



# Personal Responsibility in Medicaid: Challenges and Opportunities

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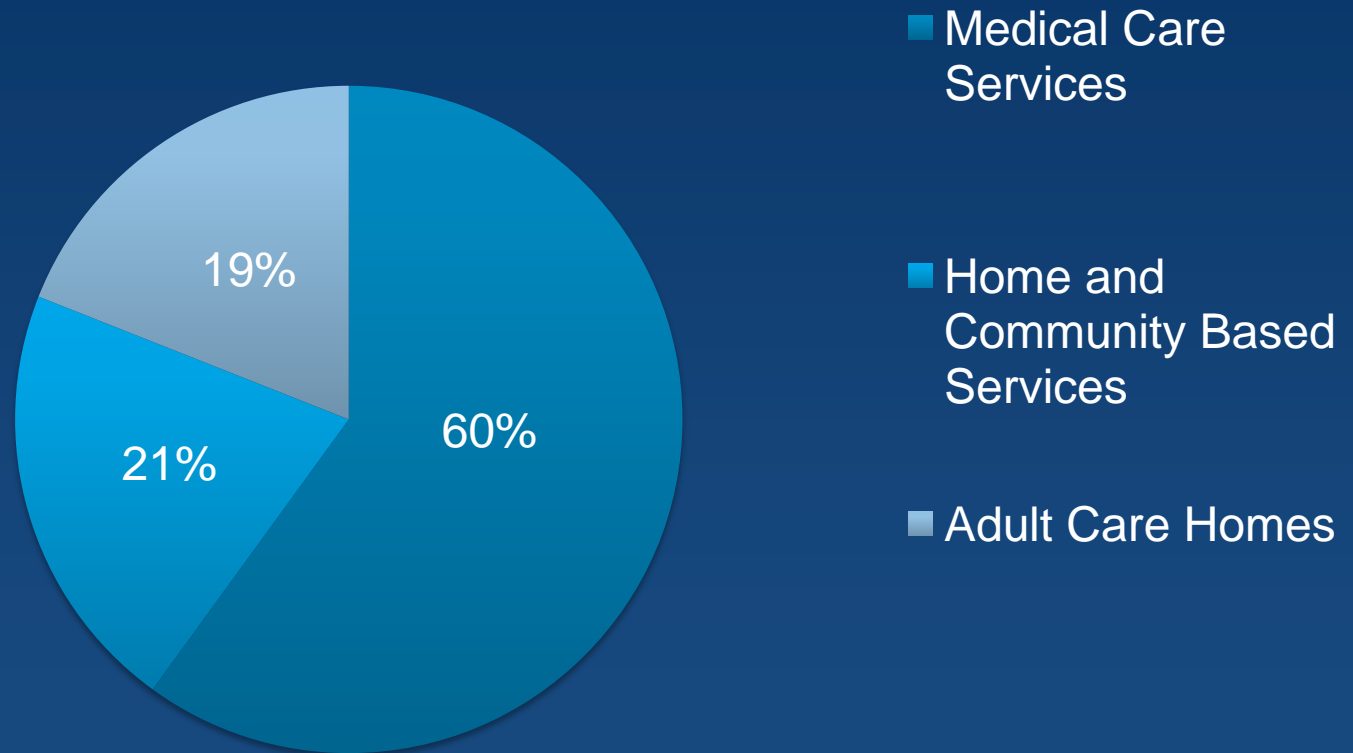
# Overview of Medicaid in 2008

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- Approximately 250,000 people enrolled
- More than \$2.4 billion spent
- Approximately \$1.3 billion was spent on medical care services
- Approximately \$1 billion is spent on long term care

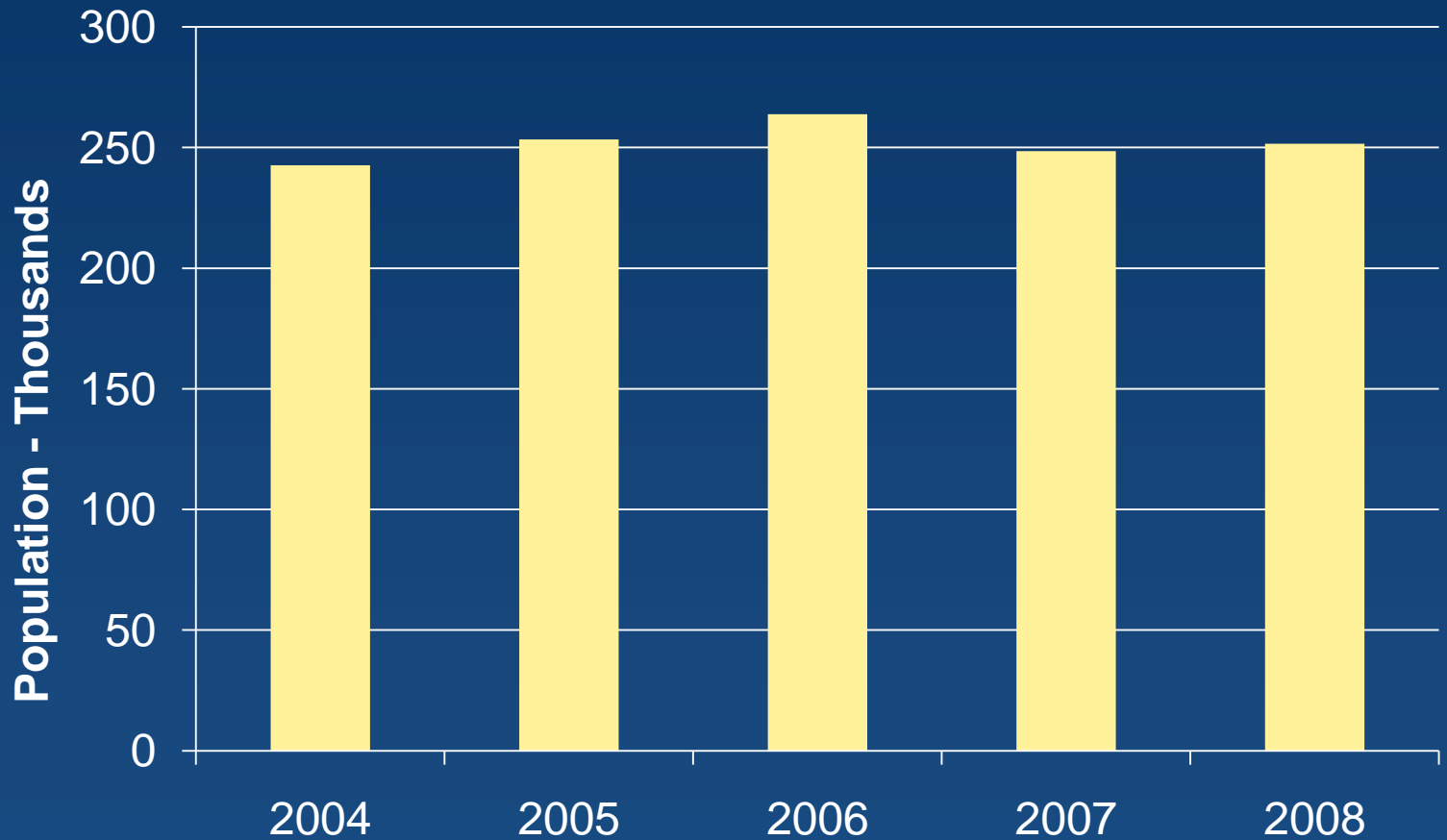


# Kansas Medicaid expenditures, FY 2008



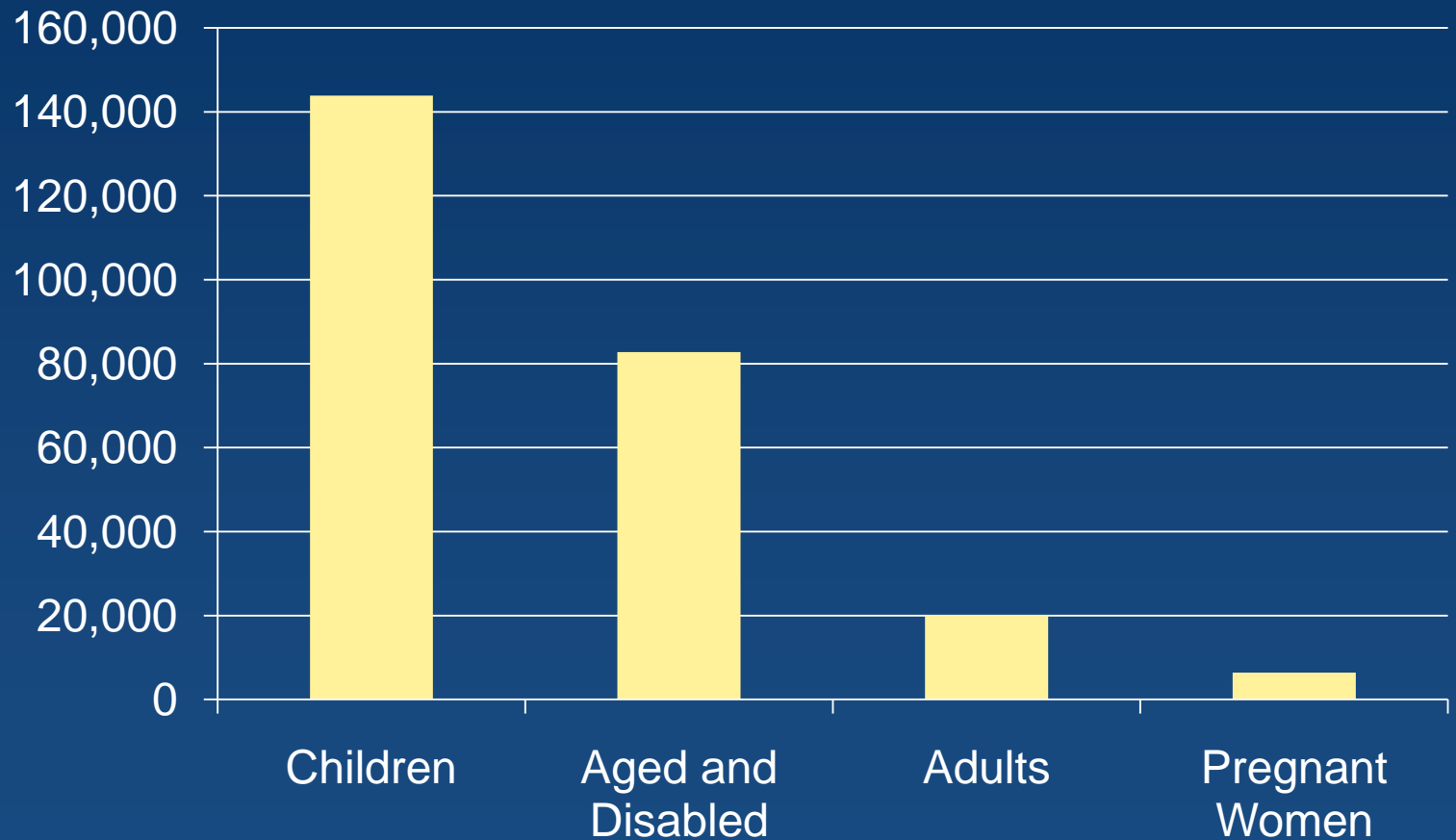


# Total Medicaid population, FY 2004 - FY2008



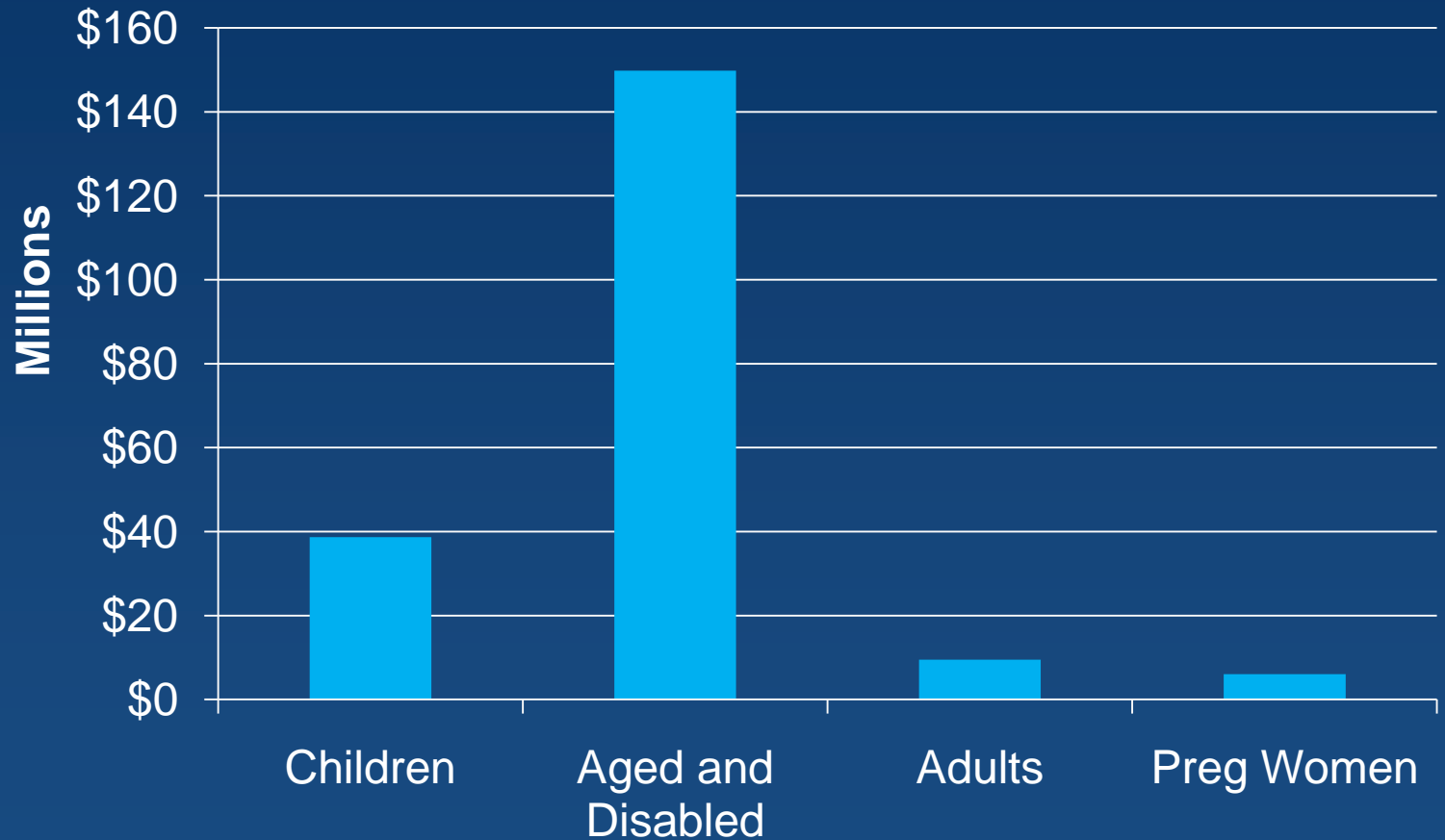


# Average monthly enrollment last quarter of CY 2008



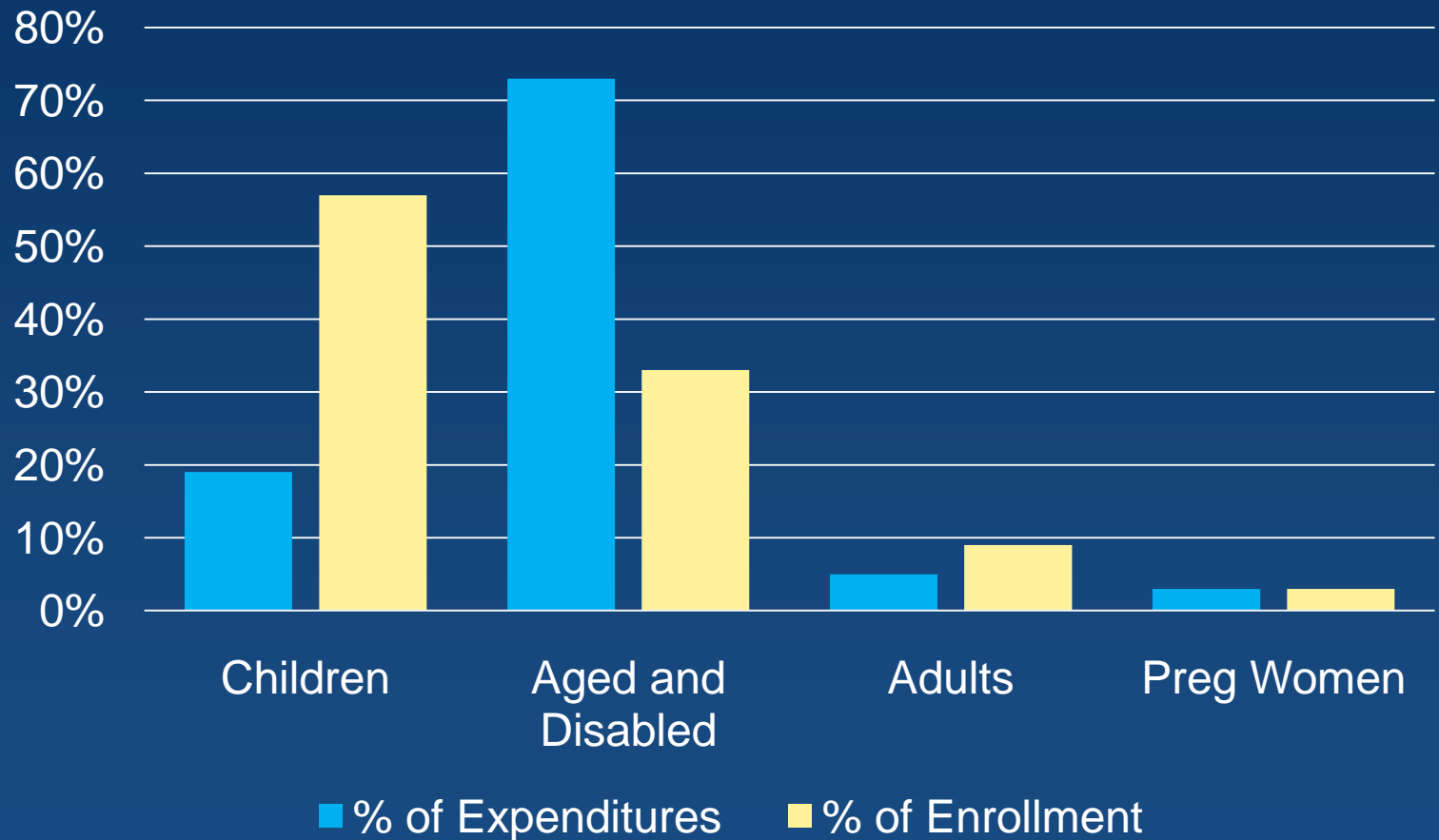


# Average monthly expenditures last quarter of CY 2008



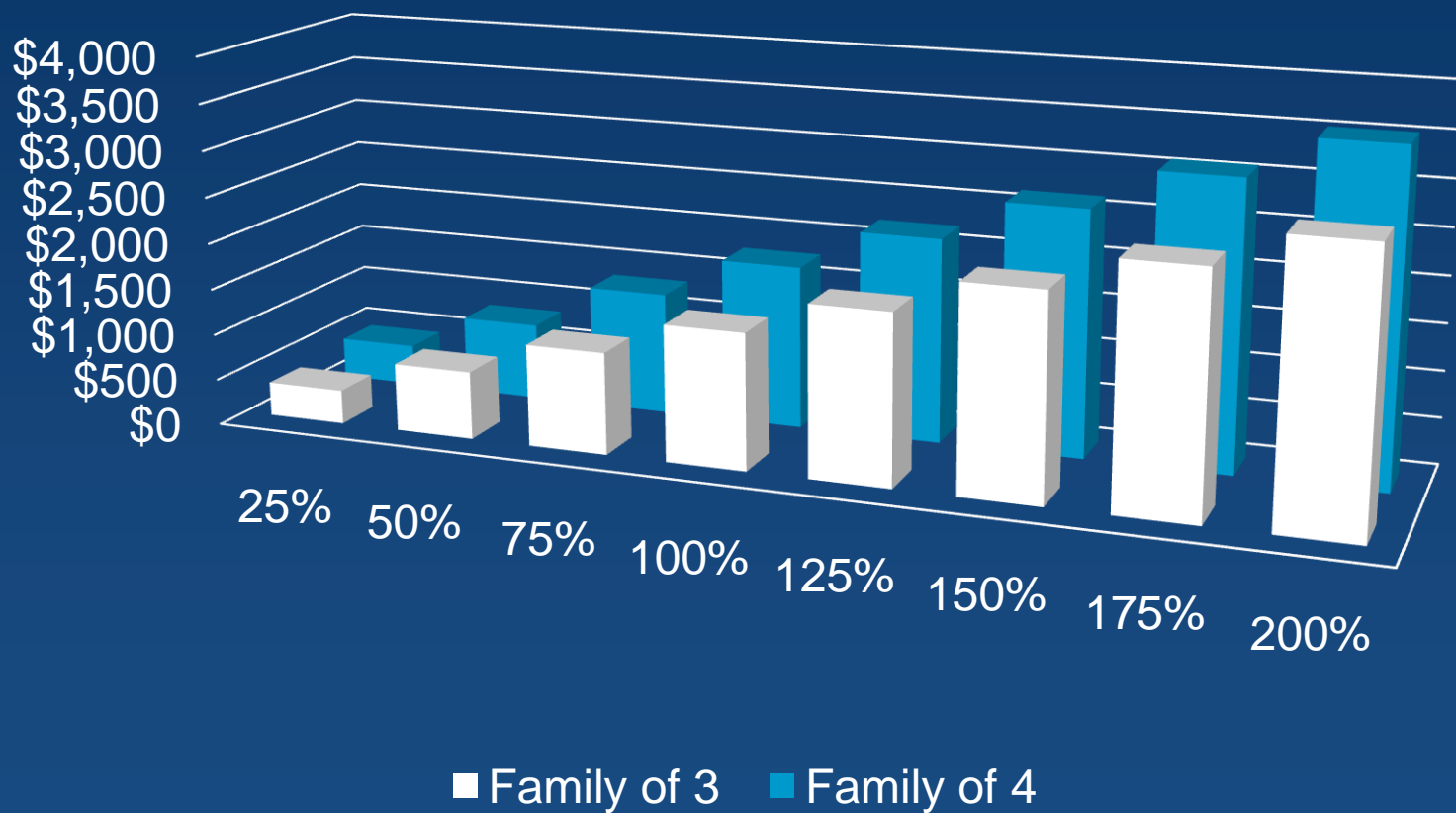


# Average monthly expenditures versus enrollment last quarter of CY 2008





# 2009 Federal poverty guidelines gross monthly income





# What drives the desire for personal responsibility in Medicaid?

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- To contain or reduce health care costs
- To improve the health of beneficiaries



# What are the underlying beliefs about personal responsibility?

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- Individual behavior can affect costs
- Individuals are in control of their health or lack of health
- Health behaviors are based on rational choice
- Individuals have the self-awareness and necessary means to live a healthy lifestyle
- Contributing to the cost of care will make individuals reduce their utilization of care



# What are the additional underlying beliefs about personal responsibility in Medicaid?

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- Some Medicaid beneficiaries are more irresponsible than the average person
- Individuals that receive public assistance are more accountable for healthy behavior



# What is needed to be personally responsible?

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- Control
- Knowledge
- Skills and abilities
- Resources
- Self-efficacy
- Opportunity
- Enabling environment



# What are the unique challenges individuals with low-incomes face?

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- Growing up poor
- Education
- Lack of Resources
- Physical Environment
- Chronic Stress
- Social Exclusion
- Survival Mentality
- Physical and mental capacity



# What have other states done to promote healthy behaviors?

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- Florida – Enhanced Benefits Account Program
  - Credits up to \$125 annually to purchase over the counter items
  - Credits earned for well-child visits, screenings, and smoking cessation
  
- Idaho – Behavior Prevention Health Assistance Program
  - Voluntary program giving incentives to change behavior
  - Up to \$200 (points) for health-related services (gym, smoking cessation)



# What have other states done to promote healthy behaviors? (continued)

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## ■ Kentucky – Get Healthy Benefits

- After one year of compliance with disease management, beneficiaries earn up to \$50 services including dental and vision, or nutritional and smoking counseling.

## ■ West Virginia – Enhanced Plan

- Beneficiaries sign contracts agreeing to routine checkups, keeping appointments, health screenings and other health behaviors.
- Beneficiaries receive benefits for mental health services, prescriptions, weight loss and smoking cessation classes, and other health services.



# What have other states done to promote healthy behaviors? (continued)

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- California – Managed care plan
  - Offered movie tickets to parents who brought their child in for well visit
  - 2004 – limited numbers of people qualified and those that did qualify few redeemed their tickets.



# What have we learned?

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- There is limited research on these policies
- Rewards and penalties don't have a significant impact in reducing Medicaid costs or improving overall health status
- Rewards may increase receipt of preventative care
- Penalties might cause harm
- States can face significant “start-up” costs for new programs
- Rewards and penalties are unlikely to reduce human and economic costs of smoking and obesity
- To pilot test new initiatives



# What have other states done to promote cost sharing?

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- Some states have introduced cost sharing as a form of personal responsibility
  - Premiums
  - Co-pays
  - Annual enrollment fees
  - Health Opportunity Accounts



# What were states experiences?

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## ■ Maryland – New premiums

- About 1 quarter of families that were subject to new premiums disenrolled from the program

## ■ Oregon – New premiums and co-payments

- Large enrollment decline accompanied increased premiums and stricter premium payment rules
- Copayments impeded access to care
- Loss of coverage significantly increased ER visits
- 67 percent of those disenrolled from the program became uninsured

## ■ Rhode Island – New Premiums

- Nearly 1 in 5 families that were subject to new premiums lost coverage
- 48 percent reported loss of coverage due to inability to pay
- 51 percent of those disenrolled from the program became uninsured



# What were states experiences?

continued

- Utah – Annual Enrollment Fee and co-pays
  - 27 percent disenrollment during a 2 month period when required to repay annual enrollment fee
  - 63 percent reported being uninsured
  - Copayments did not have a statistically significant impact on utilization
  
- Vermont – Increased premiums
  - 11 percent were disenrolled for nonpayment of premiums one month after premium increased
  
- Wisconsin – New premiums
  - Only a slight difference in enrollment between families who paid premiums and families who did not
  - Premiums delayed enrollment



# What were states experiences?

continued

- Indiana – Health Opportunity Account
  - Too early to tell
  - It is for people above 200 FPL that don't qualify for Medicaid
  
- South Carolina - Health Opportunity Account
  - Too early to tell
  - Only 5 people enrolled



# What might work?

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Policies promoting personal responsibility should ensure the individual can actually control the outcome and should increase an individual's

- Knowledge
- Skills and abilities
- Resources
- Self-efficacy
- Opportunity
- Enabling environment



# What we know about cost sharing

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- They may reduce costs
- Other things to consider
  - Reduction in enrollment
  - Increases in the uninsured
  - Negative impact on health



## What might work? continued

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- Using medical homes that provide a broad spectrum of service
- Educating consumers about healthy behaviors and appropriately accessing care
- Using a care/disease management approach
- Providing needed services to promote healthy behaviors
- Addressing broader issues that effect health



# How can Medical Homes help?

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- Can assist with educating beneficiaries
- Can assist with ensuring that needed resources are available
- Coordinate and help navigate through health care services
- Develop beneficiaries self-efficacy
- Address beneficiaries challenges in their environment



# Example of education programs

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- Health literacy for parents of head start children
  - Training on what to do when your child is sick
  - Parents reported a 48% reduction on ER visits and 37.5% in clinic visits



# Example of care/disease management Indiana

- Services/support for beneficiaries with diabetes, heart disease, asthma, and/or kidney disease
- High Risk – nurse case manager works with provider, one-on-one training in lifestyle changes and medical self-management
- Lower Risk – served by a call center that is available outside regular office hours and pro-active calls to encourage compliance
- Cost savings among congestive heart failure (CHF) participants on average \$429 per member per month (PMPM)
- Hospital costs for high risk CHF decreased \$87 PMPM and increased \$259 PMPM for those not in the program



# Example of a tobacco cessation program – Oregon

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- The program followed the following themes
  - Second-hand smoke is harmful
  - Youth initiation should be prevented
  - Cessation assistance should be provided
- Medicaid pays for all FDA approved pharmaceuticals (including over the counter), and individual, group and telephone counseling.



# What we know about obesity

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- Small weight losses of only 5-10% of initial body weight are sufficient to produce important improvements in health
- A harm reduction approach may be more effective which could include creative environmental solutions
- Food insecurity increases fat reserves
- We should be skeptical of proposals that promote activity as the sole method of treatment, especially for women



# Examples of how to address broader issues that impact health

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- Policies that increase income
  - Employment
  - Minimum Wage
- Policies that improve physical environment
  - Safety
  - Pollutants, pesticides, lead
- Policies that ensure good education for low income children
- Policies that increase food security



# Conclusion

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- Personal responsibility programs have not proven to be effective no matter the population
- Medicaid beneficiaries have increased challenges with a personal responsibility approach
- Approaches that address health and costs more broadly are more likely to be effective at improving health and reducing costs



# Kansas Health Institute

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*Information for policy makers. Health for Kansans.*