Georgetown University Health Policy Institute
Center for Children and Families

GEORGETOWN UNIVERSITY

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WEST VIRGINIA INTERIM LEGISLATIVE OVERSIGHT COMMISSION ON HEALTH AND HUMAN RESOURCES ACCOUNTABILITY

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Good morning Chairmen Perdue and Prezioso:

My name is Joan Alker and I am a Research Associate Professor at the Health Policy Institute of Georgetown University and the Deputy Executive Director of the Center for Children and Families at HPI. The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. We focus much of our work on issues affecting low-income families in public coverage (i.e. Medicaid and SCHIP). Thank you very much for the invitation to speak today.

One of the research areas that I have been focusing on recently is the issue of promoting "healthy behaviors" in the Medicaid program. In addition to the policy brief I authored on West Virginia's Medicaid Redesign that we will be discussing today, this summer I co-authored a report on Florida's "Enhanced Benefits Rewards" an incentive program that the state of Florida has implemented to encourage "healthy behaviors" as part of its broader Medicaid waiver changes[1]. In addition, CCF will soon be releasing an issue paper looking at this topic more broadly as part of a project that CCF has undertaken called *Strengthening Medicaid*, which identifies promising reform ideas for state and federal policymakers to pursue.

West Virginia's Medicaid Redesign: Of the three states attempting to promote healthy behaviors in Medicaid that I have examined most closely, (FL, ID and WV), West Virginia's program is unique in that it operates on a punitive approach rather than the principle of incentives and rewards to encourage certain behaviors as Florida and Idaho do. Children are the largest group of Medicaid beneficiaries affected in all of these states. While these states (and others) all share the same goal of promoting greater personal responsibility and improved health among Medicaid beneficiaries, only West Virginia has chosen to do so by limiting access to benefits for those who do not execute a "Member Agreement" with their physician. By contrast, Florida offers participants a credit for behaviors such as obtaining well-child visits or flu shots, and these credits can be redeemed at participating pharmacies for over-the-counter products. Neither Florida nor West Virginia's programs appear to have been successful in encouraging more healthy choices, yet Florida's lack of success is more benign. The implications of West Virginia's changes are more consequential since access to needed medical services is conditioned on successful submission of the Member Agreement.

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[1] See Alker, J and Hoadley, J. *The Enhanced Benefits Rewards Program: Is it changing the way Medicaid beneficiaries approach their health?* (Jesse Ball duPont Fund, July 24, 2008)

What did our report find? The three main findings of our report are:

1. Using data from the WV Department of Health and Human Resources Bureau for Medical Services, our analysis found that *as of July 2008, 85% of those affected by the changes are children.* This reflects data at a time when approximately 125,000 people had been moved to the new system.

   This is a concern for two reasons – children, especially young children who are disproportionately represented in the Medicaid program, are of course not primarily responsible for key health choices such as what they eat, where they live, whether or not they go to an emergency room when they are sick, and how much exercise they get. Moreover, they have no control over whether a Member Agreement is executed. Secondly, to the extent that restricting Medicaid cost growth is a goal of the changes, children are not the primary cost driver in the Medicaid program --- while they constitute 50% of enrollees, they represent only 22% of the costs.

2. Of those children who have been subject to the new policy, *93% of children (and their parents) are enrolled in "Basic" which limits key benefits including prescription drugs, mental health services, and physical and other therapies.* Even in those counties (Clay, Lincoln, and Upshur) that have had a longer time to implement the program, the enrollment rate in Basic is extremely high – 85%. This high rate of enrollment in the Basic plan strongly suggests that families are confused at best or unaware at worst of the choice they are confronted with – it is highly improbable that the vast majority of parents would choose to limit their child's benefits at the outset. Families placed in Basic must remain there for a year until their annual eligibility renewal comes up.

   Limiting children's benefits is a concern because children on Medicaid are more vulnerable and suffer from more health problems than children who have higher incomes and are privately insured. This is true of all children on Medicaid – not just those who are receiving disability payments and are excluded from West Virginia's Medicaid Redesign. A report released just last week by the Robert Wood Johnson Foundation found that in West Virginia 26% of children with incomes below poverty (the bulk of children receiving Medicaid) are in less than optimal health. In contrast, only 7% of kids with incomes greater than 400% of the poverty line in West Virginia are in less than optimal health.[2]

   Moreover, children on Medicaid are more likely than privately insured children to need prescriptions and mental health treatment – two of the key benefits that are limited under the "Basic" plan. A recent study found that children with Medicaid or

[2] *America's Health Starts with Healthy Children: How do States Compare?* (Robert Wood Johnson, October 2008).

other public health insurance coverage (16%) were more likely than children with private coverage (13%) or children with no health insurance coverage (5%) to have been on regular medication.[3] Studies have also shown a higher incidence of mental health conditions among children on Medicaid.[4]

Limiting children's benefits also does not appear to be compatible with federal requirements regarding the *Early Periodic Screening Diagnosis and Treatment* (EPSDT) benefit for children. This comprehensive benefit requires that treatment must be provided for any medically necessary services identified during a screening exam.

3. *There is no evidence that the program is working to change Medicaid beneficiaries' health choices.* If the state's goal is to encourage families to work with their primary care physicians to make better choices, then it would make sense to include all families automatically and take other steps to educate them and link them with a primary care provider and/or a medical home. Allowing the vast majority of participants to default into the "Basic" set of benefits raises questions about whether the state's goal is rather to save money by limiting access to care.

   As our report concludes, programs designed to change personal behaviors based on incentives can be valuable but they are complex and are dependent on beneficiary understanding and active participation. West Virginia's low participation rate underscores that families do not understand the Medicaid Redesign, and it has not been implemented in a way that promotes the active participation of families. Moreover children are the primary group affected – those least likely to have control over and be able to change their health habits. Unfortunately the state's changes have resulted in many of these children losing access to benefits they may need rather than making progress towards the stated goal of promoting good health.

[3] B. Bloom, "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006," (National Center for Health Statistics, September 2007).)

[4] See for example, Howell, E. *Access to Children's Mental Health Services Under Medicaid and SCHIP* (Urban Institute: August 31, 2004).