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THE FALLACY OF USING CASH AND COUNSELING TO SUPPORT PROPOSALS TO CONVERT MEDICAID TO VOUCHERS OR HEALTH SAVINGS ACCOUNTS

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Executive Summary

Several states, including South Carolina and Florida, have proposed radically changing Medicaid from a program that reimburses health care providers for the services they provide into a program that gives beneficiaries a fixed amount of money to purchase health coverage or health care services directly.[1] Some supporters of these proposals have cited the success of Medicaid's Cash and Counseling demonstration program as evidence that this far-reaching restructuring of Medicaid is a sound and tested policy direction.[2]

KEY FINDINGS

- Medicaid's Cash and Counseling program has been cited as a model for state proposals to give beneficiaries a fixed amount of money to purchase health coverage or health services. But there are critical differences between Cash and Counseling and these state proposals.
- Cash and Counseling does not expose consumers to the risk of needing medical care they cannot afford; the recent state proposals do.
- The recent state proposals more closely resemble untested "consumer-directed" health care plans in the commercial sector and would risk causing substantial numbers of low-income beneficiaries to do without needed care.

Cash and Counseling is an ongoing Medicaid demonstration project that provides some elderly beneficiaries and people with disabilities with a cash allowance to purchase personal care services. (These are disability-related supportive services usually provided in the home, such as help with bathing or eating.) Traditionally under Medicaid, these services are provided by licensed home health agencies. Under Cash and Counseling, a beneficiary can use the allowance to hire a person to provide personal care services and to purchase necessary products, such as medical supplies, that Medicaid would not usually provide.

[1] See Judith Solomon, "Risky Business: South Carolina's Medicaid Waiver Proposal," (Washington, DC: Center on Budget and Policy Priorities, August 2005).

[2] For example: Regina E. Herzlinger and Tom Nerney, "Medicine for Medicaid," *Wall Street Journal*, August 2, 2005; John Andrews, "Rocky Mountain Medicaid," *Wall Street Journal*, August 18, 2005; Michael Bond and Matthew Hisrich, "Medicaid Lessons from Former Communists," Wichita Independent Business Association, February 2005.

While the Cash and Counseling program has improved consumer satisfaction with personal care services, this success says little about the likely effects of state proposals to convert much or all of the Medicaid benefit to personal health accounts. Cash and Counseling does not expose beneficiaries to the risk of needing medical care they cannot afford: beneficiaries retain normal Medicaid coverage for acute medical care and other health care services, and the personal care services they pay for with their cash allowance are relatively constant and predictable. In contrast, proposals to replace Medicaid coverage with state-funded accounts or vouchers would expose beneficiaries to precisely that risk: the many possible health care services that beneficiaries would have to pay for with their health accounts are neither constant nor predictable and the accounts or vouchers could prove insufficient for people who become sicker and need more health care.

Recent proposals to convert Medicaid benefits to personal accounts or vouchers derive less from the Cash and Counseling program than from untested "consumer-directed" health care plans in the commercial sector. Those plans deliberately expose beneficiaries to financial risk, in the belief that it will cause them to forgo "unnecessary" care. Studies show, however, that when low-income people are required to pay more for health care, they cut back on services and medications that are necessary for their health. There is considerable risk that under proposals like those in South Carolina and Florida, many low-income individuals — especially those who are in the poorest health and consequently face the largest medical expenses — would be forced to do without needed care.

How Cash and Counseling Works

The Cash and Counseling program began in 1996, with financial support from The Robert Wood Johnson Foundation. The program originally allowed three states — Arkansas, Florida, and New Jersey — to test the effectiveness of permitting elderly Medicaid beneficiaries and people with disabilities to purchase their own personal assistance services instead of receiving them through licensed agencies. Participation in the program was voluntary. Beneficiaries who chose to participate received a monthly cash allowance and an assessment of their care needs;[3] the size of the allowance was based on their care plan or claims history.[4] Evaluation results in the original three states found that beneficiary satisfaction was higher among beneficiaries enrolled in Cash and Counseling than among beneficiaries who received personal care services through the traditional Medicaid model.[5] The program is currently operating — but has not been evaluated — in an additional twelve states.[6]

The goal of Cash and Counseling is to provide beneficiaries with more autonomy in the selection and use of personal assistance services. It was designed in part to correct for the limitations in the traditional Medicaid model of delivering personal care services. Under the traditional model, a case manager decides whether services are needed, and licensed agencies deliver a limited range of

[3] Initially, beneficiaries who chose the Cash and Counseling demonstration project had a 50 percent chance of being assigned to Cash and Counseling and a 50 percent chance of being assigned to a control group. Participating states subsequently decided to make the program available to all eligible persons.

[4] In Arkansas and New Jersey, the amount of the allowance was based on the care plan; in Florida, it was based on the claims history if the claims history was stable and consistent with the current care plan.

[5] Barbara Phillips et al, "Lessons from the Implementation of Cash and Counseling in Arkansas, Florida, and New Jersey," 2003.

[6] See: http://www.cashandcounseling.org/about.

services, which may not meet an individual's actual needs. Under Cash and Counseling, the state provides counselors to review spending plans, help locate needed services, and provide assistance with bookkeeping and other tasks.

Two key aspects of Cash and Counseling are that beneficiaries themselves decide which services they will receive, and they are not restricted to licensed agencies. They can, if they choose, purchase services from family or friends, although they can still have an agency deliver their care if they prefer that option. Beneficiaries can also use the cash allowance to buy products and services that Medicaid does not usually cover, such as medical supplies or help with banking or shopping. A portion of the allowance may also be set aside each month to purchase an item that the person could not otherwise afford. For instance, the parents of an autistic child in Florida purchased a security system to ensure that the child did not wander off during the night.[7]

Why the Model of Cash and Counseling Is Inappropriate for Medicaid as a Whole

The Cash and Counseling demonstration project was never intended to test whether the concept of converting a benefit into cash should be applied to Medicaid as a whole. Nevertheless, some have argued that the project's success demonstrates the model would also work for core Medicaid benefits such as doctor visits, diagnostic tests, and prescription drugs. This argument has been made in support of state proposals, such as those in South Carolina and Florida, to provide low-income individuals with a fixed amount of funds to purchase health coverage from managed care organizations or to purchase health care services directly from providers.

The claim that Cash and Counseling is an appropriate model for such large-scale changes ignores two critical facts:

- **Personal care needs are much more predictable than overall medical needs.** Personal care services are well suited to the cash-and-counseling approach because the need for them is relatively constant and predictable. In contrast, no individual can accurately predict the amount of medical care he or she will need, since it depends in large part on factors over which individuals often have little control, such as illness or injury.[8]

- **Converting core Medicaid health benefits to cash would expose beneficiaries to considerable financial risk.** An individual's medical needs are not only much less predictable than his or her personal care needs, but also can be much costlier. Participants in Cash and Counseling are protected against this risk, since they continue to receive coverage for acute medical care and other health care services (such as specialty care and prescription drugs) through the standard Medicaid benefits package. Beneficiaries whose Medicaid benefits were replaced with personal health accounts, in contrast, would *not* be protected.

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[7] Barbara Phillips et al, "Lessons from the Implementation of Cash and Counseling in Arkansas, Florida and New Jersey," 2003.

[8] Jeffrey S. Crowley, "An Overview of the Independence Plus Initiative to Promote Consumer-Direction of Services in Medicaid, (Washington, DC: Health Policy Institute, Georgetown University, November 2003).

South Carolina, which has proposed to replace most beneficiaries' Medicaid coverage with state-funded personal health accounts, has indicated that it would use a process known as "risk adjustment" to help ensure that beneficiaries' accounts are large enough to cover their expected health costs.[9] Specifically, the state would categorize each beneficiary according to criteria such as age and sex, determine the average amount that Medicaid spent on beneficiaries in each category in a base year, and deposit that amount (adjusted upward to reflect the increase in health care costs since the base year) in the health account of each person in that category.

This process is similar to the way in which states set per-capita payments for their Medicaid managed care programs. Risk adjustment works relatively well in the managed care context because each plan enrolls a mix of individuals: while some individuals will cost the company more than the amount that it receives from the state to cover them, other individuals will cost the company less than that amount. Thus, if the plan receives a flat payment per person that represents average costs over all of its enrollees, the plan will come out behind on some people and ahead on others — and be able to cover its costs overall.

But using risk adjustment for personal health accounts is very different. Since each account covers only a single individual, account funds cannot be shifted from people with relatively low health costs to people who turn out to have relatively high health costs. As a result, some people will likely use up the money in their accounts and be unable to afford needed health care services.

Bob Williams, who helped design the Cash and Counseling demonstration as a former advisor to the U.S. Department of Health and Human Services, has warned in public testimony that the success of Cash and Counseling for personal care services does not justify cashing out the entire Medicaid benefit. There is nothing, Williams said, in the demonstration's "basic intent, design or findings that would support such a policy leap. And even more importantly, expecting people to know how to navigate, purchase and manage their entire health and medical care is not only unrealistic, it would be setting many up to take a serious fall or worse."[10]

New Proposals Reflect Untested "Consumer-Directed" Approach to Health Care

The recent proposals from states like South Carolina and Florida derive much less from Medicaid's Cash and Counseling program than from untested "consumer-directed" health care plans in the commercial sector. These plans feature health savings accounts that beneficiaries use to pay out-of-pocket health costs. In return, these plans generally provide much less coverage — most cover only catastrophic illnesses — and much larger deductibles than comprehensive employer-sponsored plans or public plans such as Medicaid.[11]

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[9] Solomon, *op cit*.

[10] Bob Williams, Co-Director, Advancing Independence and Modernizing Medicare and Medicaid, Testimony before House Committee on Energy and Commerce, Subcommittee on Health, "Consumer Directed Services: Improving Medicaid Beneficiaries Access to Quality Care," June 5, 2003.

[11] See Edwin Park and Robert Greenstein, "Latest Enrollment Data Still Fail to Dispel Concerns About Health Savings Accounts," (Washington, DC: Center on Budget and Policy Priorities, October 2005).

Proponents of commercial consumer-directed care claim that exposing individuals to financial risk will shape better health habits and contain costs. This approach is based on the assumption that consumers use too many health care services and that if they are required to pay more, they will forgo "unnecessary" care. These plans explicitly rely on large deductibles to drive down costs.[12]

A recent 13-state study conducted by Urban Institute researchers contradicts the notion that Medicaid beneficiaries have unusually high health care utilization rates. The study found that adult Medicaid beneficiaries use about the same level of health care services as adults with private insurance.[13] A study of mothers in low-income families found similar results.[14]

Moreover, a number of studies have found that when low-income people are required to pay more for health care, many cut back on services and medications that are necessary for their health; in some cases, their health subsequently deteriorates.[15] Instead of encouraging appropriate utilization of health care (as proponents claim), shifting more of the cost of health care to low-income Medicaid beneficiaries carries considerable risk of harming vulnerable people.

[12] Karen Davis, "Will Consumer Directed Health Care Improve System Performance?" (New York, NY: The Commonwealth Fund, August 2004).

[13] Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," Health Affairs, 24(4):1073-1083, July/August 2005.

[14] Sharon K. Long, Teresa Coughlin and Jennifer King, "How Well Does Medicaid Work in Improving Access to Care?" Health Services Research, 40(1): 39-58, February 2005.

[15] Leighton, Ku, "The Effect of Increased Cost-Sharing In Medicaid: A Summary of Research Findings," (Washington, DC: Center on Budget and Policy Priorities, July 2005); Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences," (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2005).