The Role of Medicaid and the Case of South Carolina’s “Healthy Connections” Proposal

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What is the purpose of a public, means-tested health insurance program such as Medicaid? The primary purpose, one would presume, is to provide health coverage for impoverished individuals who otherwise might have no financial access to health care whatsoever. But that doesn’t end the inquiry. There are many ways that one could construct such a program, all of which would yield differing results. The ultimate outcome would be contingent on a variety of factors: What one means by “coverage,” what the scope of coverage should be, how much one is willing to pay for coverage, what one’s philosophy of health care distribution might be, whether one wishes to advance other social goals in the process of providing health care and what those goals might be, and what respective weight one assigns to the foregoing considerations.

The process by which one provides a means of public coverage isn’t an academic matter. Rather, it has a real impact not only on how easily beneficiaries are able to access care through the program, but also on our relationship as a society to people who access public coverage and even on our view, as a society, of what health coverage is.

Until recently, while states have had a certain degree of ability to craft their Medicaid programs, most hewed relatively close to the federal guidelines. Over the last decade, however, a number of legal and policy changes have made it substantially easier for states to obtain a federal waiver to create “demonstration programs” that differ from the standard framework by covering non-traditional populations, revamping benefits, or making other changes.1 States have used the waiver provisions to apply successfully for permission from the U.S. Department of Health and Human Services to alter their Medicaid program, for example, to require certain classes of beneficiaries to enroll in a Medicaid managed care plan, to provide limited health coverage for childless, able-bodied adults under the age of 65, or to provide for community-based services for individuals who otherwise would be institutionalized in a long-term care or other facility.2

While many of the changes proposed by different states in their waiver requests were relatively modest at first, they have become more sweeping in recent years. In the interest of cost containment after years of significant medical cost inflation and rapidly growing Medicaid populations, many states are now seeking to limit their Medicaid

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2 Authority for the waivers is granted under 42 U.S.C. §§ 1315(a), 1396n(b) & (c) (West 2006). A list of waiver demonstration projects, by state, may be found at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/ (last visited Mar. 28, 2006).
expenditures. Towards this end Florida, for example, recently won approval to change its Medicaid program from one that it largely administers and funds to one that it merely funds, at least with respect to many beneficiaries.3

South Carolina is presently seeking an even more radical revision of its Medicaid program. Called “South Carolina Healthy Connections” (“Healthy Connections”), it would require most classes of Medicaid beneficiaries to purchase their own health care or coverage using a set sum of money deposited into a “personal health account” (“PHA”) that would be administered by the state.4 Affected beneficiaries would have the option of paying for their health care out of pocket, purchasing qualifying private managed care coverage, participating in a “medical home network,” or opting out of Medicaid altogether by enrolling in employer-sponsored health insurance or purchasing non-qualifying private health insurance.5 Each beneficiary’s PHA would be credited with an amount equal to the average amount spent per beneficiary in his or her same age, sex and eligibility categories.6 Any amount remaining in the PHA at the end of the year would be added to the next year’s balance.7 Even if an individual exhausts the funds in his or her PHA, the individual is responsible for up to $250 in out-of-pocket expenses before the state will pick up the remainder of the tab.8 Out-of-network care does not count towards the $250 cap.9

South Carolina’s proposed program buys heavily into the notion that out-of-control spending by beneficiaries is largely responsible for cost increases in the Medicaid program. This notion, however, is either largely mistaken or based on the false belief that the Medicaid population mirrors the population with employment-based, private health insurance. While Medicaid recipients are sometimes criticized for using more medical care than the general population, at least one well-crafted study found that the medical care used by relatively healthy, adult Medicaid recipients costs significantly less than care used by relatively healthy low-income adults with private health insurance.10 According to Jack Hadley and John Holahan’s review of 1996-1999 Medical Expenditure Panel Survey data, a relatively healthy adult Medicaid recipient spent $1,752 per year on


5 Id. at 26–31.

6 Id. at 5.

7 Id. at 42.

8 Id. at 35. Co-payments are part of those out-of-pocket expenditures; participants other than children, pregnant women, institutionalized people and people in home and community-based waiver programs must pay co-payments. Id.

9 Id.

health care, as compared with a yearly expenditure of $2,253 for privately-insured individuals with similar health and income statuses.\textsuperscript{11}

That being said, many Medicaid recipients are not “relatively healthy,” but in fact have chronic illnesses and disabilities that require substantial medical care, as Medicaid was devised in part to cover low income disabled and elderly people. Thus, it is unsurprising that, when the medical expenditures of all adult Medicaid recipients, including those in poor health, are considered together, they total significantly more per person than the expenditures of adults with private health insurance.\textsuperscript{12} While the disabled and elderly comprised only 25 percent of Medicaid beneficiaries nationwide in 2004, they accounted for 69 percent of Medicaid expenditures for that year.\textsuperscript{13} Many Medicaid recipients who use more health care than an average person covered by employer-sponsored health insurance do so not because they’re wasteful, but rather because of their significant health care needs.

It may be that proponents of South Carolina’s proposal subscribe to the theory that health insurance is an individual matter, intended solely to cover people for individual health risks. Under this theory, if one is less healthy, then one should pay proportionally more for one’s health coverage or should ration one’s own care if one chooses to buy cheaper and less generous coverage. Likewise, if one is healthier, then one should pay proportionally less for one’s coverage. The communal impact of individual health care risks is either marginal or unimportant, except to the extent that they cost the community money. Accordingly, spreading the risk among a group of people, so that healthier individuals subsidize the care of sicker individuals, is unfair to the healthy and should be discouraged.

Such a theory, however, pushes the ideal of social solidarity and the goal of spreading risk as widely as possible to the background.\textsuperscript{14} It assumes atomism and social Darwinism as goals. The move to a defined contribution plan such as that envisioned by South Carolina is one step towards those goals. It continues the move of Medicaid from a state-run, publicly-financed program covering an established menu of services for the most vulnerable members of our society to one in which some amount of health care is grudgingly financed by the government and provided by a bevy of unconnected private plans or by no plan at all.

\textsuperscript{11} Id. at Table 2. Medicaid-covered children, whether relatively healthy or not, also cost less than privately insured children. Id.

\textsuperscript{12} When considered together, health care for Medicaid recipients of any health status cost $4,877 per person per year, as compared to $2,843 for all low-income, privately insured adults. Id.


The proposed South Carolina program also enthrones employer-sponsored private coverage not merely as the “traditional” form of health coverage, but also as the ideal.\textsuperscript{15} This is odd for a number of reasons, but particularly so because such coverage, when provided through a multiplicity of plans, ultimately costs more than health coverage provided through a unitary public program. Private plan costs are greater, in fact, even where the public program in question involves some private components, as in the case of Medicare and Medicaid. For example, one 2003 study found that private plans in the United States spent an average of 11.7 percent on overhead, as compared with 3.6 percent for Medicare and 6.8 percent for Medicaid.\textsuperscript{16} Greater overhead translates into less money available overall to spend on health care, as opposed to administration.

In an age of rising Medicaid enrollment and expenditures, it would seem that moving to a system with more administrative costs is both counterintuitive and counterproductive. South Carolina’s move makes sense only in the context of achieving other goals: the increasing privatization and destabilization of our public health care programs, and the atomization of health coverage in general. These goals, however, appear to have little if anything to do with saving money or offering improved health services to Medicaid beneficiaries. Perhaps it is time for a national debate over what our public health programs should be providing, and whether we still believe in their ends of social protection and cohesion.

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\textsuperscript{15} \textsc{Healthy Connections}, supra note 4, at 3.