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The View From the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients

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THE VIEW FROM THE BOTTOM: CONSUMER-DIRECTED MEDICAID AND COST-SHIFTING TO PATIENTS

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Consumer-directed health care has emerged as one of the most influential ideas in health care policy.[1] Its supporters hypothesize that health care costs are high and quality is low because our current system of health insurance fails to provide consumers with incentives to use care wisely and shop for high value services.[2] Advocates of consumer-directed health care argue that giving patients financial incentives—through higher out-of-pocket costs—to take personal responsibility for their own health and health care will create market forces to control costs and improve quality and outcomes.[3] If patients have "skin in the game," the demand for unnecessary medical services will be curtailed.

When adherents of consumer-directed health care turn to Medicaid, they complain that federal Medicaid rules prevent states from requiring that recipients accept personal responsibility for the costs of their care.[4] They warn that moral hazard is a problem with any health insurance, but it is an even bigger problem with Medicaid because Medicaid offers more generous coverage than private health insurance and imposes only very small patient cost-sharing.[5]

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1. Melinda Beeuwkes Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, HEALTH AFF., Oct. 24, 2006, at w516, http://content.healthaffairs.org/cgi/reprint/25/6/w516.pdf.

2. *See id.*

3. *Id*.

4. Michael F. Cannon, *Medicaid's Unseen Costs*, 548 CATO INST. POL'Y ANALYSIS 1, 9 (2005).

5. *Id*. "Moral hazard" posits that individuals are likely to incur more costs when someone else is financially responsible. *See* John A. Nyman, *Is "Moral Hazard" Inefficient? The Policy Implications of a New Theory*, HEALTH AFF., Sept.-Oct. 2004, at 194, 194. Proponents of consumer-directed health care often use the example of free coffee at the office to illustrate their point. People drink more coffee when they do not have to pay for it. Charging for the coffee will drive down consumption and thus drive down costs for coffee. In this worldview, imposing more

These partisans describe Medicaid as no longer a safety net for the "truly needy," but a program that includes those who should be able to purchase health insurance or health care in the private market. They do not believe that working families need the comprehensive coverage that Medicaid provides—coverage that mimics employer-sponsored insurance should be adequate. Consumer-directed Medicaid proclaims: "[A]nyone can pay a few dollars, personal responsibility is important."

As in the private sector, consumer-directed Medicaid has emerged as a new, powerful vision in an ongoing debate about Medicaid's form and future. A few states have begun applying the tools of consumer-driven health care to Medicaid, reducing benefits and increasing patient costs.[6] Florida has made the boldest move: an approved Section 1115 Waiver that transforms Medicaid from health insurance into a defined-benefit voucher program.[7] Now the Deficit Reduction Act (DRA) of 2005 gives states unprecedented flexibility to transform Medicaid in the direction of consumer-directed health care through increased patient cost-sharing, limited-benefit packages benchmarked to private insurance coverage, and high-deductible Medicaid plans linked to Health Savings Accounts.[8]

Yet consumer-directed Medicaid rests on myths and misconceptions. Part I of this article provides an overview of Medicaid's structure, explaining its unique design as a safety net insurer. Part I concludes with an analysis of recent Medicaid enrollment increases and the financial pressures that have led states to call for Medicaid reform. Part II explains how consumer-directed health care has stepped into the Medicaid reform debate. In particular, Part II examines three aspects of the DRA of 2005—increased cost-sharing, limited-benefit packages, and vouchers—that give states new discretion to shift costs to Medicaid patients.

Part III explains why consumer-directed health care is a misdiagnosis for Medicaid. While Medicaid recipients are no longer just very poor welfare recipients, the near poor and even moderate-income Americans can no longer afford the premiums and out-of-pocket costs imposed by private insurance. Medicaid is a cost-effective health insurer with a track record of providing quality medical care. The prescription should be more Medicaid, not less. Medicaid recipients do not use extra, unnecessary medical services. The challenge for Medicaid recipients is not too little personal responsibility but too much.

costs on patients will cause them to become more astute users and discourage unnecessary use of medical services, driving down costs and driving up quality.

6. *See infra* Part II.

7. *See infra* Part II.D.

8. CONG. BUDGET OFF., COST ESTIMATE: S. 1932 DEFICIT REDUCTION ACT OF 2005 40–42 (2006), *available at* http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf.

I. MEDICAID: THE VIEW FROM ABOVE

Medicaid is the nation's safety net health insurance program.[9] Codified at Title XIX of the Social Security Act, Medicaid is a joint federal-state program that provides federal financial assistance to states operating approved medical-assistance plans.[10] Federal law outlines broad "mandatory" requirements that state Medicaid programs must meet, but states retain considerable flexibility to cover additional "optional" eligibility groups and categories of services.[11] States may also seek "waivers" from the Secretary of Health and Human Services to use Medicaid funds to pay for services not otherwise authorized by the federal statute and regulations.[12] As a result, Medicaid eligibility and services vary widely among states, and Medicaid operates as fifty-one distinct programs—one in each state and the District of Columbia.

Medicaid's joint federal-state structure has made Medicaid an attractive financing option for states looking to cover new health care needs for vulnerable populations. The federal Medicaid contribution is open-ended, limited only by the amount of state funds individual states are willing to contribute.[13] The federal match rate ranges from 50% to 77%, depending on the state's per capita income—with poorer states entitled to a higher federal contribution.[14] With an average federal match rate of 57%, Medicaid allows states to, at a minimum, "double their money" by using Medicaid to finance medical care.[15]

As a result, Medicaid has grown to finance an astonishing range of safety net health insurance expansions, public health initiatives, and state health reform initiatives.[16] Medicaid now provides health insurance for over 55 million children, parents, seniors, and persons with disabilities, covering more

9. *See generally* ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY IN MEDICAID (1974) (providing a thorough history of the passage and initial years of Medicaid).

10. *See* 42 U.S.C.A. §§ 1396–1396v (2003 & Supp. 2006).

11. *See id.* §§ 1396(a), 1396(d).

12. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs, like Medicaid. 42 U.S.C.A. § 1315(a)(1) (2003 & Supp. 2006). Section 1915(c) of the Act gives the Secretary authority to waive statutory and regulatory provisions to allow states to operate home and community based long-term programs. *Id.* § 1396(n). Managed care programs are operated by many states under Section 1915(b) waivers.

13. ANDY SCHNEIDER ET AL., KAISER COMM'N ON MEDICAID & UNINSURED, THE MEDICAID RESOURCE BOOK, 86 (2002), *available at* http://www.kff.org/medicaid/2236-index.cfm.

14. *Id.* at 89–90.

15. *Id.*

16. Sarah Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 9–10 (2001).

Americans than Medicare or any private health insurer.[17] Medicaid is now the largest source of federal funds to states, accounting for 44% of all federal funding that goes to states.[18]

As Medicaid has grown, it has become three programs in one: First, it is a safety net health insurance program providing acute care physician, hospital, and prescription drug coverage to children, parents, and pregnant women. Medicaid now insures a quarter of all children in the U.S.[19] It pays for 37% of births in the U.S.[20]

Second, Medicaid is the nation's primary source of financing for long-term care, both institutional and community based services. Medicaid funds 46% of all nursing home care.[21] Medicaid "home and community based waiver" programs serve the frail elderly, children and adults with physical and developmental disabilities, and persons with HIV/AIDS.[22] It is the leading source of funding for community based long-term care services.[23] Medicaid also pays for over half of all publicly financed mental health care in the U.S.[24]

Third, Medicaid fills in gaps in Medicare. Although Medicare provides near-universal coverage for people over age 65, it has substantial gaps in coverage.[25] Medicare provides almost no long-term care benefits, either in nursing homes or community settings.[26] It also has substantial deductibles and co-payments.[27] Until the enactment of Medicare Part D, Medicare provided no

17. VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & UNINSURED, LOW MEDICAID SPENDING GROWTH AMID REBOUNDING STATE REVENUES: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY STATE FISCAL YEARS 2006 AND 2007 5 (2006), *available at* http://www.kff.org/medicaid/upload/7569.pdf.

18. *Id*.

19. News Release, Comm. on Fin., Floor Statement of U.S. Senator Max Baucus on Motion to Instruct Conferees Regarding Medicaid Provisions in Budget Reconciliation Spending Legislation (Dec. 13, 2005), *available at* http://finance.senate.gov/press/Bpress/2005press/prb121205sub.pdf.

20. Daniel C. Vock, *Medicaid: Biggest Insurer is a Budget Buster*, STATELINE.ORG, Aug. 3, 2006, http://www.stateline.org/live/printable/story?contentId=131622.

21. *Medicaid and Long-Term Care Services*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), July 2006, *available at* http://www.kff.org/medicaid/upload/Medicaid-and-Long-Term-Care-Services-PDF.pdf.

22. *Id.*

23. *Id.*

24. Jeffery A. Buck, *Medicaid, Health Care Financing Trends and the Future of State-Based Public Mental Health Services*, 54 PSYCHIATRIC SERVS. 969, 969 (2003), *available at* http://psychservices.psychiatryonline.org/cgi/reprint/54/7/969.pdf. Medicaid pays for both clinical services and psychotropic medications. *Id.*

25. *See* PETER H. STOLOFF ET AL., CNA CORP. & INST. FOR DEF. ANALYSES, EVALUATION OF THE TRICARE PROGRAM: FY 2002 REPORT TO CONGRESS 5-16–5-22 (2002), *available at* http://www.tricare.mil/ocfo/_docs/eval_report_fy02.pdf.

26. *See id*. at 5-17.

27. *See id*. at 5-16–5-18.

outpatient prescription drug coverage.[28] Medicaid fills these gaps for low-income seniors who are "dually eligible" for full Medicaid benefits. Medicaid also provides limited benefits—paying Medicare premiums, deductibles, and co-payments—for Medicare recipients with incomes up to 120% of the FPL.[29]

Medicaid also fills gaps in private insurance coverage. Medicaid has never mimicked private insurance coverage. Because Medicaid has always covered more—and different—services than private insurers, it has been uniquely positioned to grow to cover evolving safety net health care needs.[30]

In the acute care arena, Medicaid has always given states the option to cover important medical care services excluded from 1965-era private insurance and still not covered by many private plans—prescription drugs, dental care, rehabilitation, and physical therapy services.[31] Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, added to the federal Medicaid law in 1967, was the country's first, and remains the most, comprehensive preventive health and treatment program for children.[32] Medicaid is the only health insurance that covers non-emergency transportation to and from medical care.[33]

Medicaid also requires states to cover treatments for chronic diseases and congenital conditions routinely excluded by private insurance.[34] Private insurance typically limits coverage to services necessary to "restore normal functioning" following an "illness or injury."[35] The "illness or injury"

28. Medicare Learning Network, *Important Information about Medicare Coverage of Drugs Under Part B and the New Medicare Prescription Drug Coverage (Part D), and Vaccines Administered in a Physician's Office—The Ninth in the MLN Matters Series on the New Prescription Drug Plans*, MLN MATTERS (Ctrs. for Medicare & Medicaid Servs., Washington, D.C.), at 2, *available at* www.cms.hhs.gov/MLNMattersArticles/downloads/SE0507.pdf (last visited Feb. 28, 2007).

29. Social Security Act §§ 1902(a)(10)(A)(i)(I), 1902(a)(10)(A)(ii)(IV), 1902(a)(10)(A)(ii)(X), 42 U.S.C.A. § 1396a (2003 & Supp. 2006).

30. *See* Rosenbaum & Rousseau, *supra* note 16; SMITH ET AL., *supra* note 17, at 5.

31. *See* 42 U.S.C.A. § 1396a(a)(10)(A) (2003 & Supp. 2006) (listing Medicaid mandatory services); *id*. § 1396d(a)(xiii)(4) (listing Medicaid optional services); STEVENS & STEVENS, *supra* note 9, at 65–67; *see also* Kaiser Fam. Found., *Medicaid: A Timeline of Key Developments (1965–1969)*, http://www.kff.org/Medicaid/timeline/pf_65.htm (last visited Feb. 28, 2007).

32. *See* JANE PERKINS & SARAH SOMERS, NAT'L HEALTH L. PROGRAM, TOWARD A HEALTHY FUTURE: MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES FOR POOR CHILDREN AND YOUTH 21–23 (2003).

33. *Health Coverage for Low-Income Populations: A Comparison of Medicaid and SCHIP* (Kaiser Comm'n on Medicaid & Uninsured), Apr. 2006, at 3, fig. 4, http://www.kff.org/medicaid/upload/7488.pdf [hereinafter *Health Coverage for Low-Income Populations*].

34. S*ee* Rosenbaum & Rousseau, *supra* note 16, at 12–14 (discussing this distinction between Medicaid and private insurance). States have discretion to set reasonable limits on Medicaid coverage, but states may not discriminate in the provision of medically necessary services solely because of the type of condition or diagnosis. *See* 42 C.F.R. § 440.225 (2004).

35. *See* Rosenbaum & Rousseau, *supra* note 16, at 13.

requirement excludes treatments for cerebral palsy and other developmental conditions which are defined as neither "illness" nor "injury."[36] The "restore normal functioning" standard excludes treatments that improve quality of life, but do not correct the underlying condition, such as occupational or speech therapy for a child with autism. [37]

Medicaid covers the long-term care services not provided by private health insurance. Medicaid mandatory services include nursing home care,[38] and states have the option to cover intermediate care facilities, a crucial source of residential care for children and adults with developmental disabilities.[39] Over the years, Congress has given states increasing options to use Medicaid to pay for long-term care in community settings including coverage for personal care, habilitation, case management, and a variety of other "home and community based" services.[40]

In recognition that Medicaid insures the poorest Americans, Medicaid has protected beneficiaries from the out of pocket costs typically imposed by private insurers. While Medicare has always imposed substantial premiums, deductibles and co-payments, Medicaid, as originally enacted, prohibited states from imposing any premiums or cost-sharing on Medicaid recipients.[41] In the early 1980s, the Medicaid Act was amended to allow states to impose "nominal" co-payments for most services for adults, but still prohibited co-pays for children's services.[42] In 2005, when private insurers were typically imposing co-payments of $15 to $25 for physician visits and $11 to $38 for prescription drugs,[43] Medicaid capped co-payments at $0.50 to $3.00 per service.[44] Moreover, while Medicaid recipients are legally obligated to pay cost-sharing amounts, providers have historically been prohibited from

36. *Id.*

37. *See, e.g.*, Bedrick v Travelers Ins. Co., 93 F.3d 149, 151 (4th Cir. 1996); *see also* Rosenbaum & Rousseau, *supra* note 16, at 13–14 (discussing these provisions).

38. *See* 42 U.S.C.A. § 1396d(a)(xiii)(4) (2003 & Supp. 2006) (listing Medicaid optional services); STEVENS & STEVENS, *supra* note 9, at 65–67; *see also* Kaiser Fam. Found., *supra* note 31.

39. 42 U.S.C.A. § 1396d(a)(xiii)(4) (2003 & Supp. 2006) (listing Medicaid optional services).

40. *Id*.

41. JONATHAN ENGEL, POOR PEOPLE'S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965 50 (2006).

42. *See* 42 U.S.C. §§ 1396o(a)–(b) (1982); 42 C.F.R. § 447.53 (1986). Co-pays were also prohibited for emergency services, family planning, hospice care, and institutionalized individuals. 42 U.S.C. § 1396o(a)–(b) (1982); 42 C.F.R. § 447.53 (1986). States were specifically prohibited from imposing premiums or enrollment fees. 42 U.S.C. § 1396o(a)(1) (1982).

43. KAISER FAM. FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2006 ANNUAL SURVEY 78, 124 (2006), *available at* http://www.kff.org/insurance/7527/upload/7527.pdf [hereinafter KFF/HRET 2006 ANNUAL SURVEY].

44. 42 U.S.C.A. § 1396o(a)(3) (2003); 42 C.F.R. §§ 447.54, 447.55 (2005).

denying care, services, or drugs to Medicaid recipients who are unable to make their co-payments.[45]

Initially, Medicaid's safety net health insurance coverage was linked to cash welfare payments: Medicaid was an additional benefit for single mothers and their children receiving Aid to Families with Dependent Children (AFDC), and aged, blind, or disabled persons receiving disability and old age assistance.[46] Over the last forty years, Medicaid has delinked from welfare and expanded to cover more poor and near-poor Americans. However, the Medicaid statute still uses categorical as well as income eligibility standards—a holdover from its beginnings as an adjunct to welfare—and the primary categories of Medicaid eligibility remain fairly close to those recognized by the world of cash welfare.[47]

The federal Act now authorizes states to extend Medicaid coverage to children and to adults who are parents, pregnant women, disabled, or elderly.[48] Children's eligibility now depends solely on family income rather than single parent status, and states may use the State Children's Health Insurance Program (SCHIP) to extend Medicaid or other government-subsidized coverage to children in families earning up to 200% of the federal poverty line (FPL).[49] For parents, categorical eligibility now extends beyond single parents to all poor parents.[50] However, federal law still prohibits states, absent a waiver, from offering Medicaid coverage to non-parent, non-disabled adults.[51] A few states have such waivers, but in forty-two states childless adults cannot qualify for Medicaid.[52]

45. 42 U.S.C.A. § 1396o(e) (2003).

46. STEVENS & STEVENS, *supra* note 9, at 61–62.

47. Social Security Act § 1902(a)(10)(A)(i), 42 U.S.C.A. § 1396a (2003 & Supp. 2006); *id.* § 1902(a)(47), 42 U.S.C.A. § 1396a; *id.* § 1920A, 42 U.S.C.A. § 1396r-1a (2003).

48. *Id.* §§ 1902(a)(10)(A)(ii), 1902(aa), 1905(b)(4), 42 U.S.C.A. §§ 1396a (2003 & Supp. 2006). The Medicaid Act also allows states to cover a few other discrete categories of adults, including women seeking treatment for breast and cervical cancer. *See* 42 U.S.C.A. § 1396(aa)(3) (2003). Forty-four states have opted to provide Medicaid coverage for this treatment for these low income uninsured women.

49. The federal Medicaid Act also requires states to cover children who are recipients of adoption assistance and foster care under Title IV-E of the Social Services Act. 42 U.S.C.A § 1396a(a)(10)(A)(ii)(VIII) (2003 & Supp. 2006).

50. Title XIX only requires that states cover parents living in single parent households or two-parent households in which the primary wage earner is unemployed. However, Title XIX also gives states the option to cover all two-parent families. 42 U.S.C.A. § 1396u (2003 & Supp. 2006).

51. Marc Steinberg, *Working Without A Net: The Health Care Safety Net Still Leaves Millions of Low-Income Workers Uninsured*, SPECIAL REPORT (Families USA, Washington, D.C.), Apr. 2004, at 3, *available at* http://www.familiesusa.org/assets/pdfs/Holes_2004_update_revb622.pdf.

52. *Id*. at 1, 3.

Federal Medicaid categorical eligibility rules remain mired in Medicaid's history as a welfare benefit, but Medicaid has changed: it is no longer a program for welfare recipients. Twenty years ago, 75% of Medicaid recipients were also receiving welfare benefits.[53] Now, close to 75% of Medicaid recipients receive no cash welfare assistance.[54] Most Medicaid recipients are children and parents in working families, but less than 20% of families with Medicaid also receive Temporary Assistance for Needy Families (TANF) or other welfare assistance.[55] Even among the elderly and disabled, where Medicaid eligibility typically is linked to qualifying for Supplemental Security Income (SSI), almost half of Medicaid recipients receive no SSI payments.[56]

Medicaid now finances health and long-term care for over 55 million Americans.[57] Medicaid provides health insurance to 42% of non-elderly Americans with incomes below 100% of the FPL, and 27% of those with incomes between 100% to 199% of the FPL.[58] More than half (53%) of Medicaid recipients are very poor, earning under 100% of the FPL, and 28% are near poor, earning between 100% to 200% of the FPL.[59]

53. *Id.*

54. STAFF OF H. COMM. ON WAYS AND MEANS, 106TH CONG., 2000 GREEN BOOK: BACKGROUND MATERIAL ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS (Comm.Print 2000); *see also* EILEEN R. ELLIS ET AL., KAISER COMM'N ON MEDICAID & UNINSURED, MEDICAID ENROLLMENT IN 50 STATES: DECEMBER 2002 DATA UPDATE (2003) (noting that as of December 1997, only 27.8% of Medicaid recipients also received cash welfare).

55. VERNON K. SMITH & GREG MOODY, NAT'L GOVERNORS ASS'N, MEDICAID IN 2005: PRINCIPLES & PROPOSALS FOR REFORM 7–8 (2005), *available at* http://www.nga.org/Files/pdf/0502MEDICAID.pdf.

56. *Id.*; *see also* ELLIS ET AL., *supra* note 54 (noting that as of December 1997, only 27.8% of Medicaid recipients also received cash welfare).

57. SMITH ET AL., *supra* note 17, at 5.

58. *The Medicaid Program at a Glance*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), May 2006, at fig. 4, *available at* http://www.kff.org/medicaid/upload/7235.pdf (including as part of Medicaid figures SCHIP, other state programs, Medicare, and military related coverage).

59. Kaiser Fam. Found., *State Health Fact: Distribution of the Nonelderly with Medicaid by Federal Poverty Level (FPL)*, http://www.statehealthfacts.org/ (Click 50 State Comparisons link; Select Medicaid & SCHIP Category; Scroll down left panel and select Distribution by FPL under Health Coverage & Uninsured: Nonelderly With Medicaid) (last visited Feb. 28, 2007). Commentators typically classify the "very poor" as people with incomes up to 100% of the FPL and the "near-poor" as those with incomes between 100% to 200% of the FPL; they use the term "low-income" when referring to all those earning below 200% of the FPL. Many refer to those with incomes in the 200% to 400% FPL income range as moderate income. *See infra* text accompanying notes 143–152 (providing an explanation of why the FPL understates the number of Americans who fail to earn enough to meet their basic needs).

Medicaid plays a crucial role in maintaining the nation's health care delivery system. With projected expenditures of over $300 billion in 2006,[60] Medicaid supports 17% of all spending for personal health care, including 17% of hospital care, 46% of nursing home costs, and 19% of prescription drug costs.[61] Medicaid accounts for 41% of revenues for safety net hospitals,[62] and one-third of the funding for community health centers, including federally qualified health clinics serving medically underserved inner city areas as well as rural health clinics and migrant clinics.[63] Medicaid also helps finance special education services in public schools by funding medically necessary therapies provided in school settings.[64]

But Medicaid enrollment—particularly among parents and children—tends to be countercyclical: when the economy is good and jobs are plentiful, lower wage workers have more access to both jobs and employer-sponsored health insurance. When the economy slows down and people lose jobs and health benefits, workers and their children become eligible for Medicaid and turn to it to tide them over until the economy picks up.

The countercyclical nature of Medicaid enrollment imposes a substantial fiscal burden on states. State tax revenues—from income, sales, and payroll taxes—decline when the economy slows down: just when states need additional revenue, rather than less, to pay for the increased demand for Medicaid.[65] Medicaid is the second-largest expenditure in most states' general fund budgets, accounting for 18% of state revenue spending compared with 36% spent for elementary and secondary education.[66] States feel the pinch when demand grows for even more Medicaid funding.

Medicaid's countercyclical pattern hit states most recently during the 2001 recession. The slow economic recovery fueled a jump in Medicaid enrollment,[67] and total Medicaid spending spiked by more than 20% from 2000

60. Off. Mgmt. & Budget, *The Nation's Fiscal Outlook*, http://www.whitehouse.gov/omb/budget/fy2006/outlook.html (last visited Feb. 28, 2007).

61. KAISER COMM'N ON MEDICAID & UNINSURED, MEDICAID: A PRIMER, KEY BACKGROUND INFORMATION ON THE NATION'S HEALTH INSURANCE PROGRAM FOR LOW-INCOME AMERICANS 8 (2005), *available at* http://www.kff.org/medicaid/7334.cfm.

62. Diane Rowland & Rachel Garfield, *Health Care for the Poor: Medicaid at Thirty-Five*, 22 HEALTH CARE FINANCING REV. 23, 23–24 (2000).

63. Sara Rosenbaum et al., *Health Centers' Role as Safety Net Providers for Medicaid Patients and the Uninsured*, ISSUE PAPER (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Feb. 2000, at 5–6, fig. 5, *available at* http://www.kff.org/medicaid/2181-index.cfm.

64. Alan Weil, *There's Something About Medicaid*, HEALTH AFF., Jan.-Feb. 2003, at 13, 22–23.

65. *See* SMITH ET AL., *supra* note 17, at 14.

66. *Id*. at 13–14.

67. VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & UNINSURED, THE CONTINUING MEDICAID BUDGET CHALLENGE: STATE MEDICAID SPENDING GROWTH AND COST

to 2002, while state general revenue funding plummeted.[68] States complained that large Medicaid spending increases were outstripping state revenue increases and crowding out other important state budget needs like education.[69]

Governors began describing Medicaid as a program that was "unsustainable," and the National Governors Association called for changes in Medicaid to reduce the burden on state coffers.[70] Some of their proposals are familiar refrains in an ongoing debate about the relative roles that federal and state governments should play in funding and administering the joint federal-state safety net program, and whether the federally funded Medicare program should function more as a safety net insurer.[71] Governors argue that the costs of nursing home care for the nation's elderly should be shifted to Medicare—a federally funded program.[72] They maintain that federally funded Medicare should take over the costs now born by Medicaid for low-income "dually eligible" seniors who depend on Medicaid coverage to pay Medicare premiums, deductibles, and co-payments, and to other gaps in Medicare home and community based coverage.[73] The governors also propose removing federal limits on categorical eligibility to allow states to cover non-disabled, non-parent adults without a special Medicaid waiver.[74] In general, state governors appeal for increased federal law flexibility to allow states to restructure their Medicaid programs via statutorily authorized optional service and eligibility categories without being required to go through the Medicaid waiver processes.[75]

State pleas for Medicaid reform through shifting costs from the states to the federal government are familiar cries in the world of Medicaid reform, but recently the National Governors Association took up a new refrain: demands for increased state flexibility to shift more of the costs of care onto Medicaid beneficiaries.[76] Proposals for Medicaid cost-shifting to patients are fueled by the same theories pushing consumer-directed health care in private insurance as well as concerns that Medicaid is displacing employer-sponsored insurance.

CONTAINMENT IN FISCAL YEARS 2004 AND 2005 1 (2004), *available at* http://www.kff.org/medicaid/7190.cfm; John Holahan & Arunabh Ghosh, *Understanding the Recent Growth in Medicaid Spending, 2000–2003*, HEALTH AFF., Jan. 26, 2005, at W5–52 (Jan. 26, 2005), http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.52v1.pdf.

68. SMITH ET AL., *supra* note 17, at 5–6.

69. SMITH & MOODY, *supra* note 55, at 9.

70. *See, e.g.*, NAT'L GOVERNORS ASS'N, SHORT-RUN MEDICAID REFORM (Aug. 29, 2005), *available at* http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF.

71. *See id.*

72. NAT'L GOVERNORS ASS'N, MEDICAID REFORM: A PRELIMINARY REPORT 2 (June 15, 2005), *available at* http://www.nga.org/Files/pdf/0506medicaid.pdf.

73. *Id.* at 2.

74. *Id.* at 6–7.

75. *Id.*

76. SMITH & MOODY, *supra* note 55, at 14.

II. SHIFTING COSTS TO PATIENTS: CONSUMER-DIRECTED MEDICAID

Proponents of consumer-directed health care worry that health insurance shelters patients from the costs of health care causing patients to use unnecessary services and drives up costs. [77] They warn that this problem is particularly acute with Medicaid because Medicaid offers more generous coverage than private health insurance and imposes little or only very small patient cost-sharing. [78]

These advocates point out that Medicaid recipients are no longer exclusively the very poor welfare recipients that the program was designed to serve in 1965, but predominately working parents and children.[79] They argue that working families on Medicaid should not get better health insurance coverage than working families with private employer sponsored insurance.[80] They worry that Medicaid discourages work because it is means-tested, and thus recipients may forgo work because of fear of losing Medicaid coverage.[81] They describe the program as "discouraging self-sufficiency and encouraging dependence among beneficiaries"[82] and fear that the existence of Medicaid causes low-income workers to forgo purchasing private insurance and results in employers of low-income workers failing to offer coverage.[83]

As in the private sector, consumer-directed Medicaid has emerged as a new vision in an old Medicaid reform debate. A few states, including Utah and Oregon, have Medicaid waivers to offer limited-benefit packages that make Medicaid coverage more like private insurance.[84] New Mexico, Washington, and a handful of other states have approved Medicaid waivers to increase patient cost-sharing.[85] South Carolina submitted a waiver seeking permission to give recipients the option of Medicaid high-deductible catastrophic coverage with health savings accounts.[86] Florida has an approved

77. Buntin, et al., *supra* note 1, at w516.

78. Cannon, *supra* note 4, at 9.

79. *Id*. at 2.

80. *Id*. at 16–17.

81. *Id*. at 5.

82. Cannon, *supra* note 4, at 1.

83. *Id*. at 7.

84. Samantha Artiga & Cindy Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, POL'Y BRIEF (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Mar. 2005, at 3, *available at* http://www.kff.org/Medicaid/7286.cfm; *Overview of the Utah Section 1115 Waiver*, MEDICAID FACTS (Kaiser Comm'n on Medicaid Uninsured, Washington, D.C.), July 2004, at 1, *available at* http://www.kff.org/medicaid/upload/Utah-Section-1115-Waiver-Fact-Sheet.pdf.

85. Artiga & Mann, *supra* note 84, at 3.

86. Judith Solomon, *Still Risky Business: South Carolina's Revised Medicaid Waiver Proposal* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), Jan. 11, 2006, at 1, *available at* http://www.cbpp.org/1-11-06health.pdf.

waiver to replace Medicaid health insurance with a defined-contribution voucher.[87]

Congress has also jumped on the consumer-directed Medicaid bandwagon: The Deficit Reduction Act (DRA) of 2005 gives states unprecedented flexibility to cost shift to patients without federal waiver approval.[88] Ushering in possibly the most far-reaching changes to the Medicaid program since its creation in 1965, the DRA gives states new authority to offer thinner benefit packages that make Medicaid coverage more like private insurance, increase patient cost-sharing, and allow states to transform Medicaid from a health insurance program with defined benefits to a defined-contribution voucher system.[89] These provisions—along with Florida's Medicaid Waiver that allows the state to convert Medicaid into a voucher system—signal a new era of experimentation with consumer-directed Medicaid.

A. Increased Patient Cost-Sharing

The DRA adds a new section to the Medicaid Act that, for the first time, gives states the option to impose substantial patient cost-sharing, including co-payments, co-insurance, premiums, and deductibles. The Act removes previous federal law requiring that premiums and cost-sharing be comparable for all eligibility groups, allowing states to vary premiums and cost-sharing for parents, children, the disabled, and the aged.

States may now impose cost-sharing as high as 20% of the cost of the service for those with incomes above 150% of the FPL and up to 10% of cost for those with incomes between 100% to 150% of the FPL.[90] Those with incomes below 100% of the FPL are still subject to the current "nominal" co-payment limit of $0.50 to $3 per service, but these ceilings will increase annually pegged to the medical care component of the Consumer Price

87. *Florida Medicaid Waiver: Key Program Changes and Issues*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Dec. 2005, at 1, *available at* http://www.kff.org/medicaid/upload/7443.pdf.

88. *See* 42 U.S.C.A. § 1396o-1 (West 2006). For a discussion of the competing political philosophies that resulted in the DRA, see Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5 (2006).

89. *See* 42 U.S.C.A. § 1396o-1 (West 2006).

90. Deficit Reduction Act of 2005 § 6041(b)(1)(B), 42 U.S.C.A. § 1396o-1 (West 2006). The DRA does not address those with incomes below 100% of the FPL, but the Centers for Medicare & Medicaid Services (CMS) has indicated that pre-DRA provisions limiting cost-sharing to "nominal" amounts remain in effect for these recipients. Letter from Dennis G. Smith, Director for Ctrs. for Medicare & Medicaid Servs., to State Medicaid Director (June 16, 2006), *available at* http://www.cms.hhs.gov/smdl/downloads/SMD061606.pdf. CMS indicates that it will be providing further guidance on those with incomes below 100% through the administrative rule-making process. *Id.*

Index—a figure that has been rising twice as fast as the general inflation rate.[91] States may also charge premiums to children and adults in families with incomes over 150% of the FPL.[92]

States are still prohibited from charging co-pays for children's preventive care. Co-pays also remain prohibited for pregnancy-related services, family planning, institutionalized individuals, emergency services, and treatment for breast or cervical cancer.[93]

However, all other services can be subject to co-payments.[94] States may impose co-payments for sick child care for children up to age 5 with incomes above 133% of the FPL and for children age 6 and older with incomes above 100% of the FPL.[95] The DRA also authorizes states to create separate co-payment requirements for non-preferred prescription drugs.[96] States using this prescription drug option may impose cost-sharing on all Medicaid recipients including all children: No services or groups are exempt from cost-sharing for non-preferred drugs.[97]

The DRA limits total out-of-pocket costs—premiums, deductibles, and co-payments—to 5% of family income, computed on either a monthly or quarterly basis.[98] However, families, not the state, are responsible for keeping track of when cost-sharing hits the 5% ceiling. This documentation can be difficult for families, especially when income and expenses vary throughout the year.

91. Deficit Reduction Act of 2005 § 6041(b), 42 U.S.C.A. § 1396o-1 (West 2006); Leighton Ku et al., *The House Reconciliation Bill's Provisions on Medicaid Co-Payments and Premiums: Are They Mild or Harsh?* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), Nov. 22, 2005, *available at* http://www.cbpp.org/11-10-05health.pdf.

92. Deficit Reduction Act of 2005 § 6041(b)(2)(A), 42 U.S.C.A. § 1396o-1 (West 2006). The only groups exempted from premiums are pregnant women, those receiving hospice care, institutionalized individuals, and women receiving breast or cervical cancer treatment. *See id.* § 6041(b)(3)(A), 42 U.S.C.A. § 1396o-1. Children in a "mandatory" category of Medicaid eligibility are also exempt from premium requirements. *See id*. But except for children in foster care, children who are mandatory eligibles live in families with incomes below 150% of the FPL, i.e., children who are ages 0 to 5 with incomes up to 133% of the FPL and children 6 and older with incomes up to 100% of the FPL. *See id*.

93. 42 U.S.C.A. § 1396o-1(b)(3)(B)(ii)–(ix).

94. *Id*. Children ages 0 to 5 with incomes below 133% of FPL and children age 6 and older with income up to 100% of FPL are "mandatory" Medicaid eligibles and thus children exempt from cost sharing requirements. *See id*.

95. Deficit Reduction Act of 2005 § 6041(b)(3)(B), 42 U.S.C.A. § 1396o-1 (West 2006).

96. *Id.* § 6042(a)(1)(A), 42 U.S.C.A. § 1396o-1. Co-payments on non-prescription drugs can be up to 20% of the cost of the drug for those with incomes over 150% of the FPL, and a "nominal" amount (up to $3 per prescription) for those with incomes below 150% of the FPL, including those with incomes below 100% of the FPL. *Id.* § 6042(a)(2)(A), 42 U.S.C.A. § 1396o-1.

97. *See id.* § 6042.

98. *Id.* § 6041(b)(2)(A), 42 U.S.C.A. § 1396o-1 (West 2006).

The DRA also allows states to deny coverage and services to Medicaid recipients who are unable to pay premiums and co-payments. States may permit health care providers to deny care and services to Medicaid beneficiaries who have unpaid co-payments—even in circumstances in which the recipient is financially unable to make payment.[99] The DRA also allows states to terminate Medicaid coverage for failure to pay premiums for sixty days.[100]

Kentucky has already taken advantage of the DRA's new provisions and implemented state plan amendments to increase Medicaid cost-sharing.[101] There, most non-elderly adults—parents, pregnant women, and adults with disabilities—are now subject to increased co-pays, a $225 annual out of pocket maximum for prescription drugs, and a separate $225 maximum for other medical services.[102]

B. Limited Benefits

The DRA also gives states a new option to place children and parents in limited-benefit Medicaid plans with coverage similar to employer-sponsored insurance rather than Medicaid's more comprehensive coverage.[103] A number

99. *See id.* § 6041(d)(1), 42 U.S.C.A. § 1396o-1 (West 2006). For detailed analysis of the new premium and cost-sharing provisions, see *The Deficit Reduction Act of 2005: Congress Targets Beneficiaries for Cuts*, 224 HEALTH ADVOC. 1, 21–25 (2006), *available at* http://www.healthlaw.org/library.cfm (Click link to Medicaid Page; Click link to Deficit Reduction Act of 2005; Scroll to Document).

100. Deficit Reduction Act of 2005 § 6041(d)(2), 42 U.S.C.A. § 1396o-1 (West 2006).

101. *KyHealth Choices Medicaid Reform: Key Program Changes and Questions*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), July 2006, at 1–2, *available at* http://www.kff.org/medicaid/upload/7530.pdf [hereinafter *KyHealth Choices*].

102. *Id.* Co-pays are not imposed for preventive services. *Id.* at 2.

103. *See* Deficit Reduction Act of 2005 § 6044, 42 U.S.C.A. § 1396u-7 (West 2006); *see also* Letter from Dennis G. Smith, Director of the Center for Medicare & Medicaid Services, to the State Medicaid Director, at 5 (Mar. 31, 2006), *available at* http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf; Ctrs. for Medicare & Medicaid Servs., *Roadmap to Medicaid Reform: New Options to Improve and Expand Insurance Coverage for Acute Care Needs* (State Medicaid Director Letters), at 1 (Mar. 31, 2006), http://www.cms.hhs.gov/smdl/downloads/Rvacutecare.pdf. States may use benchmark coverage for all Medicaid-eligible children and for parents, elderly, and pregnant women who are not "mandatory" eligibles under the federal statute. *Deficit Reduction Act of 2005: Implications for Medicaid* (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Feb. 2006 [hereinafter *Implications for Medicaid*], *available at* http://www.kff.org/medicaid/upload/7465.pdf. Individuals who qualify for Medicare as well as Medicaid and those with long-term care needs are exempt from benchmark coverage. *Id.* Parents with incomes as low as 9% of the FPL fall above Medicaid mandatory eligibility levels and could be moved into mandatory benchmark coverage. *Id.* For an excellent discussion of issues raised by Medicaid limited benefits, see Sara Rosenbaum, *Defined-Contribution Plans and Limited-Benefit Arrangements: Implications for Medicaid Beneficiaries*, POL'Y BRIEF (Geo. Wash. U. Sch. Pub. Health & Health Servs.), Sept. 13, 2006, http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Rosenbaum_AHIP_FNL_ 091306.pdf.

of states have used Medicaid waivers to expand Medicaid eligibility using limited benefit plans.[104] However, the DRA gives states the option to reduce coverage to presently eligible groups through limited benefit plans, while requiring states to continue to use the more complicated waiver process to obtain federal permission to expand coverage through limited benefit plans.[105]

Limited-benefit plans are already a state option in the SCHIP, the safety net health insurance program for children in families with incomes above Medicaid levels, typically between 100% to 200% of the FPL.[106] The DRA allows states to use limited-benefit plans for lower income Medicaid children—even those with incomes below 100% of the FPL.[107] It also allows limited-benefit plans for Medicaid-eligible parents and pregnant women who are not "mandatory" eligibles under federal law.[108] In some states this includes parents with incomes as low as 9% of the FPL.[109] Moreover, CMS has interpreted the DRA to allow states to offer all Medicaid recipients the choice of enrolling in limited plans rather than traditional Medicaid.[110] Idaho, Kentucky, and West Virginia have already used this increased flexibility to reduce benefits, and enroll children and their parents in limited-benefit Medicaid plans.[111]

Limited-benefit plans are typically referred to as "benchmark" coverage because plans must be similar to policies offered in the private market.[112] The DRA gives states a wide variety of plans they may benchmark against: the standard Blue Cross/Blue Shield Plan offered under the Federal Employee Health Benefits Plan, a health plan offered by the state to its own employees, or a plan offered by an HMO with the largest commercial enrollment in the state.[113] Benchmark equivalent coverage can also be any other coverage

104. *See* Rosenbaum, *supra* note 103, at 5.

105. Deficit Reduction Act of 2005 § 6041(b), 42 U.S.C.A. § 1396o-1 (West 2006).

106. *Health Coverage for Low-Income Populations*, *supra* note 33, at 3.

107. *Implications for Medicaid*, *supra* note 103, at 4–5.

108. *Id*.

109. *Id*. at 3.

110. Letter from Dennis G. Smith, *supra* note 103, at 3; Ctrs. for Medicare & Medicaid Servs., *supra* note 103, at 2; *see* Judith Solomon, *The Illusion of Choice: Vulnerable Medicaid Beneficiaries Being Placed in Scaled-Back "Benchmark" Benefit Packages* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), Sept. 14, 2006, at 1, *available at* http://www.cbpp.org/9-14-06health.pdf.

111. *KyHealth Choices*, *supra* note 101, at 1–2; *West Virginia Medicaid State Plan Amendment: Key Program Changes and Questions*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), July 2006, at 1, *available at* http://www.kff.org/medicaid/upload/7529.pdf; Rosenbaum, *supra* note 103, at 5.

112. *Health Coverage for Low-Income Populations*, *supra* note 33, at 3.

113. *See* Ctrs. for Medicare & Medicaid Servs., *supra* note 103, at 1.

proposed by the state that the Centers for Medicare and Medicaid Services (CMS) determines provides "appropriate" coverage.[114]

Limited-benefit plans reduce Medicaid coverage. Even the most generous benchmark plans do not offer key services covered by traditional Medicaid: family planning, case management, personal care services, non-emergency transportation to and from medical care, nursing home care, intermediate care facilities for children and adults with developmental disabilities, and home and community based services.[115] Moreover, since the DRA gives states the option to benchmark to any "health plan offered by the state to its own employees," states now have the option to force Medicaid-eligible parents and children into "bare bones" catastrophic coverage with a high deductible if such an option is available to state employees.[116]

Moreover, benchmark private insurance plans use more restrictive definitions of "medical necessity" than does traditional Medicaid.[117] Private plans place limits on rehabilitation services like physical, occupational, and speech therapy and home health services that are not permitted under traditional Medicaid rules.[118]

Private insurance does not cover the outreach, education, and screening services provided by Medicaid's EPSDT program. The DRA requires that children enrolled in benchmark plans be provided EPSDT services as "wrap around" services, i.e., as an additional benefit to their limited-benefit plan.[119] However, it is unclear how well children will be able to access EPSDT services offered separate and apart from their benchmark plan.

114. *Id*. Benchmark equivalent coverage must include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, well-baby and well-child care including immunizations, and other appropriate prevention services. Letter from Dennis G. Smith, *supra* note 103, at 4. Benchmark coverage must also provide coverage for rural health clinic and federally qualified health center services for all recipients. Deficit Reduction Act of 2005 § 6044(a)(4).

115. *Health Coverage for Low-Income Populations*, *supra* note 33, at 3.

116. *See* Deficit Reduction Act of 2005 § 6044(b)(1)(B), 42 U.S.C.A. 1396u-7 (West 2006) (explaining that benchmark coverage includes any "plan that is offered and generally available to State employees").

117. *Health Coverage for Low-Income Populations*, *supra* note 33, at 3.

118. *Id*. at 3.

119. *Id*. The DRA also requires that states ensure that both child and adult beneficiaries with benchmark coverage have access to rural health clinics and federally qualified health center (FQHC) services. Letter from Dennis G. Smith, *supra* note 103, at 5.

C. High Deductibles + Health Savings Accounts

The DRA also introduces high-deductible coverage combined with health savings accounts (HASs) to Medicaid, authorizing the Secretary of Health and Human Services to allow up to ten states to set up Health Opportunity Account (HOA) demonstrations.[120] To many, high-deductible insurance policies combined with HSAs are the signature form of consumer-directed health care.[121] High deductibles + HSAs are designed to give consumers the financial incentive to keep their health care costs below the amount in their HSAs. Not only are consumers allowed to retain money remaining in the account at the end of the year but these plans also typically create a "donut hole" gap between the annual HSA deposited amount and catastrophic health insurance coverage.

States participating in the HOA demonstration will be allowed to voluntarily enroll Medicaid-eligible parents and children in coverage that combines high deductibles + HSAs.[122] States may claim federal Medicaid matching funds for HOA deposits of up to $2,500 per adult and $1,000 per child.[123] States must provide participating families with high-deductible Medicaid coverage, but the DRA authorizes states to impose a donut hole of up to $250 per adult and $100 per child beyond the funds in the HOA before Medicaid coverage begins.[124]

Prior to passage of the DRA, South Carolina was negotiating a Section 1115 waiver to give recipients the option of Medicaid-funded, risk-adjusted "personal health accounts" in lieu of traditional Medicaid.[125] While South Carolina is revamping its plan in light of new DRA provisions, the original proposal provides a glimpse of how states may try to structure HOA demonstrations.

Under South Carolina's proposal, once an individual's HSA is exhausted, he or she must cover a donut hole of $250 before being eligible for catastrophic coverage through a Medicaid-approved private managed care plan or Preferred Provider Organization (PPO).[126] Each personal health account is

120. *Implications for Medicaid*, *supra* note 103, at 6.

121. *See also* Michele Melden, *Guarding Against the High Risk of High Deductible Health Plans: A Proposal for Regulatory Protections*, 18 LOY. CONSUMER L. REV. 403, 403 (2006); *see, e.g.*, Carolyn M. Clancy & Anne K. Gauthier, *Consumer-Driven Health Care—Beyond Rhetoric with Research and Experience*, 39 HEALTH SERVS. RES. 1049 (2004); .

122. Deficit Reduction Act of 2005 § 6082(b)(5), 42 U.S.C.A. § 1396u-8 (West 2006).

123. *Id.* § 6082(d)(2)(C), 42 U.S.C.A. 1396u–8 (West 2006).

124. Deductibles cannot exceed 110% of the amount contributed by the state. Deficit Reduction Act of 2005 § 6082(c)(2), 42 U.S.C.A. § 1396u-8 (West 2006). These maximum amounts are subject to be increased based upon inflation. *Id*.

125. ROBERT M. KERR, S.C. DEP'T OF HEALTH & HUM. SERVS., SOUTH CAROLINA MEDICAID CHOICE: AN 1115 DEMONSTRATION WAIVER PROPOSAL 10 (2005), http://www.dhhs.state.sc.us/Internet/pdf/SCMC.pdf. For descriptions of other aspects of the South Carolina waiver proposal, see Solomon, *supra* note 86, at 1.

126. Solomon, *supra* note 86, at 1.

risk-rated based on the person's age, sex, eligibility category, and (in some cases) health status.[127] However, fears are that risk rating systems are still rather inaccurate, and individuals often have unanticipated medical problems, making it likely that participants will exhaust their accounts and run into the $250 donut hole.[128]

D. Vouchers

The DRA does not give states the option to use Medicaid vouchers, but Florida has an approved Section 1115 waiver to transform the state's Medicaid program into a Medicaid voucher system.[129] While health spending accounts provide consumers with money with which to directly purchase health care, health insurance vouchers give consumers a set dollar amount to be used toward the purchase of health insurance coverage.[130] Both are forms of defined contribution health plans that place the consumer at increased financial risk when compared with traditional health insurance. HSAs place consumers at risk that their health care costs will be less than the amount in their health spending account. Health insurance vouchers place consumers at risk that their voucher will not cover the cost of adequate health insurance.

Florida's voucher program assigns each Medicaid recipient a "risk-adjusted premium" based on their health status and historic use of Medicaid services.[131] Medicaid-eligible Floridians can use the vouchers to purchase health insurance from Medicaid-approved managed-care plans, or through employer-sponsored or individual insurance coverage.[132] Recipients who use

127. *Id*. at 6.

128. *Id*. at 6–7. South Carolina's Section 1115 Waiver proposal would also allow recipients to use the funds as a voucher: (1) to purchase an individual private insurance policy, through a Managed Care Organization or other entity, (2) to purchase coverage through a Medicaid PPO "medical home network," or (3) to purchase employer-sponsored insurance. *Id*. Recipients opting to purchase PPO "medical home network" coverage would be charged their entire personal health accounts (PHAs). *Id*. With the other three options, recipients could keep any amount in their PHA remaining after paying their health insurance premium and out-of-pockets costs. *Id*. Private insurance plans would not be required to provide the range of benefits now offered under Medicaid. *Id*.

129. Gov. Jeb Bush, *Market Principles: The Right Prescription for Medicaid*, 17 STAN. L. & POL'Y REV. 33 (2006); Joan Alker, *Understanding Florida's Medicaid Waiver Application*, POL'Y BRIEF (Winter Park Health Found., Winter Park, Fla.), Sept. 2005, at 4, *available at* http://www.wphf.org/pubs/briefpdfs/Medicaid5.pdf.

130. Alker, *supra* note 129, at 4.

131. FLA. MEDICAID REFORM, FLA. AGENCY FOR HEALTH CARE ADMIN., APPLICATION FOR 1115 RESEARCH AND DEMONSTRATION WAIVER 8 (2005), *available at* http://www.fccmh.org/content/1/file/medicaid_reform_waiver_final_101905.pdf.

132. *Id*. at 4–5, 30–33; *see also* SARA ROSENBAUM & ANNE MARKUS, COMMONWEALTH FUND, THE DEFICIT REDUCTION ACT OF 2005: AN OVERVIEW OF KEY MEDICAID PROVISIONS AND THEIR IMPLICATIONS FOR EARLY CHILDHOOD DEVELOPMENT SERVICES (2005), *available at* http://www.cmwf.org/usr_doc/Rosenbaum_DRA_Medicaid_ provisions_958.pdf; Alker, *supra*

their vouchers for private insurance are responsible for any premium costs in excess of their voucher, all patient cost-sharing such as deductibles and co-payments, and all costs of uncovered services.[133]

For Medicaid-approved plans, Florida is giving the private plans more flexibility to design benefit packages that differ from each other and from Florida's previous Medicaid coverage.[134] The state hopes to generate a variety of plan types to better meet the special needs of various types of Medicaid beneficiaries, particularly those with serious and chronic health problems.[135] However, the state does not guarantee that a recipient's voucher will be sufficient to purchase the plan that best meets his or her specific medical needs.[136] Neither does the state have any financial responsibility if a Medicaid approved plan's benefit package does not cover unanticipated medical needs that arise during the enrollment year.[137]

Moreover, all adults except pregnant women who purchase state approved private Medicaid plans will be subject to an annual maximum benefit limit on covered services.[138] When the cost of care reaches this limit, neither the state

note 129 (describing various aspects of the Florida waiver); Cindy Mann & Samantha Artiga, *New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility?*, ISSUE PAPER (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), June 2006, at 1, *available at* http://www.kff.org/medicaid/upload/7507.pdf; *The Medicaid Program at a Glance*, *supra* note 58.

133. FLA. MEDICAID REFORM, *supra* note 131, at 33.

134. *Id*. at 17. Plans must cover all services that are mandatory under federal Medicaid law, but there is increased flexibility to determine which optional Medicaid services to cover and increased discretion to determine the amount, duration, and scope of covered services, including setting numerical limits on services such as physician visits or prescription drug coverage. *Id*. Benefit packages must meet the state's sufficiency standard which requires that "the overall level of services provided is appropriate for the premium received." FLA. MEDICAID REFORM, IMPLEMENTATION PLAN, *available at* http://ahca.myflorida.com/Medicaid/medicaid_reform/implementationplan/implementationplan_11-29-05.pdf; *see* Mann & Artiga, *supra* note 132, at 21, n.16 ("Neither the waiver nor the state's implementation plan for the waiver requires coverage of all currently covered optional services; state legislation enacted to implement the waiver may require optional services be covered but not any particular scope of coverage.").

135. *See, e.g.*, Fla. Medicaid Reform, Fla. Agency for Health Care Admin., Medicaid Reform Expansion, http://ahca.myflorida.com/Medicaid/medicaid_reform/ (last visited Feb. 15, 2007).

136. For example, the following sources provide comprehensive detail about the Florida 1115 waiver and make no mention of a guarantee: FLA. MEDICAID REFORM, *supra* note 131; FLA. MEDICAID REFORM, *supra* note 134. "Neither the waiver nor the state's implementation plan for the waiver requires coverage of all currently covered optional services; state legislation enacted to implement the waiver may require optional services be covered but not any particular scope of coverage." Mann & Artiga, *supra* note 132, at 21 n.16. "[T]he overall level of services provided is appropriate for the premium received." *Id.* at 10.

137. *See* Mann & Artiga, *supra* note 132, at 1.

138. FLA. MEDICAID REFORM, *supra* note 131, at 23. Children will also be required to enroll in the new system, but plans offered to children are not subject to the maximum cap and such plans must offer the full range of Medicaid EPSDT services. *Id*. at 17.

nor the Medicaid approved private plan is responsible for covering further medical costs.[139] Florida officials estimate that annually 5% of Medicaid recipients—those with the most serious chronic and disabling medical conditions—will max out their benefit coverage.[140]

Thus, consumer-directed Medicaid is born: higher cost-sharing, limited benefits, high deductibles + HSAs, and vouchers purposefully shift the cost of medical care to Medicaid patients. This cost-shifting seeks to incentivize Medicaid recipients to be prudent consumers of health care, but it also shifts the financial risk to low-income families who have few resources to absorb these additional costs.

III. THE VIEW FROM THE BOTTOM

A triumvirate of ideas governs consumer-directed Medicaid: First, Medicaid is no longer a safety net for the "truly needy," but a program that includes those who should be able to purchase health insurance or health care in the private market. Second, the working families who now make up a majority of Medicaid recipients do need the comprehensive coverage that Medicaid provides: coverage that mimics employer-sponsored insurance should be adequate. Third, Medicaid costs are high and quality is low because Medicaid recipients are shielded from the cost of care. Each of these ideas rests on false premises.

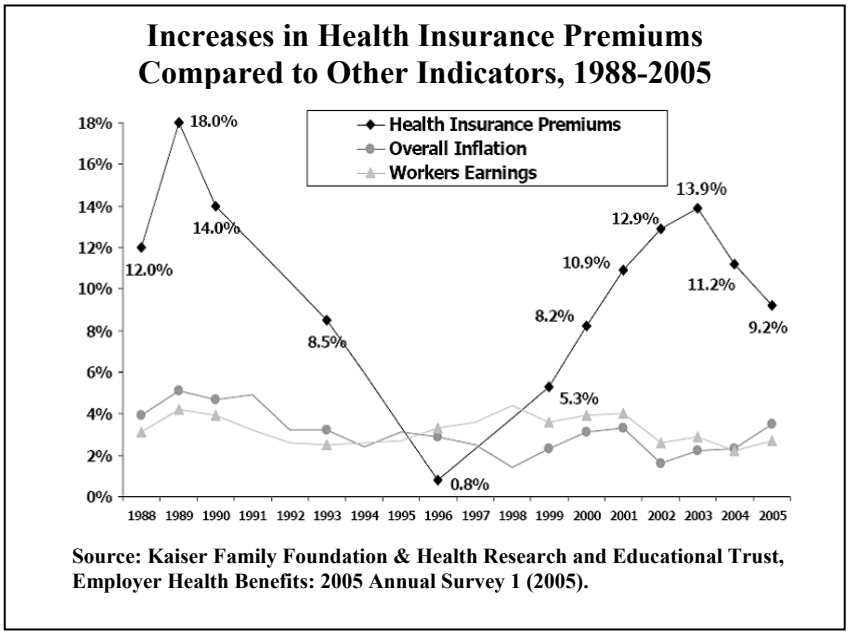
First, it is not just the very poor who are priced out of private insurance, low- and even moderate-income working Americans can no longer afford private insurance premiums and need some kind of safety net health insurance. Since 2000, the percentage of firms offering health insurance has slipped from 69% to 61%: Only 42% of workers earning less than $20,000 a year have an employer who offers health benefits.[141] Among firms that offer health insurance, premiums have skyrocketed 87% while workers' wages have increased by only 22%.[142]

139. *Id*. at 21–23.

140. Robert Pear, *U.S. Gives Florida A Sweeping Right to Curb Medicaid*, N.Y. TIMES, Oct. 20, 2005, at A1.

141. KFF/HRET 2006 ANNUAL SURVEY, *supra* note 43, at 35. Also, higher income workers are more likely to work for employers who offer health insurance. *Id*. Sixty-five percent of employers who pay two-thirds of their work force at least $20,000 annually offer health benefits, but only 42% of employers who pay two-thirds of their work force $20,000 or less annually offer health benefits. *Id*.

142. *See id*. at 32.



Source: Kaiser Family Foundation & Health Research and Educational Trust, Employer Health Benefits: 2005 Annual Survey 1 (2005).

In 2006, a full-time minimum wage worker earned about $11,000 a year, but the annual premium for employer-sponsored health insurance averaged $11,480 for a family of four and $4,242 for single coverage.[143] Even with an employer subsidy, the average worker's share of the premium was $2,973 a year for family coverage and $627 for single.[144] The issue is not that Medicaid has expanded beyond the "truly needy," but that more American families "truly need" an affordable alternative to private insurance.

In 2004, the median family of four had to earn $36,120 just to cover basic costs for housing, utilities, food, transportation, child care, state and local taxes, and other necessities such as telephone, clothes, and household supplies.[145] In higher cost cities, the same family needed between $40,000 and $50,000 to cover these basic needs.[146] On average, U.S. families must earn about 200% of the FPL to cover basic expenses, and more than half of Americans live in cities where it takes between 200% and 300% of the FPL to cover basic expenses. And these figures do not include health care premiums or out-of-pocket costs.

143. *Id.* at 18.

144. *Id.* at 60.

145. *See* Economic Policy Institute Basic Family Budget Calculator (2004), *available at* http://www.epinet.org/content.cfm/datazone_fambud_budget.

146. *Id.*

Basic Budget for Family of Four, 2004 Estimates[147]					
	St. Louis, Misouri	Boston, Massachusetts	Median Sioux City, Iowa	Johnstown, Pennsylvania	Rural Missouri
Housing & Heat	$741	$1,266	$585	$428	$459
Food	$587	$587	$587	$587	$587
Transportation	$358	$321	$375	$375	$420
Child Care	$835	$1,298	$924	$954	$523
Other Necessities	$359	$500	$316	$274	$282
Taxes	$316	$824	$223	$243	$24
Monthly Budget	$3,196	$4,896	$3,010	$2,861	$2,295
Annual Budget	$38,352	$58,752	$36,120	$34,332	$27,540
% FPL	203%	305%	192%	182%	146%

Contrary to popular perception, people who earn double and even triple the FPL are "truly needy" in today's economy. The FPL uses a formula developed in the early 1960s by Molly Orshansky, an employee of the Social Security Administration.[148] In the mid-1950s American families spent about one-third

147. *Id.*; Sylvia Allegretto, *Basic Family Budgets: Working Families' Incomes Fail to Meet Living Expenses Around the U.S.*, Econ. Pol'y Inst. Briefing Paper, at 3–4 (2004), *available at* http://www.epinet.org/briefingpapers/165/bp165.pdf. Costs are for a basic family budget. Housing costs are based on the Department of Housing and Urban Development's fair market rents for the lower 40th percentile. Food costs are based on the USDA's low-cost plan to achieve nutritionally adequate diets. Transportation expenses are based on the costs of owning and operating a car for work and other necessary trips drawn from the National Travel Household Survey by metropolitan or rural area. Child care is based on center-based child care or family child care centers for 4 to 8 year-olds as reported by the Children's Defense Fund. Other necessities include: the cost of telephone, clothing, personal care expenses, household supplies, school supplies, etc. from the Consumer Expenditure Survey. Taxes are for tax year 2004 as computed by Citizens for Tax Justice and include federal tax credits for children and the earned income tax credit. Taxes include federal personal income taxes, federal Social Security and Medicare payroll taxes (worker payments only), and state and local income or wage taxes. The 2004 federal poverty guideline for a family of four in the continental U.S. was $18,850. U.S. Dep't of Health & Hum. Servs., *The 2004 HHS Poverty Guidelines*, http://aspe.hhs.gov/poverty/04poverty.shtml (last visited Feb. 28, 2007).

148. *See* Mollie Orshansky, *Children of the Poor*, SOC. SEC. BULL., July 1963, at 3; *see also* U.S. Dep't of Health & Hum. Servs., Frequently Asked Questions Related to Poverty Guidelines and Poverty, http://aspe.hhs.gov/poverty/faq.shtml (last visited Feb. 28, 2007) [hereinafter Poverty Guidelines FAQ] (describing the differences between the federal poverty thresholds and the federal poverty guidelines). The correct term is "federal poverty guideline," but the figures are typically referred to as the federal poverty level or federal poverty line. *See* U.S. Dep't of

of their after-tax income on food, so Orshansky calculated poverty thresholds by multiplying the cost of the United States Department of Agriculture's least expensive food plan by three to estimate the costs of basic household expenses.[149] Orshansky's formula is still used to calculate the FPL, but now food costs reflect only about one-sixth of household expenses resulting in an FPL that underestimates basic living costs by almost one-half.[150]

Federal Poverty Line, 2006

Federal Poverty Guideline	Family size 1	2	3	4
100%	$9,800	$13,200	$16,600	$20,000
200%	$19,600	$26,400	$33,200	$40,000

Source: U.S. Dep't of Health & Hum. Servs., The 2006 HHS Poverty Guidelines, http://aspe.hhs.gov/poverty/06poverty.shtml.

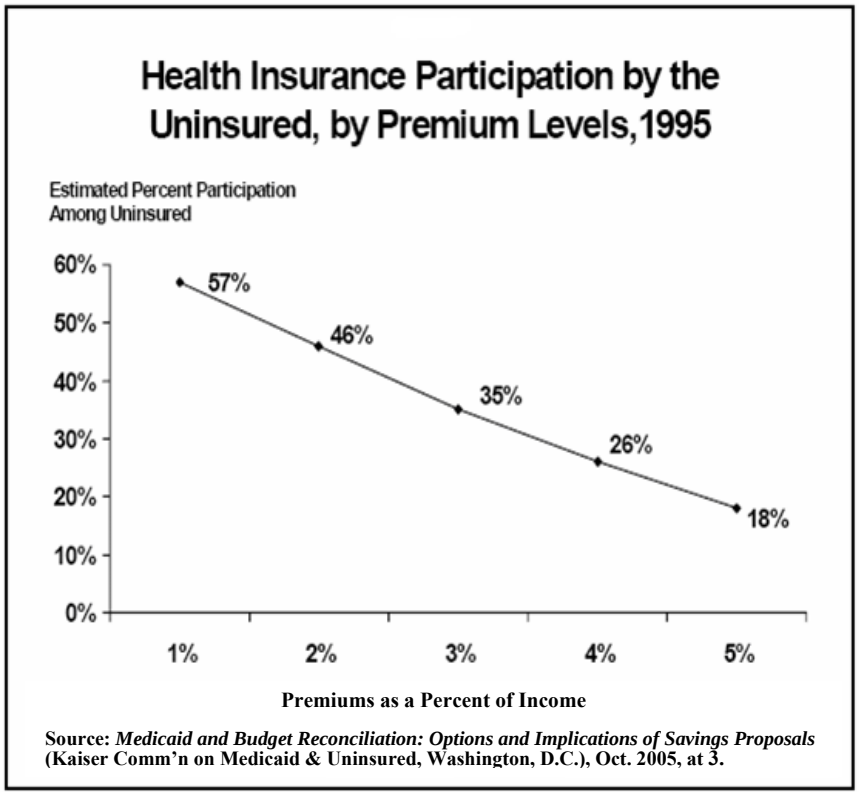
Thus, even small premiums can price families earning less than 300% of the FPL out of insurance: States that have imposed Medicaid and SCHIP premiums well below the 5% of income cap allowed by the DRA have seen

Health & Hum. Servs., Poverty Guidelines, http://aspe.hhs.gov/poverty/06poverty.shtml (last visited Feb. 28, 2007). The federal poverty threshold is the original version of the federal poverty measure. Poverty Guidelines FAQ, *supra*. It is used mainly for statistical purposes, i.e., estimating the number of people living below that threshold each year. *See* Off. Mgmt. & Budget, Statistical Policy Directive No. 14: Definition of Poverty for Statistical Purposes (May 1978), *available at* http://www.census.gov/hhes/www/povmeas/ombdir14.html. The federal poverty guidelines are issued each year in the Federal Register by the Department of Health and Human Services and are used for administrative purposes to determine financial eligibility for certain federal programs. Poverty Guidelines FAQ, *supra*.

149. Orshansky, *supra* note 148, at 3, 8–10; Poverty Guidelines FAQ, *supra* note 148. In 1965 Orshansky expanded and adjusted her poverty measures to encompass virtually all family sizes. *See* Mollie Orshansky, *Who's Who Among the Poor: A Demographic View of Poverty*, SOC. SEC. BULL., July 1965, at 3; *see also* Gordon M. Fisher, *The Development and History of the Poverty Thresholds*, SOC. SEC. BULL., Winter 1992, at 3 (discussing the origins of the poverty levels).

150. *See* Federal Poverty Guidelines FAQ, *supra* note 148. The FPLs are updated annually to account for increases in the Consumer Price Index, but the underlying formula is still Orshansky's, i.e., multiply the cost of the USDA thrifty food plan by three. *Id.* For criticisms of the methodology, see NAT'L RES. COUNCIL, MEASURING POVERTY: A NEW APPROACH 26–31 (Constance F. Citro & Robert T. Michael eds., 1995).

substantial drops in enrollment.[151] An Urban Institute analysis, based on these and other states' experiences, concludes that premiums equal to 5% of income will price over 80% of potentially eligible families out of Medicaid.[152]



Source: ***Medicaid and Budget Reconciliation: Options and Implications of Savings Proposals*** **(Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Oct. 2005, at 3.**

Second, employer-sponsored insurance increasingly offers inadequate financial protection for low-income families: Even when low-income families are able to obtain private insurance through generous employer subsidies, out-of-pocket costs can be staggering. In 2006, the average deductible for employer-sponsored single-coverage was $352 for HMO coverage, $553 for point-of-service (POS), and $1,715 for high-deductible plans.[153] Co-payments

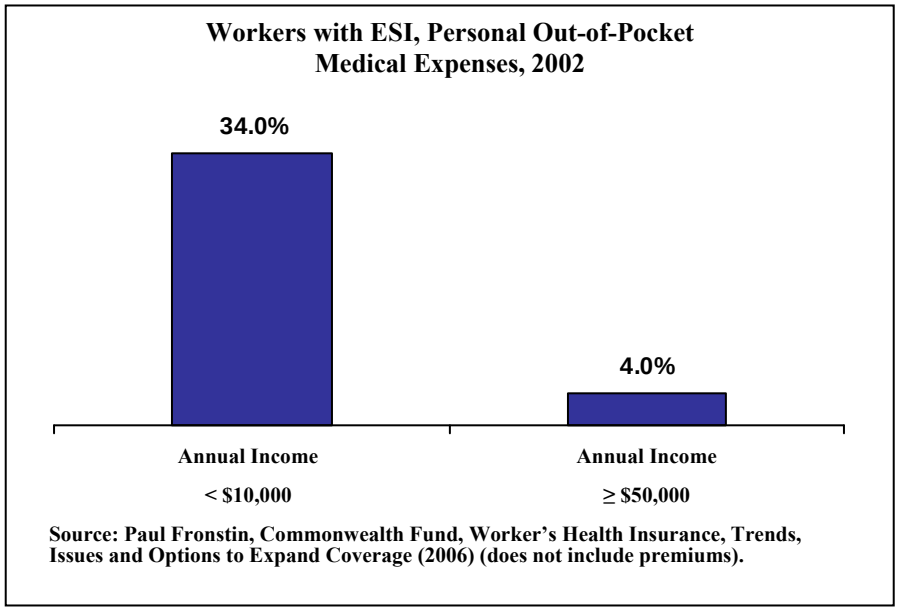
151. *See, e.g.*, Leighton Ku & Victoria Wachino, *The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), July 7, 2005, *available at* http://www.cbpp.org/5-31-05health2.pdf; Samantha Artiga & Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, ISSUE PAPER (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), May 2005, at 4, *available at* http://www.kff.org/medicaid/7322.cfm.

152. Leighton Ku & Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471, 477 (1999).

153. KFF/HRET 2006 ANNUAL SURVEY, *supra* note 43, at 32, 78–79, 111. Fifty-five (54.8) percent of workers must pay a general deductible. Sixty percent of workers are covered by PPOs,

typically ranged from $15 to $20 for physician visits and $11 to $38 for prescription drugs.[154]

Because private insurance imposes the same cost-sharing on all, these burdens fall more heavily on low-wage workers and the sick, and most heavily on those who are both low-wage and sick. Workers with employer-insured insurance earning less than $10,000 per year spent on average 34% of their income on health insurance deductibles and co-payments.[155] In comparison, workers earning over $50,000 a year spent only 4% of their income on medical out-of-pocket costs.[156]



Medicaid coverage benchmarked to private plans is likely to leave Medicaid recipients paying even higher percentages of income on out-of-pocket medical expenses: Medicaid recipients get a double whammy when it comes to out-of-pocket costs—they are both poorer and sicker than most Americans with private insurance. More than half (53%) of Medicaid

13% by POS, 20% by HMOs, 4% by high-deductible plans, and 3% by conventional plans. *See id.* The prevalence of general deductibles by plan type is as follows: 69% of PPOs impose general deductibles on workers, 32% of POS, 12% of HMOs and 100% of high deductible and conventional plans. *Id*. at 81–82.

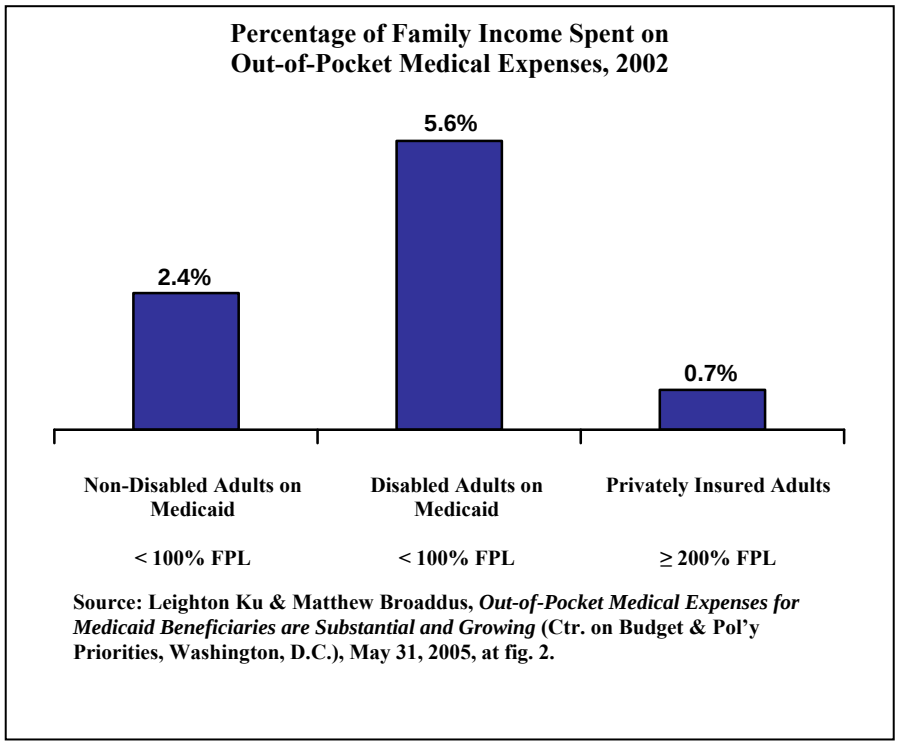
154. *Id*. at 121. Prescription drug co-pays typically are tiered averaging $11 for generics, $24 for preferred drugs, and $38 for non-preferred drugs. *Id.* at 121.

155. PAUL FRONSTIN, COMMONWEALTH FUND, WORKER'S HEALTH INSURANCE: TRENDS, ISSUES AND OPTIONS TO EXPAND COVERAGE 8 (2006) (explaining that figures are for worker income and worker expenses and do not include family income or medical spending), *available at* http:www.cmwf.org/usr_doc/Fronstin_workershltins_908.pdf.

156. *Id.*

recipients are very poor, earning under 100% of the FPL, and another 28% are near poor, with incomes between 100% to 200% of the FPL.[157] Most children and almost half of parents enrolled in Medicaid have serious functional health limitations.[158]

Even now, Medicaid recipients are not insulated from the cost of medical care: Adults on Medicaid pay a larger share of their income on out-of-pocket medical expenses than do higher income privately insured Americans.[159] In 2002, non-disabled working adults with Medicaid coverage spent on average 2.4% of their income on out-of-pocket medical expenses, and disabled adult Medicaid recipients spent almost 6% (5.6%) out-of-pocket for medical care.[160] In contrast, privately insured adults earning over 200% of the FPL spent on average less than 1%—only 0.7% on out-of-pocket medical costs.[161]



157. Kaiser Fam. Found., *supra* note 59.

158. ROSENBAUM & MARKUS, *supra* note 132.

159. Leighton Ku & Matthew Broaddus, *Out-Of-Pocket Medical Expenses For Medicaid Beneficiaries Are Substantial and Growing* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), May 31, 2005, at 2, fig. 2, *available at* http://www.cbpp.org/5-31-05health.pdf.

160. *Id.*

161. *Id.* Studies also demonstrate that in recent years, the share of Medicaid beneficiaries' income that is consumed by out-of-pocket medical expenses has been rising twice as fast as their incomes. *Id.* at 2, fig. 1.

In stark contrast to the claims of consumer-driven health care, Medicaid's generous benefit package has not resulted in higher costs: Medicaid actually costs less per enrollee than employer-provided health insurance. In 2003, Medicaid spending averaged $1,872 per working parent and $1,467 per child,[162] while the average cost for single employer-sponsored insurance was $3,383.[163] Medicaid can insure two people—a parent and child—for less than the cost of employer-sponsored insurance for just the parent.

Medicaid has also done a superb job of holding down per capita spending increases. The growth in Medicaid spending for services is only about one-third the growth in overall private insurance spending and only half the increase in premium costs for employer-sponsored insurance.[164] From 2000 to 2004, Medicaid per capita spending for acute care services rose 6.4% while long-term care costs rose only 4.2%.[165] In comparison, private insurance per capita costs—primarily for acute care services—rose 9.5% for all Americans and 12.2% for those with employer-sponsored health insurance.[166]

While low Medicaid reimbursement rates are one explanation for lower Medicaid costs, Medicaid also delivers lower cost coverage because it has lower administrative overhead. State Medicaid programs report administrative costs of only 4% to 6%, compared with private HMO administrative costs of 8% to 12% and commercial health insurer administrative costs of 15% to 20%.[167]

Neither has Medicaid's more comprehensive benefit package resulted in unnecessary medical care. No data substantiates claims that Medicaid recipients overuse medical care. To the contrary, one study of thirteen states found that adult Medicaid beneficiaries use about the same level of health care services as adults with private health insurance who have higher cost-

162. Kaiser Fam. Found., Medical Payments per Enrollee, FY2003, http://www.statehealthfacts.org/ (Click 50 State Comparisons Link; Select Medicaid & SCHP from left column; Click Payments by Enrollee Group, FY2003 in left column under Medicaid Spending).

163. KAISER FAM. FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2003 ANNUAL SURVEY 32 (2003), *available at* http://www.kff.org/insurance/upload/Kaiser-Family-Foundation-2003-Employer-Health-Benefits-Survey-Full-Report.pdf [hereinafter KFF/HRET 2003 ANNUAL SURVEY].

164. SMITH ET AL., *supra* note 17, at 21.

165. *Id.*

166. KFF/HRET 2003 ANNUAL SURVEY, *supra* note 163; *see also* SMITH ET AL., *supra* note 17, at 21.

167. SMITH & MOODY, *supra* note 55, at 8.

sharing.[168] Another study of mothers in low-incomes families found similar results.[169]

Shifting costs to Medicaid recipients will not result in better quality care: It will result in poorer care and worse outcomes. Cost-sharing is perhaps the most studied aspect of the Medicaid program: a plethora of research concludes that even modest co-payments—far below those contemplated by the DRA—cause Medicaid patients to forego necessary, not just excess, medical care.[170] The RAND Health Insurance Experiment, considered the landmark study of cost-sharing, found that although higher patient cost-sharing did not adversely affect the health of middle and higher income people, cost-sharing did create barriers to access and poorer health outcomes for lower income patients.[171] A recent study in Minnesota found that when the state imposed tiered Medicaid drug co-payments of $1 for generic drugs and $3 for brand name drugs—far below amounts authorized by the DRA—slightly more than half of Medicaid patients using a public hospital reported being unable to fill prescriptions because of co-payment charges.[172] About one-third of those who went without prescription drugs had more serious health problems, like strokes, diabetes problems, or asthma attacks, and required expensive emergency room care or hospital admission.[173]

168. Teresa A. Coughlin et al., *Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF. 1073, 1081 (2005).

169. Sharon K. Long et al., *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERVS. RES. 39, 55 (2005).

170. *See, e.g.*, Artiga & O'Malley, *supra* note 151, at 3; Ku & Wachino, *supra* note 151, at 11; Bill J. Wright, et al., *The Impact of Increased Cost-Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106 (2005).

171. JOSEPH NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND INSURANCE EXPERIMENT 183–243 (1993). The RAND study found that co-payments led to a marked reduction in "episodes of effective care" among low-income adults and children. As a consequence, health status was poorer among low-income adults and children who were reported to make co-payments to obtain care than among comparable low-income adults and children who were not subject to payments. *Id.* at 251; *see also* JONATHON GRUBER, KAISER FAM. FOUND., THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND (2006), *available at* http://www.kff.org/insurance/upload/7566.pdf.

172. Melody Mendiola et al., Hennepin County Medical Center (Minneapolis, Minn.), Medicaid Patients Perceive Copays as a Barrier to Medication Compliance, Presentation at the Society of General Internal Medicine National Conference (May 2005).

173. *Id.* A Canadian study found that after Quebec imposed co-payments for prescription drugs on adults who were receiving welfare, these individuals filled fewer prescriptions for essential medications and emergency room use subsequently increased 14% among these adults. Robyn Tamblyn et al., *Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 JAMA 421 (2001). The number of "adverse events" such as death and hospitalization rose by 78%. *Id.*

In fact, studies show that Medicaid provides better quality preventive services for children than does private health insurance.[174] Advocates of consumer-driven Medicaid taut SCHIP benchmark coverage as a model for redesigning Medicaid co-payments and benefits, but studies show that Medicaid-like SCHIP coverage results in better quality care—and better health outcomes—than does SCHIP coverage that is benchmarked to private insurance.[175]

Finally, increased Medicaid cost-sharing puts financial pressures on low income families already juggling tight budgets. In Oregon, more than a third of Medicaid recipients subject to increased Medicaid cost-sharing reported cutting back on food to pay for medical costs.[176] Another study reported that nearly 30% of families with incomes up to 200% of the FPL had at least one critical hardship such as missed meals, an eviction, utilities disconnected, doubling up in housing, or inability to access needed medical care.[177] Over 72% of these families reported at least one serious hardship such as worries about food, missed rent or mortgage payments, reliance on the emergency room as the main source of medical care, or inadequate child care arrangements.[178]

CONCLUSION

Consumer-directed Medicaid rests on false assumptions. Medicaid has grown, but it remains a program for those who priced out of private health insurance. Medicaid's comprehensive benefit package and relatively low-cost sharing are crucial design components for a safety net health insurance program covering those with limited financial resources. No data supports the claims of critics that Medicaid recipients overuse medical services. In fact, studies conclude that Medicaid delivers better quality care to low-income Americans than coverage modeled on private insurance.

174. Lisa Dubay & Genevieve M. Kenney, *Health Care Access and Use Among Low-Income Children: Who Fares Best?*, HEALTH AFF., Jan.-Feb. 2001, at 112, 116 (explaining their study which looked at children in families with incomes between 100% to 200% of the FPL).

175. This outcome likely reflects the success of Medicaid in facilitating preventive services for children as well as Medicaid's historical lower cost sharing

176. BILL J. WRIGHT ET AL., COMMONWEALTH FUND, IMPACT OF CHANGES TO PREMIUMS, COST-SHARING AND BENEFITS ON ADULT MEDICAID BENEFICIARIES: RESULTS FROM AN ON-GOING STUDY OF THE OREGON HEALTH PLAN 11 (2005), *available at* http://www.cmwf.org/usr_doc/Wright_impact_changes_premiums_Medicaid_Oregon.pdf.

177. *See* HEATHER BOUSHEY ET AL., ECON. POL'Y INST., HARDSHIPS IN AMERICA: THE REAL STORY OF WORKING FAMILIES 2 (2001).

178. *See id.* While the very poor, those living below the FPL, have the most difficulty making ends meet, the rate of hardships was almost identical for the near-poor, those with incomes between 100% and 200% of the FPL, and the very poor. *Id.*

Ultimately, cost-shifting to Medicaid patients hurts not only consumers but the health care system. Medicaid plays a critical role in funding the nation's safety net hospitals and clinics. When costs are shifted to patients, they may go unpaid. For some hospitals this translates into a drop in funding, for others it translates into more aggressive collection actions against patients.[179] For patients who can qualify for credit cards, it may begin a cycle of debt that ends in bankruptcy.[180] As the title of this symposium says, cost-shifting to Medicaid patients is likely to go "from risk to ruin."

179. *See* John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 433, 443–44 (2007); Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 459–62 (2007).

180. *See* Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 ST. LOUIS U. L.J. 307, 319–20 (2007).