels	Nominal levels	Up to 20% of cost of drug
Non-Emergency ER use	Nominal levels	Nominal levels	2x nominal levels	No limit

\* Exempt groups include (1) pregnant women for pregnancy-related services, (2) individuals receiving hospice care, (3) residents of nursing facilities (NFs) or intermediate facilities for the mentally retarded (ICF/MRs) and certain inpatients in hospitals and other medical institutions, (4) children under age 18 in mandatory coverage groups and certain foster care and adoption assistance children, (5) women covered under the breast and cervical cancer group.

\*\* Exempt services include preventive services for children, emergency services, and family planning and supplies.

Source: Herz, E. *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*. CRS Report to Congress, January 25, 2007.

Since the passage of the DRA, states have new flexibility to incorporate beneficiary cost sharing into their Medicaid programs. Medicaid still prohibits nearly all cost sharing for some populations and services (see Table 2 and notes). For others, states can now increase the “nominal” levels for Medicaid cost sharing annually, based on the national medical inflation rate for non-preventive services (e.g., emergency room visits), and can impose nominal cost sharing on some services (use of non-preferred prescription drugs and non-emergency use of emergency care) for even exempt enrollees. Further, states can increase cost sharing above traditional nominal levels for enrollees with incomes above the federal poverty level. The maximum permissible cost sharing requirement is limited to a specified share of the cost of the service (that share is based on an individual’s income), and there is an aggregate limit on enrollees’ out-of-pocket costs of five percent of income. Cost sharing is now enforceable for beneficiaries with incomes above the poverty level; that is, providers can withhold care or services for individuals who do not meet their cost-sharing obligations. Finally, states may require premiums as a condition of participation in Medicaid for some populations.

**Table 3: Use of Cost Sharing and Premiums Under DRA Authority in Medicaid**

State/Program	Cost sharing above nominal levels	Cost sharing enforceable	Premiums
Delaware		X	
Illinois			X
Iowa			X
Kentucky		X	
Louisiana			X
Maine			X
Maryland			X
Minnesota		X	
Nevada*	X	X	
North Dakota			X
Oklahoma**		X	
Wisconsin	X	X	X

\* Nevada’s changes are for FY2009.

\*\* Oklahoma’s enforceable cost sharing is under a section 1115 waiver rather than DRA authority.

NOTES: Oregon and Pennsylvania used DRA authority to reduce cost sharing for certain groups and/or services.

Source: Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn.” Vernon Smith, Ph.D., Kaiser Commission on Medicaid and the Uninsured. September 2008. Available at <http://www.kff.org/medicaid/upload/7815.pdf>

States have expressed an interest in incorporating beneficiary cost sharing into Medicaid. During the relatively weak economy of 2003 to 2004, 37 states introduced new or increased Medicaid co-payments.<sup>48</sup> In contrast, from 2007 to 2008, only 5 states imposed such changes. This differential suggests that states primarily viewed these efforts as a cost-control mechanism. As of 2008, all but six states<sup>49</sup> imposed co-payments on at least some Medicaid services, and one of these non-copayment states (Nevada) indicated that it plans to introduce new co-payments in FY2009.<sup>50</sup> Currently, just two states (Wisconsin and Nevada) have used DRA authority to extend cost sharing requirements beyond traditional nominal levels, and four states (Delaware, Kentucky, Minnesota, and Wisconsin) have used DRA authority to make cost sharing enforceable (see Table 3). States have also used premiums to require Medicaid beneficiaries to share in costs: as of 2008, 35 states were collecting premiums in 58 Medicaid programs.<sup>51</sup> Of these, many (23) premium programs were enacted under section 1115 waiver authority, though seven states have used DRA provisions to impose premiums that were previously not allowed in Medicaid.

In Pennsylvania, most Medicaid recipients are subject to nominal co-payments for most services. Children, pregnant women, and residents of a long-term care facility are exempt from this cost sharing. Co-payments are also waived for all emergency services, family planning, and laboratory services, among others. Pennsylvania also reimburses most recipients for co-payments exceeding \$90 in a given 6-month period.

### *Benefits Incentive Programs*

To provide incentives for healthy behaviors, some states have begun to make the receipt of certain benefits contingent on adherence to specific actions. Traditionally, states could not (without a waiver) offer targeted Medicaid benefits to a subset of their enrollees or make receipt of benefits contingent on certain enrollee actions. With the passage of the DRA, these rules were changed, and states were allowed to design different benefits packages for different populations. Some states have used this rule to offer incentive programs under which beneficiaries who engage in certain behaviors are rewarded with “extra” benefits or, conversely, those who do not follow healthy behavior guidelines are penalized by losing benefits.

Several states have explored the provision of behavior-dependent benefits (see Table 4). In general, under these programs, enrollees who engage in designated healthy behaviors receive state funds in a credit account, known as a Personal Responsibility Account (PRA) or Enhanced Benefit Account (EBA). Beneficiaries may use these funds to purchase approved health-related goods and services. The design of benefit incentive programs varies across states. Kentucky and Idaho use their programs to encourage participation in programs for individuals with certain conditions (e.g., obesity or diabetes). For example, Kentucky’s *KyHealth Choices*, implemented in May 2006, encourages people with diabetes, cardiac conditions, and other targeted diseases<sup>52</sup> to participate in a disease management program.<sup>53</sup> After one year of participation in a designated program, individuals earn credits that can be exchanged for additional benefits such as dental, vision, and smoking cessation services.<sup>54</sup>

Other states design their incentive programs to include a broader range of beneficiaries. Florida’s “Enhanced Benefits Reward\$,” established in July 2006, rewards all Medicaid reform enrollees for a variety of healthy behaviors such as use of health screening services, completion of disease management programs, and keeping primary care appointments. Reform enrollees include non-institutionalized disabled individuals receiving SSI, parents and children. Florida’s enrollees may use funds in their accounts to purchase a variety of over-the-counter health-related products from any participating pharmacy. West Virginia’s program takes a different approach by requiring all participants in its Mountain Health Choices program to sign a compliance contract in order to access a set of enhanced benefits. Medicaid enrollees are by default enrolled into a basic benefits program unless they make an active choice to receive enhanced benefits. Enrollees who adhere to their contractual obligations receive a wide range of enhanced benefits and additional access to disease management programs. Recipients who fail to meet the terms of their contract (general requirements include keeping appointments and compliance with provider instructions) are returned to a limited incentive programs varies across states.

Other states design their incentive programs to include a broader range of beneficiaries. Florida’s “Enhanced Benefits Reward\$,” established in July 2006, rewards all Medicaid reform enrollees for a variety of healthy behaviors such as use of health screening services, completion of disease management programs, and keeping primary care appointments. Reform enrollees include non-institutionalized disabled individuals receiving SSI, parents and children. Florida’s enrollees may use funds in their accounts to purchase a variety of over-the-counter health-related products from any participating pharmacy. West Virginia’s program takes a different approach by requiring all participants in its Mountain Health Choices program to sign a compliance contract in order to access a set of enhanced benefits. Medicaid enrollees are by default enrolled into a basic benefits program unless they make an active choice to receive enhanced benefits. Enrollees who adhere to their contractual obligations receive a wide range of enhanced benefits and additional access to disease management programs. Recipients who fail to meet the terms of their contract (general requirements include keeping appointments and compliance with provider instructions) are returned to a limited set of basic benefits for a year.

To date, Pennsylvania has not used any benefit incentive programs in its Medicaid program.

**Table 4: Use of Benefits Incentive Programs in Medicaid**

<b>State/Program</b>	<b>Population targeted</b>	<b>Behaviors rewarded</b>	<b>Incentive received</b>	<b>Authorized use of funds</b>
<b>Florida: “Enhanced Benefits Reward\$”</b>	Individuals in Medicaid Reform plans*	Screenings & preventive care; keeping appointments; medication compliance; disease management participation; smoking cessation/weight loss/substance abuse treatment	Up to \$125 per year in personal account	State-approved over-the-counter health items
<b>Idaho: “Preventive Health Assistance”</b>	Obese individuals, smokers, and children	Participation in weight management or tobacco cessation; keeping well-child appointments	Up to \$200 for obese individuals and smokers; up to value of premiums for children	Weight management programs, tobacco cessation products, and Medicaid premiums
<b>Kentucky: “Get Healthy Benefit Account”</b>	Individuals with certain chronic conditions	Compliance with disease management program	Access to additional benefits	Allowance for \$50 worth of dental & \$50 worth of vision services, 5 nutritionist visits, 2 months of smoking cessation program
<b>West Virginia: “Mountain Health Choices”</b>	Non-disabled adults and children**	Keeping appointments; medication compliance; adherence to screenings and health classes in individual health improvement plan	Continued access to the Enhanced Plan benefits	N/A

\* A “Medicaid Reform Plan” is a consumer-focused plan developed as part of Florida’s 2005 § 1115 Research and Demonstration waiver. This demonstration is for five counties in the state. Disabled beneficiaries receiving Supplemental Security Income (SSI) (excluding those in institutions or covered by Medicare), parents, and children are required to enroll; other beneficiaries can voluntarily participate.

\*\* West Virginia’s program excludes SSI recipients, waiver beneficiaries, pregnant women, nursing home residents, and foster care children.

SOURCES: State plan details from information posted to state websites: FL:

[http://www.fdhc.state.fl.us/Medicaid/Enhanced\\_Benefits/index.shtml](http://www.fdhc.state.fl.us/Medicaid/Enhanced_Benefits/index.shtml);

ID: <http://healthandwelfare.idaho.gov/site/4161/default.aspx>; KY: <http://www.chfs.ky.gov/NR/rdonlyres/70AC8C04-BDEF-4A64-AB06-45FEE8285A04/0/COMPLETEPACKAGE.pdf>;

WV: [http://www.wvdhhr.org/bms/oadministration/medicaid\\_redesign/medredesign\\_main.asp](http://www.wvdhhr.org/bms/oadministration/medicaid_redesign/medredesign_main.asp)

#### **CASH TRANSFERS AND VOUCHERS**

Medicaid is an individual entitlement to defined services, meaning each person who meets a state’s eligibility criteria has a right to payment for a defined benefits package offered in that state.<sup>55</sup> Even when services are provided through an MCO, Medicaid covers a specific set of services for enrollees. In line with the movement toward consumer-directed health plans in the private market, states have begun to experiment with strategies that shift Medicaid from a defined benefit plan to one in which states contribute a set dollar amount towards enrollees’ health coverage and give individuals control over spending those dollars. These strategies vary in scope from providing the cash equivalent for a subset of services to a traditional defined contribution voucher program (see Table 5).

One example of a limited cash transfer is the Cash and Counseling program described above. With the passage of the DRA, the waiver demonstration program was expanded to a state option to include a “self-directed personal assistance service program” in state Medicaid programs. States can include this option without obtaining a waiver from CMS. Under this option, states may allow beneficiaries to voluntarily enroll in Cash and Counseling

and self-direct Medicaid funds for personal assistance services. As in the original demonstration program, both the services (personal care) and populations (those who otherwise qualify for personal care services) covered under this initiative are restricted, and states must provide administrative assistance and decision support to enrolled individuals. As of January 2009, Alabama used the state plan amendment option under the DRA to establish a Cash and Counseling program, and Hawaii’s legislature was considering adding such a program. Kansas used a state plan amendment to implement a Cash and Counseling “model” for workers with disabilities in its WORK program.

Another type of cash transfer takes the form of personal health savings accounts (HSAs), or tax-free, short-term savings accounts used to purchase health services. Similar to Cash and Counseling programs, HSA programs provide enrollees with dedicated funds and give consumers control over where and how to spend their funds. Unlike Cash and Counseling, HSAs typically expand consumer direction to general health care services and are coupled with a high-deductible health plan to cover catastrophic health expenses. HSAs are a relatively recent phenomenon in the private market,<sup>56</sup> and the DRA included a 10-state demonstration program to test their use in Medicaid. Under this program, states may use Medicaid funds to establish Health Opportunity Accounts (HOAs) for some enrollees.<sup>57</sup> States contribute up to \$2500 per adult and \$1000 per child into an HOA, which is coupled with high-deductible coverage (up to 110% of the amount in the HOA). Enrollees use funds from their HOA to cover the out-of-pocket costs they face under a high-deductible plan. Enrollee participation in the demonstration is voluntary, but once an individual opts in, he or she must remain in the HOA program for 12 months.<sup>58</sup> As of 2009, the HOA demonstration in Medicaid is halted from further expansion, as CHIPRA prohibits the Secretary from approving any HOA demonstrations under the DRA authority.<sup>59</sup>

South Carolina is the only state operating an HOA pilot program under DRA authority. The program was approved in 2007 and targets 1000 children and parents in Richland County. Under the program, once enrollees exhaust the funds in their HOA account, they are responsible for paying an out-of-pocket deductible (\$250 per adult, \$100 per child), after which they will continue to receive standard Medicaid coverage. South Carolina exempts preventive services from any cost sharing and provides counselors to assist beneficiaries in choosing whether to opt into the program. Indiana launched an HOA-like plan (the Healthy Indiana Plan) in January 2008; that program is targeted to the state’s coverage expansion population and operates under section 1115 waiver authority. The Healthy Indiana Plan enrolls individuals in a high-deductible (\$1100) plan and sets up “POWER” (Personal Wellness and Responsibility) Accounts. Enrollees make income-based payments to their POWER accounts (from 2-5 percent of income), and the state pays the remaining amount until the annual account total is \$1100. Enrollees face penalties for missed payments, including loss of coverage, forfeit of POWER account contributions, and a 12-month ban from re-enrollment. From January 2008 to June 2008, Indiana enrolled approximately 32,000 individuals in the Healthy Indiana Plan.<sup>60</sup>

**Table 5: Use of Cash Transfers and Vouchers in Medicaid**

State	Population targeted	Amount of transfer or voucher	Services included in transfer or voucher	Wrap-around/support provisions
<i>Cash &amp; Counseling Programs</i>				
Alabama	Seniors and adults with physical disabilities currently receiving personal care or personal assistance under HCBS waiver*	Monthly budget depending on individual’s needs	Personal care, homemaker, unskilled respite, companion, and personal assistance	State-assigned counselor to support and monitor use of funds; voluntary peer support group available to enrollees
Arkansas	Elderly and adult recipients in need of personal care services	Monthly budget based on individual needs	Any purchases related to personal assistance or enhancing independence	Counselor assistance in managing cash

				allowance and payroll/bookkeeping
Florida	Seniors and adults with disabilities currently receiving personal care under one of 3 HCBS waivers	Actuarially equivalent to value of services received under waiver	Services and purchases related to long-term care needs	Consultants work with enrollees to develop a Purchasing Plan and manage employee payments
Iowa	Elderly and disabled persons eligible for HCBS waivers	Budget based on individual needs	Services and purchases related to personal care needs	Consumers hire “Independent Support Brokers” for help with budgeting, hiring employees, and other administrative needs
Illinois	Elderly “Community Care” Participants	Monthly budget equivalent to allowance for homemaker or adult day services	Services related to personal care needs	
Kentucky	Persons enrolled in Aged/Disabled, MR/DD, or Acquired Brain Injury waiver programs	Budget based on past service utilization	Non-medical waiver services	Support Brokers help with service arrangements and budgeting
Michigan	Elderly and disabled persons eligible for MI Choice waiver	Budget based on individual needs	Services and purchases related to personal care needs	Support coordinators help develop and revise budgets
Minnesota	Elderly and disabled adults	Budget based on individual needs	Services and purchases related to personal care needs	Counselors help with budgeting and paying workers
New Jersey	Elderly and disabled adults	Budget based on individual needs	Personal Care Assistant services	Consultants and fiscal managers help develop individual budgets and manage payroll matters
New Mexico	Elderly, disabled, HIV/AIDS and medically fragile waiver participants	Budget based on individual needs	Services and purchases related to personal care needs	Consultants help develop and revise budgets. Peer support groups are available.
Pennsylvania	Elderly and disabled persons	Budget based on individual needs	Services and purchases related to personal care needs	Support brokers help with budgeting and employees
Rhode Island	Elderly and disabled persons eligible for waiver services	Budget based on individual needs	Independence-related goods and services not normally covered by Medicaid	Service advisors help with budgeting; fiscal Inter-mediaries support payroll & financial functions.
Vermont	Children, disabled	Base rate plus	Services and purchases	Consultants help

	adults and elderly persons eligible for LTC waivers	allowance based on individual needs	related to health, well-being and independence at home	with developing budgets but do not support payroll or employment activities
Washington	Disabled adults and elderly persons who require nursing facility level of care	Budget based on individual needs	Services and purchases related to personal care needs	Counselors help develop and revise budgets. Peer support groups are available.
West Virginia	Elderly and disabled adults	Budget based on individual needs	Personal assistant services and supports	Consultants help with budgets and employment matters.
<i>Other Programs</i>				
Florida	Mandatory for most non-institutionalized individuals eligible through TANF and SSI pathways; voluntary for other groups**	Risk-adjusted premium actuarially comparable to traditional Medicaid coverage	All	Choice counselors to assist enrollees in choosing plans
Indiana	Expansion population (non-disabled, low-income uninsured adults)	\$1,100 per adult, contributed by enrollee (up to 5% of income) and state; additional \$500 allowance for preventive services	Physician services, prescriptions, diagnostic exams, home health services, outpatient hospital, inpatient hospital, hospice, preventive services, family planning, and case and disease management	Enrollment assistance and care management as provided by health plan
South Carolina	Non-disabled children and parents***	Annually, \$2500 per adult and \$1000 per child	All Medicaid services except preventive care	State-assigned counselors to support and monitor program understanding

\* Alabama's program is targeted to 7 counties in West Alabama and is expected to serve up to 700 participants. Participation is voluntary.

\*\* Florida's program is targeted to five counties.

\*\*\* South Carolina's program is targeted to 1 county and is expected to serve 1000 participants. Participation is voluntary.

SOURCE: Cash and counseling info from: <http://www.cashandcounseling.org>

IN: <http://www.in.gov/fssa/hip/index.htm>; FL: [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml) SC: <http://www.dhhs.state.sc.us/dhhsnew/HealthOpportunityAccounts.asp>;

A final form of cash transfer takes the form of vouchers that enrollees can use to purchase health insurance coverage. Voucher programs are based on the defined contribution approach used in the private market, in which payers provide a capped amount to enrollees, who are in turn responsible for selecting a plan and making all premium and cost sharing payments to that plan. Under this model, consumers choose the plan that they feel best meets their needs, but they are required to compare and contrast several plan characteristics in order to make the choice. Further, payers' financial obligation is capped; unless enrollees pay their own money above the contribution level, they can only obtain the level of coverage allowed by the contribution. In contrast to other cash transfer strategies, which place control and liability for up-front costs in the hands of enrollees, this approach leaves enrollees liable for costs beyond what their insurance covers.

In September 2006, Florida implemented a voucher pilot program which is now available in five counties.<sup>61</sup> Under the program, Florida Medicaid pays each enrollee's chosen managed care plan a risk-adjusted premium. Plans must cover all federally mandated services, but may create tailored benefit packages by offering other optional

services and varying cost-sharing requirements. Florida supports voucher recipients through a “Choice Counseling” program (similar to the operation of Cash & Counseling) to help enrollees select the most appropriate health plan. The voucher program also operates in conjunction with Florida’s “Enhanced Benefit Reward\$” program described above. Since June 2008 the state has enrolled 224,052 Medicaid recipients in the voucher program, which Florida plans to implement statewide by June 2010.<sup>62</sup>

### **Program Outcomes**

While several states are moving forward to incorporate consumer-focused approaches into their Medicaid programs, the impact of these initiatives is largely unknown. Most are in the early stages of implementation, and evaluations to assess whether they achieve stated goals are still underway. Despite limited evidence, existing research on the use of these strategies in waivers or pilot programs, combined with broader knowledge of the population covered by Medicaid, provides insight into the likely effects of recent initiatives.

### **IMPACT ON COSTS**

With Medicaid budgets consuming a growing share of state budgets and state policymakers concerned about the ability to meet future demand for coverage, cost control is a principal goal of efforts to introduce consumer-focused approaches into Medicaid. Based on what is known to date, it is not certain that the initiatives described above will achieve this goal.

### **Cost to States**

Studies of the use of cost sharing in Medicaid show that it leads patterns of care to shift but does not necessarily decrease overall health expenditures, although it may decrease spending for the state. For example, the use of even nominal cost sharing for physician services by the California Medicaid program in the 1970s was associated with increased costs in other service areas such as inpatient care.<sup>63</sup> More recently, under Oregon’s section 1115 waiver, cost sharing above nominal levels similarly shifted care patterns but did not lead to expected savings, as total expenditures per person remained unchanged.<sup>64</sup> Despite the stability of overall expenditures, the state did see an 18 percent reduction in direct Medicaid costs, since a share of the expenditures was shifted to beneficiaries.

It is also questionable whether premiums can generate revenue for states. Use of premiums under waiver programs has led to disenrollment, which ultimately dampens the amount the state can collect.<sup>65</sup> Program drop-out will decrease costs for the Medicaid program, but the loss of insurance may lead to higher costs in other areas: one study found a 20 percent increase in uninsured emergency department (ED) visits following premium-related drop-out from Medicaid in Oregon.<sup>66</sup> Ultimately, shifting patterns of care might disrupt revenue streams to safety net providers and threaten their ability to cross-subsidize care for the uninsured.<sup>67</sup>

Other strategies also might not produce the cost savings that states seek. It is too early to gauge whether benefits incentive programs reduce costs, but early reviews do indicate that many are costly to set up, market, and administer. For example, Florida spent about \$1.1 million in the first year administration of Enhanced Benefits Reward\$.<sup>68</sup>

Similarly, evidence on costs under cash transfers and vouchers is still being collected. Based on what was learned from the Cash and Counseling demonstration—under which overall Medicaid costs were slightly higher than in traditional Medicaid—it is not clear that the primary benefit of personal accounts is lower per person costs (versus other benefits, such as improved enrollee satisfaction). As one review notes, the ability of the state to trim spending rests largely in the calculation of the amount in the account: if the account value is calculated based on the value of recommended care, spending might actually *increase*, since many services (particularly preventive care) were traditionally underused in Medicaid.<sup>69</sup> The ultimate cost to the state will depend on the enrollment

implications of the use of personal accounts, or whether more people enroll in Medicaid out of a “woodwork” effect or fewer enroll due to the new out-of-pocket costs to enrollees. In addition, health accounts are, like incentive programs, costly to set up and administer. The Congressional Budget Office anticipates that health accounts will increase Medicaid direct costs by \$265 million over 10 years.<sup>70</sup>

Even for vouchers, which cap the state’s expenses at the amount of the voucher, the cost implications are unclear. Early evidence from Florida shows a small (3 percent) decrease in expenditures, but savings might have been offset by administrative spending for other reform components.<sup>71</sup> Further, Florida has not fully phased in its risk adjusted payments, and, depending on the risk profile of who enrolls (or remains in) the program, per person costs could go up or down.<sup>72</sup>

### **Costs to Beneficiaries**

The cost implications for beneficiaries under consumerism strategies are more predictable than those for states, as transferring costs to enrollees (via out-of-pocket costs or uncovered services) is a core mechanism of many such approaches. In these cases, the key question is not whether enrollee costs will increase, but rather whether enrollees are able to absorb these costs. Previous studies of cost sharing and premiums in Medicaid have shown that even low levels can lead to financial hardship.<sup>73</sup> For example, a survey of beneficiaries who were required to pay a premium in Utah found that nearly half said the cost disrupted their monthly budget, even though premiums were relatively low (\$15-50/month, depending on year of enrollment and eligibility category).<sup>74</sup> In Utah and other states that have used premiums, many beneficiaries left Medicaid and cited the cost as the primary reason.<sup>75</sup> Cash transfers and vouchers do not necessarily increase the financial risk of enrollees, since these strategies may aim to give individuals control over spending but not necessarily increase their financial liability. Still, there are many ways in which vouchers could expose beneficiaries to additional risk. State experience with personal accounts to date (under the Cash and Counseling programs) has been in long-term care, which has predictable, ongoing costs. The ability to adequately set voucher amounts for acute care may be more difficult, since such spending is more variable and unpredictable. Individuals’ costs could rise if transfer values are not: risk adjusted to account for wide variation in spending; adjusted to account for changes in cost of services over time; or adjusted for differences in price/fees between Medicaid and private market.<sup>76</sup>

### **IMPACT ON HEALTH**

Policymakers are hopeful that Medicaid consumer-focused strategies—particularly benefit incentive programs—will lead to healthy behaviors among beneficiaries. Studies have not yet measured the impact on health status, but early reports from Florida’s efforts show that enrollees have accrued \$12.5 million in credits under the state’s benefit incentive program.<sup>77</sup> It is not clear whether the credits translate into behavior change. First, the majority (60 percent) of credits earned are for keeping appointments, while there has been limited use of disease management programs and no use of exercise/weight management or smoking cessation programs. Importantly, focus groups with enrollees indicate that many of the behaviors for which they earn credits are things they would have done in the absence of the incentive program. Second, analysts note that the design of the programs might not promote behavior change. Some incentives (e.g., \$50 for dental care in Kentucky, or the equivalent of about \$10/month in Florida) might not be high enough to motivate change. For example, a Center on Budget and Policy Priorities report calculates that benefits under Idaho’s program would not provide sufficient resources for a smoker to engage in long-term cessation support (e.g., use of a nicotine patch or prescription drugs).<sup>78</sup> Another analyst notes that most programs do not track or reward the lifestyle changes that are the ultimate goal of behavior change.<sup>79</sup> Last, many note that, even if incentive programs work, enrollees still face a host of other challenges to adopting healthy lifestyles, such as transportation to and from services, geographic availability of recreational facilities and fresh produce, and access to providers (especially dentists) willing to accept Medicaid.

Research suggests that consumer-focused efforts might not only fail to improve health as policymakers hope, it might also threaten Medicaid enrollees' access to health care. As mentioned above, several studies of Medicaid have found that cost sharing for health care services leads to decreased participation, lower utilization, and increased unmet need for care, and some studies directly link cost sharing to poor health outcomes among low-income populations.<sup>80</sup> This pattern holds true for both nominal cost sharing traditionally used in Medicaid (particularly for prescription drugs) and higher levels for expansion populations (used under waivers). Research also shows a negative relationship between non-service related costs (i.e., premiums) and access, since people losing coverage due to inability to afford the cost frequently became uninsured. For example, as noted above, use of premiums in Oregon led to a significant decline in participation<sup>81</sup> and subsequent poor access to care. Enrollees who left Medicaid due to inability to pay their share of costs were more likely than those who left for other reasons to have an unmet need for care, skipped a medication, or lack a usual source of care.<sup>82</sup> Though less studied, the use of transfers and vouchers could also inhibit access due to a mismatch between Medicaid beneficiaries' needs and the coverage available. Under Florida's voucher program, two-thirds of physicians reported that their patients have a harder time accessing needed services because of plan limits or rules, and 60 percent of enrollees hit their plans' limits for prescription drug coverage.<sup>83</sup> Anecdotal reports of poor quality care and problems accessing timely care have led one Florida county to request that the legislature repeal the program.<sup>84</sup>

#### **IMPACT ON COVERAGE MODEL**

A fundamental, long-term goal of consumer-focused approaches in Medicaid is to shift the coverage model to one that empowers enrollees and more closely resembles private coverage. Achievement of self-direction is difficult to measure, but some evidence points to the promise and challenges of this objective. In Florida, Medicaid beneficiaries surveyed about a benefits incentive program responded that such an initiative would be welcomed by participants, with 88 percent indicating their approval of the program and high rates predicting that they would make use of it.<sup>85</sup> However, actual enrollee use of the initiative's programs is currently quite limited. In Florida, just one in eight incentive program enrollees had redeemed any of their earned incentive credits (amounting to just 10 percent of total credits being redeemed), and a large proportion of enrollees had no familiarity with program specifics or were unaware that the program existed.<sup>86</sup> Many enrollees exercised choice in picking a plan under the voucher program, and a very small number chose to use their voucher to buy into the private market.<sup>87</sup> Similarly, a small share (approximately 10 percent) of eligible recipients had enrolled in West Virginia's enhanced benefits program as of September 2008.<sup>88</sup> Most eligible enrollees in West Virginia instead remained in the "basic" plan due to their not executing the compliance contract, and therefore few have used the "enhanced" benefits that aim to improve healthy behaviors. Research on use of choice in Medicaid managed care programs also shows that in some states, a significant share<sup>89</sup> of Medicaid beneficiaries in managed care are assigned their plans by default, rather than making a deliberate choice of one MCO over another.

There are several reasons why self-direction is difficult to achieve in Medicaid programs. As the least activated of any group,<sup>90</sup> Medicaid enrollees have limited experience in directing their health care, and many have limited experience in navigating the private market or in managing any type of cash account.<sup>91</sup> Thus, efforts to increase beneficiaries' cost sensitivity may not be sufficient to activate patients; rather, enrollees will need education, motivation, and personal resourcefulness.<sup>92</sup> Many have noted the challenge of educating Medicaid beneficiaries about new coverage models, citing low literacy levels or English proficiency among enrollees, difficulty in reaching people by mail, and conflicting messages from providers and policymakers as a hindrance to implementing consumer-focused strategies.<sup>93</sup> Information comparing plans on quality is frequently sparse and difficult to access or interpret,<sup>94</sup> which means it is likely of limited use in supporting beneficiary choice. Finally, some enrollees simply might not want to shift to a self-directed coverage model. For example, in the Arkansas Cash & Counseling demonstrations, one in five enrollees opted out of the program and back into traditional Medicaid within a year.<sup>95</sup>

There are also market challenges to shifting the Medicaid coverage model to one that aligns enrollees with the private market. In some cases, choice has led MCOs to offer additional benefits (e.g., extra case management),

special provisions to facilitate access (e.g., direct access to specialists), or extended provider networks, but most provisions are more commonly required by the state and thus are similar for all plans enrolling Medicaid beneficiaries.<sup>96</sup> Commentators note that many benefits provided by Medicaid, such as services for those with serious mental illness, nursing home care, or special education for children, do not have parallels in the private market.<sup>97</sup> Further, the fact that many people qualify for Medicaid coverage based on their poor health (e.g., through disability pathways) makes the program incompatible with coverage that pools people based on non-health factors and insures for unpredictable health costs.<sup>98</sup>

There is debate over whether consumer incentives can facilitate attracting and incorporating commercial plans and private providers into Medicaid. Experience with managed care found that commercial plan participation in Medicaid declined over time,<sup>99</sup> which calls into question the ability of choice to drive competition and integration for the Medicaid market. The use of vouchers might be more successful on this front. On one hand, plans could see the development of new Medicaid products as a way to expand their offerings for the privately-insured low-income population and integrate coverage, while the adoption of commercial fee schedules could expand the pool of providers willing to see Medicaid patients. On the other hand, commercial plans could (as in the past) find the Medicaid population difficult to serve and choose not to participate, and providers could turn away from Medicaid out of belief that limited coverage restricts their ability to adequately serve enrollees. Evidence to date indicates that challenges in aligning Medicaid with private coverage persist under consumerism. For example, while Florida enrollees may choose among 42 different benefit plans from 17 different insurers<sup>100</sup> — an increase in the number of plans available to beneficiaries—the state has not seen a large influx of commercial insurers or new plan models to its Medicaid program.<sup>101</sup> Further, there was actually a decline in overall provider Medicaid participation after reform, since many traditional Medicaid providers were not in the new plans’ networks.<sup>102</sup>

## **Conclusion**

Many states are actively pursuing consumer-focused strategies in the Medicaid programs. Though there is limited evidence that these efforts will achieve the goals of decreased costs, improved health, and alignment with the private market, analysis of experience to date indicates some key features of necessary conditions to create consumerism in Medicaid.

Enrollee education is clearly a crucial component of consumer-focused strategies. Given evidence of low activation and health literacy among beneficiaries, along with early reports of limited active consumerism in existing state efforts, it is unlikely that a “if you build it, they will come” approach will lead to successful initiatives. It is not clear if low participation is related to enrollee disinterest or lack of information, but the current structure of programs points to the latter. For example, in West Virginia, enrollees who do not comply with their member agreements under the benefits incentive program are transferred to the basic level of benefits; however, most enrollees have not signed the member agreements, even though they would be no worse off if they signed them and were not able to meet the requirements. The shift to consumer-focused strategies in Medicaid might require more extensive enrollee education than states initially believed.

States should also carefully consider the role of provider payment or voucher amounts in designing consumer incentives. Payment will impact provider participation in Medicaid programs or health plans; without multiple providers from which to choose, efforts to draw on the power of choice or promote “shopping” for services will likely fall flat. Experience with managed care has proven this to be true, and Florida has already experienced challenges in rolling out its voucher program. Without a concomitant shift to aligning payment or vouchers with commercial coverage, efforts to align Medicaid with private insurance are likely to face challenges.

Last, the review of consumer incentives in Medicaid shows that policy makers need to take a broad, long-term view of consumerism and Medicaid to design successful initiatives. Many single strategies have indirect effects or do not consider indirect inputs. Cost sharing on a particular service might address moral hazard in the use of that service, but it could induce additional utilization in other areas or lead to access problems with long-term health and financial consequences. Incentive programs targeted to address motivation to take up healthy behaviors may not account for other barriers Medicaid beneficiaries will face in acting on these incentives. States considering implementing or reforming their strategies might be well-served by taking a holistic view of how beneficiaries can successfully assert their role as health consumers.

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## Appendix A

### Consumer Initiatives in State Medicaid Programs, 2009

State	Strategy	Authority	Summary
Alabama	Vouchers/transfers	DRA	- Cash & counseling for seniors and adults with disabilities receiving personal care or personal assistance under HCBS waiver (7-county program)
Arkansas	Vouchers/transfers	§1115	- Cash & counseling for seniors and adults in need of personal care services
Delaware	Cost sharing	DRA	- Cost sharing enforceable
Florida	Benefits incentives Vouchers/transfers	§1115	- Enhanced Benefits Reward\$ allows enrollees to accrue up to \$125 in credits for healthy behaviors and redeem them for over-the-counter products - State pays health plan of enrollee's choice a risk-adjusted premium; benefits & delivery system vary by plan - Cash & counseling for seniors and adults with disabilities
Idaho	Cost sharing Benefits incentives Vouchers/transfers	DRA	- Enforceable cost sharing for children and working-age adults with new copayments for inappropriate emergency use, missed appointments, or non-preferred drugs; premiums for those above 133% FPL - Offering children and working-age adults personal health accounts that can be used to cover copayments or purchase services that encourage healthy behaviors - Cash & counseling program for Medicaid developmentally disabled over age 21
Illinois	Cost sharing Vouchers/transfers	DRA §1115	- Premiums - Cash & counseling for seniors
Indiana	Vouchers/transfers	§1115	- Expansion population (uninsured low-income adults) receive up to \$1,100 in individual account to cover expenses related to high-deductible coverage
Iowa	Cost sharing Vouchers/transfers	DRA §1115	- Premiums for Adults Aged 19-64: \$1 - \$82/mo - Cash & counseling for elderly and disabled persons eligible for HCBS waiver services
Kansas	Vouchers/transfers	DRA	- Cash & counseling for working disabled under Ticket to Work program (up to 300% FPL)
Kentucky	Cost sharing Benefit incentives Vouchers/transfers	DRA §1915(c)	- Enforceable co-payments for most services and co-insurance for non-emergency use of ER. - Premiums - Enhanced benefits for beneficiaries who participate in disease management program - Cash & counseling for elderly and disabled
Louisiana	Cost sharing	DRA	- Premiums for Disabled Children up to Age 12 in families up to 300% FPL: \$35 if uninsured, \$15 if have other health insurance
Maine	Cost sharing	DRA	- Premiums for Children in families 150-200% FPL: \$8 - \$64/mo - Premiums for Katie Beckett Children in families over 150% FPL: 0.5% - 2.5% of gross income

Maryland	Cost sharing	DRA	- Premiums for Children in families 200-300% FPL: \$46-\$58/mo
Michigan	Vouchers/transfers	§1115	- Cash & counseling for elderly and disabled
Minnesota	Cost sharing Vouchers/transfers	DRA §1115	- Cash & counseling for elderly and disabled adults
Nevada	Cost sharing	DRA	- Enforceable cost sharing - Quarterly income-adjusted premiums for Children
New Jersey	Vouchers/transfers	§1115	- Cash & counseling for elderly and disabled adults
New Mexico	Vouchers/transfers	§1115	- Cash & counseling for elderly, disabled, HIV/AIDS, and medically fragile waiver participants
North Dakota	Cost sharing	DRA	- Premiums for Disabled Children in families up to 200% FPL: 5% of countable income minus other insurance premiums
Oklahoma	Cost sharing	DRA	- Enforceable cost sharing
Pennsylvania	Vouchers/transfers	§1115	- Cash & counseling for elderly and disabled
Rhode Island	Vouchers/transfers	§1115	- Cash & counseling for elderly and disabled
South Carolina	Vouchers/transfers	DRA	- Beneficiaries may opt out of traditional Medicaid and instead receive \$2500 per year to manage their own health care
Vermont	Vouchers/transfers	§1115	- Cash & counseling for children, elderly, and disabled adults eligible for LTC waivers
Washington	Vouchers/transfers	§1115	- Cash & counseling for elderly and disabled adults requiring nursing home level of care
West Virginia	Benefits incentives Vouchers/transfers	DRA §1115	- Healthy adults and children who sign membership agreement requiring adherence to recommended screenings and health improvement programs, medication compliance, and keeping appointments receive enhanced benefits; those who do not sign agreement receive basic benefits only. Beneficiaries in enhanced benefits plan who adhere to requirements receive health account with funds to purchase services not covered by Medicaid - Cash & counseling for elderly and disabled adults
Wisconsin	Cost sharing	DRA	- Enforceable cost sharing - Premiums for Caretakers earning 150-200% FPL: \$10-\$268/mo - Premiums for Children in families 200-300% FPL: \$10-\$97/mo

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- <sup>16</sup> The discussion here focuses on the arguments in support of consumerism. Some analysts believe that this movement is an attempt to shift health care costs from the healthy and wealthy to the sick and poor. See: Reinhardt, U. "Insurance: A Closer Look at HSAs." *Health Affairs (web blog)*. April 12, 2007. Available at: <http://healthaffairs.org/blog/2007/04/12/insurance-a-closer-look-at-hsas/>.
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- <sup>25</sup> See Ku, L., and V. Wachino. *The Effect of Increased Cost-Sharing in Medicaid.* (Washington, DC: Center on Budget and Policy Priorities), July 7, 2005.
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- <sup>33</sup> Other types of waivers (1915(b) Freedom of Choice Waivers and 1915(c) Home- and Community-Based Services Waivers) allow states to use delivery systems such as mandatory managed care or community-based alternatives to institutional long-term care, respectively, and to target these initiatives to a subset of their Medicaid population.
- <sup>34</sup> Initial cash & counseling states were Arkansas, Florida and New Jersey. James R. Knickman, Robyn I. Stone. *The Public/Private Partnership behind the Cash and Counseling Demonstration and Evaluation: Its Origins, Challenges, and Unresolved Issues.* *Health Services Research* 42 (1p2), 362-377 (2007).
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- <sup>36</sup> The private benchmark plans are: Federal Employees Blue Cross/Blue Shield PPO plan; coverage available to state employees; or coverage offered by the HMO with the state's largest commercially enrolled population. Separate SCHIP programs can also cover "Secretary-approved coverage," or coverage the Secretary of Health and Human Services determines appropriate for low-income children.
- <sup>37</sup> See: Mann, C. *The New Medicaid and CHIP Waiver Initiatives.* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured), February 2002.
- <sup>38</sup> See NASBO. *Redesigning Medicaid Using the Deficit Reduction Act.* (Washington, DC: National Association of State Budget Officers), September 18, 2007.
- <sup>39</sup> The term "wrap-around benefits" generally refers to a benefit package that covers health care services for which an individual may otherwise not be covered under their primary health insurance plan. In Cash & Counseling,

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enrollees may allocate their personal care budget independently, but are still eligible (through wrap-around) for the standard benefits that they would have received but for their enrollment in the program.

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<sup>41</sup> Health Literacy Innovations. *National Survey of Medicaid Guidelines for Health Literacy*. (Bethesda, MD: Health Literacy Innovations, LLC), October 2007.

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<sup>43</sup> Kaplan, S.A. et al. *Educating Medicaid Beneficiaries about Managed Care: Approaches in 13 Cities*. (New York: The Commonwealth Fund), May 2000.

<sup>44</sup> Alker, J., C. Fish-Parcham, and J. Waxman. *Medicaid Managed Care Final Regulations Issued*. (Washington, DC: Families USA), September 2002.

<sup>45</sup> Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment as of December 31, 2006*. Available at: <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcp06.pdf>

<sup>46</sup> Greene, J. *State Approaches to Consumer Direction in Medicaid*. Center for Health Care Strategies, Inc. July 2007.

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<sup>48</sup> Smith, V. *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn*. Kaiser Commission on Medicaid and the Uninsured. September 2008. Available at <http://www.kff.org/medicaid/upload/7815.pdf>

<sup>49</sup> Connecticut, Hawaii, New Jersey, Nevada, Texas, and Washington had no copayment requirements in FY2008.

<sup>50</sup> Notably, several states have also *decreased* Medicaid cost sharing requirements in recent years (Smith p.38).

<sup>51</sup> Smith p.37.

<sup>52</sup> Examples include chronic diseases like pulmonary disease and obesity.

<sup>53</sup> Kentucky's Medicaid Transformation Initiative. Kentucky Cabinet for Health and Family Services. May 2, 2006. Accessed on January 14, 2008 at <http://www.chfs.ky.gov/NR/rdonlyres/70AC8C04-BDEF-4A64-AB06-45FEE8285A04/0/COMPLETEPACKAGE.pdf>.

<sup>54</sup> Kentucky State Plan Amendment. National Conference of State Legislatures. May 2006. Accessed on January 14, 2008 at <http://www.ncsl.org/programs/health/kymedicaid2.htm>.

<sup>55</sup> Schnieder, A., et al. *The Medicaid Resource Book*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), July 2002, p.87.

<sup>56</sup> "Health Savings Accounts" (HSAs) were enacted as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 and added to the already-available Archer Medical Savings Accounts (MSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). Though these various accounts differ, they all share the general approach of tax-exempt accounts that individuals can use for medical expenses. See: Miller & Chevalier Chartered, *Overview of Health Savings Accounts, with Comparison to Archer MSAs, HRAs, and FSAs*. 2003, <http://benefitslink.com/articles/hsachart031231.pdf>.

<sup>57</sup> Certain groups, including beneficiaries 65 and older, persons with a disability, pregnant women, those who have only been eligible for medical assistance for less than three months, and those in hospitals, nursing homes and other medical institutions, are not eligible to participate.

<sup>58</sup> In other words, an enrollee cannot opt out of the HOA program once he/she uses up the HOA. Enrollees who lose Medicaid eligibility can keep 75% of what is left in their accounts and have three years to use these funds.

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- <sup>75</sup> Artiga and O’Malley.
- <sup>76</sup> Milligan, Woodcock, and Burton.
- <sup>77</sup> Alker, J. and J. Hoadley.
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- <sup>79</sup> Greene, *Medicaid Efforts to Incentivize Healthy Behaviors*.
- <sup>80</sup> Artiga and O’Malley.
- <sup>81</sup> Ku, L. and T. Coughlin. “Sliding-Scale Premium Health Insurance Programs: Four States’ Experiences,” *Inquiry* 36:471-80m Winter 1999-2000.
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- <sup>83</sup> Alker, Hoadley and Thompson, p.5.
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- <sup>90</sup> Hibbard and Cunningham.
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- <sup>92</sup> Hibbard and Cunningham.
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