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issue brief

Turning Medicaid Beneficiaries into Purchasers of Health Care:

Critical Success Factors for Medicaid Consumer-Directed Health Purchasing

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A number of states are considering Medicaid consumer-directed health purchasing initiatives. Interest in these initiatives was originally sparked when health savings accounts were authorized as part of the Medicare Modernization Act of 2003. Consumer-directed Medicaid reforms, mirroring the development of "defined contribution" products in the private health insurance market, are intended to contain the growth in Medicaid expenditures, create incentives for beneficiary use of preventive services, and promote more "personal responsibility." This movement away from the traditional "defined benefits" Medicaid model comes as states take advantage of Section 1115 waiver authority and the new flexibility offered by the Deficit Reduction Act (DRA). Some of the resulting approaches are a significant change from current Medicaid benefit design and policymakers must carefully consider the implications these initiatives may have for access to care.

Two primary models are emerging. In the direct services model, the state funds a health spending account for each Medicaid beneficiary, ranging from "rewards" for pursuit of healthy behaviors to more comprehensive accounts intended for direct purchasing decisions by beneficiaries such as the payment of deductibles, copayments, and/or the purchase of health services. Medicaid reforms being implemented in Florida, Kentucky, and West Virginia include spending accounts to reward healthy behaviors. To date, no state has implemented the more comprehensive direct services model.

This Issue Brief is an executive summary and update to a more comprehensive SCI monograph dated January 2006. To review the monograph, also titled "*Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing*," please visit www.statecoverage.net/publications.

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The second model is the insurance model. Here the state allots each Medicaid beneficiary a premium amount to purchase a state-approved insurance product or insurance through the beneficiary's employer. Under this model, the beneficiary may not be guaranteed a specified benefit package, or benefits could be capped as in some commercial products. The premium amount assigned to a beneficiary will affect the nature and amount of benefits a beneficiary may purchase, which could impact access to needed care. Florida will assign beneficiaries a risk-adjusted premium to purchase insurance from among a selection of state-approved, actuarially equivalent products. South Carolina is considering a reform that will give beneficiaries a risk-adjusted premium to select from among four choices: a self-directed plan consisting of major medical benefits and an account for fee-for-service purchases; private insurance; employer-sponsored insurance that may be available to the beneficiary; or the state's existing medical home network.

With passage of the DRA, experimentation with these Medicaid reforms is expected to intensify. The DRA authorized ten state demonstrations of Health Opportunity Accounts in which the approved states will be able to offer Medicaid health savings accounts attached to high-deductible health insurance plans. The DRA also gives states new flexibility with premiums and cost-sharing and allows states to offer "benchmark" plans similar to those authorized under the State Children's Health Insurance Program (SCHIP). States such as Kentucky are already taking advantage of the DRA to implement consumer-directed benefit designs.

While Medicaid consumer-directed health purchasing programs increasingly are viewed as a tool to incentivize preventive care and slow the growth in state Medicaid spending, these reforms remain untested, and numerous risks remain. Four critical success factors that states should consider in developing such programs are discussed below.

Critical Success Factor 1: Protect Access to Care

Risk Adjustment: States should carefully analyze health care utilization and expenditure patterns and risk-adjust account allocations to reflect an individual's level of need. Current methodologies are better adapted to the insurance model of consumer-directed health programs because this model facilitates pooling of risk within groups. Even so, health plans may "cherry pick" beneficiaries whose allocations are expected to exceed their predicted utilization. Even the best risk-adjustment methods will not be able to account for variation in health spending at the individual level. A stop-loss arrangement is one mechanism states might consider to protect high-cost beneficiaries whose needs are unpredictable.

Carve-Outs: States should consider carving certain benefits out of Medicaid consumer-directed purchasing. Carve-outs might include benefits for which it is especially difficult to predict individual-level utilization and to adequately risk adjust. Carve-outs should also be considered for benefits not generally offered in the commercial insurance market because the providers of these services are not constrained in setting prices by other market players. Benefits for children with special needs and adults with serious mental illness typically meet these criteria.

Purchasing Power: States must ensure that a beneficiary's purchasing power does not unduly erode over time. Otherwise the beneficiary's allocation will be insufficient to purchase needed benefits. The trend (inflation) factor applied to beneficiary accounts over time should be tied to health care inflation indices rather than general inflation factors. Purchasing power may be adversely affected if beneficiary allocations are based on historic Medicaid costs, particularly if beneficiaries are required to purchase insurance or services in the commercial market.

Cost Sharing: Higher cost sharing has been shown to reduce utilization and discourage

low-income individuals from obtaining necessary care. Research is not yet available on how the financial incentives behind consumer-directed health purchasing will drive beneficiaries' utilization decisions in positive ways, as anticipated. States must carefully monitor how these new benefit designs impact out-of-pocket spending and the use of health care services.

Use of Account Funds: Many states are linking consumer-directed accounts to policies designed to encourage healthy lifestyles and the use of preventive services. States must consider what kinds of services may be purchased with account funds (e.g., smoking cessation aids, weight loss programs, or acupuncture), the level of funding that is likely to have the desired impact on behavior, and whether and for how long a beneficiary may keep the funds if he/she loses Medicaid eligibility.

Safety-Net Providers: Because Medicaid consumer-directed health purchasing gives consumers more choice, it is likely to redirect "paid" utilization away from public hospitals and federally qualified health centers to other hospitals and private physicians that have lower prices and costs. States must consider new ways to subsidize safety-net providers to ensure the survival of these vital institutions and their role in caring for the uninsured. Florida successfully negotiated a $1 billion annual fund to subsidize public hospitals as part of their Section 1115 waiver.

Critical Success Factor 2: Anticipate Effects on the Behavior of Insurers, Providers, and Employers

Insurers: States must develop policies that offer insurers sufficient "covered lives" and stable Medicaid enrollment. Insurers will not enter the market unless they are protected against unpredictable risks. Insurers likely will want some level of risk sharing with the state, such as stop-loss, a state reinsurance plan, and/or a risk pool, as well as premiums trended to the cost of medical care inflation. Insurers may also want to leverage products across the Medicaid and commercial markets. States must take measures to maintain a vibrant, competitive marketplace for insurers.

Providers: Movement away from a Medicaid fee schedule toward a "commercial" fee structure will appeal to existing providers. Higher fees and new benefit designs may attract new providers. Providers may feel less pressure to negotiate higher rates for employer-sponsored insurance, resulting in less cost-shifting. However, higher provider fees may undercut the purchasing power of consumer-directed spending accounts based on historic Medicaid fees.

Employers: Enrollment in Medicaid consumer-directed programs is new, and has no established track record. This makes it unpredictable. Families not previously enrolled in Medicaid may now come forward to register, the "woodwork" effect. Conversely, families may choose not to enroll if the program is too complicated or the benefits are too "thin." Employers may encourage low-wage employees to enroll in Medicaid instead of the company plan. States must devise policies that address the potential for "woodwork" and substitution effects.

Critical Success Factor 3: Reformulate the Roles of State Agencies

Insurance Superintendent: Moving Medicaid beneficiaries into commercial insurance products may require changes in the staffing, role, and authority of the state insurance superintendent. The insurance superintendent will need to approve insurance products for Medicaid beneficiaries, monitor market performance and solvency, and ensure compliance with state regulations. For Medicaid beneficiaries purchasing services directly through health spending accounts, state regulators would need to address potential provider price gouging and complaints about quality.

Medicaid Agency: This agency would likely retain many of its functions, such as eligibility determinations, enrollment, and benefit carve-outs. It will also be important for

the Medicaid agency to launch effective and culturally appropriate outreach and consumer education campaigns on consumer-directed health purchasing.

State Budget Agency: A consumer-directed program simplifies the state budgeting process by converting Medicaid into a defined-contribution program with known monthly allocations. However, enrollment is likely to be unpredictable, given the potential "woodwork" and substitution effects described above. Moreover, a change in the risk composition of beneficiaries (i.e., skewing toward healthier or sicker enrollees) may impact the state budget, if individual allocations are keyed to these factors. The state budget agency would need to apply reasonable trend rates to premium increases and monitor carved-out benefits to guard against cost-shifting by insurers.

Critical Success Factor 4: Develop New Risk Management Approaches

To mitigate risk under a consumer-directed health purchasing program, states should develop policies that set forth program expectations and potential risks related to beneficiaries' choices. For example, states must have policies that address an inappropriate choice of caregiver or health plan, financial victimization of a beneficiary by a provider or insurer, and a beneficiary's mismanagement of spending account funds.

Conclusion

Momentum appears to be gathering to pilot various forms of consumer-directed models in Medicaid. These reforms would fundamentally alter the role of the state, the state's expectations of beneficiaries, and the behavior of every participant in the health care system. States must carefully balance efforts to influence consumer behavior, reduce Medicaid expenditure growth, and preserve access to care. The operational success of a consumer-directed program will depend on how well a state executes its plans. This, in turn, is dependent on how well a state identifies and meets the four critical success factors described in this issue brief.

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