



Imposing Personal Responsibility for Health

Robert Steinbrook, M.D.

The concept of personal responsibility in health care is that if we follow healthy lifestyles (exercising, maintaining a healthy weight, and not smoking) and are good patients (keeping our

appointments, heeding our physicians' advice, and using a hospital emergency department only for emergencies), we will be rewarded by feeling better and spending less money. The details of programs that emphasize personal responsibility, however, are often sketchy, and many difficult questions related to individual freedom and patients' autonomy remain unanswered. For instance, which well-meaning measures to promote responsible behavior actually make a difference, and which are primarily coercive and potentially counterproductive? Which measures may actually improve health or save money, and which may merely shift costs from government, private insurers, or employers to patients?

There are many examples of initiatives that are meant to promote personal responsibility. The World Health Organization will no longer hire persons who smoke, suck, chew, or snuff any tobacco product, although it will still recruit people "who do not have a healthy lifestyle." In the United States, some employers target smokers, some even going so far as to fire workers who smoke when they are not at work. At some companies, health insurance may cost less for nonsmokers or for people who complete weight-loss programs, and employees may receive financial incentives to participate in health screenings, fitness programs, or tobacco-cessation programs. Wal-Mart has considered discouraging unhealthy

people from applying for work by including some physical activity in all jobs. A national survey conducted in July 2006 estimated that 53 percent of Americans think it is "fair" to ask people with unhealthy lifestyles to pay higher insurance premiums and higher deductibles or copayments for their medical care than people with healthy lifestyles.¹ In November 2003, the comparable figure was about 37 percent. A healthy lifestyle was defined as not smoking, frequent exercising, and weight control.

Promoting personal responsibility for health and for obtaining health care is also part of the federal government's "Roadmap to Medicaid Reform." Under the Deficit Reduction Act of 2005, states have increased flexibility in designing and implementing their Medicaid programs, which are jointly financed with the federal government. For example, they can require cost sharing for cer-

tain medical services, such as the use of nonpreferred drugs and nonemergency care furnished in a hospital emergency department, and can participate in a demonstration program to evaluate the potential effectiveness of Medicaid-funded personal health accounts, which are similar to health savings accounts.²

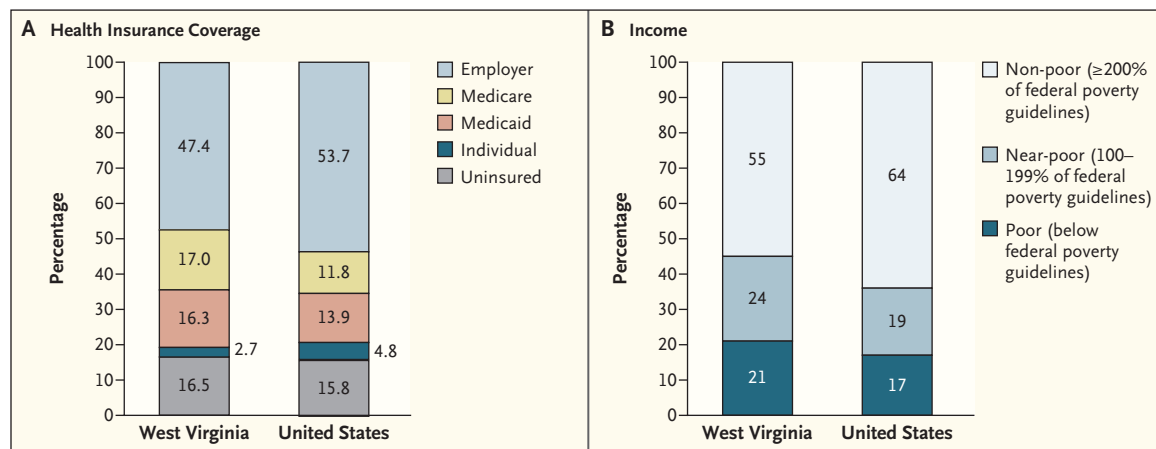
The redesign of the West Virginia Medicaid program has recently become a leading but controversial example of efforts to reward personal responsibility. West Virginia has a population of 1.8 million; as compared with the United States, it has a higher percentage of residents with Medicaid coverage and near-poor or poor incomes (see graphs). In May 2006, the federal government approved the state's plan to provide reduced basic benefits to most healthy children and adults who are eligible for Medicaid because of low income while allowing them to qualify for enhanced benefits by signing and adhering to a "Medicaid Member Agreement" (see box).³ The enhanced benefits include all mandatory services as well as additional age-appropriate services that focus on wellness. Examples include diabetes care

beyond basic inpatient and outpatient services, cardiac rehabilitation, tobacco-cessation programs, education in nutrition, and chemical-dependency and mental health services. Under the basic plan, prescriptions are limited to four per month; under the enhanced plan, there is no monthly limit. According to Nancy Atkins, the commissioner of the Bureau for Medical Services in the West Virginia Department of Health and Human Resources, the goals of the redesign are to streamline administration; tailor benefits to specific groups; coordinate care, especially for members with chronic conditions; and "provide members with the opportunity and incentive to maintain and improve their health."

To remain in the enhanced plan, members must keep their medical appointments, receive screenings, take their medications, and follow health improvement plans; West Virginia will monitor "successful compliance with these four responsibilities."³ Members whose benefits are to be reduced because they have not met these criteria will receive advance notice and have the right to appeal. Those who meet their health

goals will receive "credits" that will be placed in a "Healthy Rewards Account" to be used for purchasing services that are not covered by the Medicaid plan. Although details about how these accounts will work and what services will be eligible for purchase are forthcoming, the services might include fitness-club memberships for adults or vouchers for healthful foods for children. In July 2006, transition to the new plan began in three West Virginia counties; the program will eventually include about 160,000 people — or about half the state's Medicaid beneficiaries. Beneficiaries who are 65 years of age or older or who have disabilities will retain their current level of coverage, as will some others, such as children in foster care.

There have been no previous efforts to change Medicaid benefits in the way West Virginia intends to do, nor are there comparable examples among private health insurance programs. Thus, it is difficult to predict the effects, including those on costs, beneficiaries' health, and medical practice. Many specifics are uncertain, including the level of acceptance of the member agreement on the



Health Insurance Coverage and Income in West Virginia and the United States.

Data are for 2003–2004 and are from the Kaiser Commission on Medicaid and the Uninsured.

West Virginia Medicaid Member Agreement

This Agreement outlines your Rights and Responsibilities as a person in the West Virginia Medicaid Program. It also is about ways you can work with your doctor and other health care providers to become healthier.

Member Responsibilities

- I will follow the requirements of the West Virginia Medicaid program.
- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.
- I will use the hospital emergency room only for emergencies.

Member Rights

1. I have the right to pick my medical home. This is where I go for check-ups or when I am sick and where my health care records will be.
2. I have a right to decide things about my health care and the health care of my children. I have a right to see my medical records. I have the right to ask questions about my health care and the health care of my children.
3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the Medicaid program.
4. I have a right to know about all laws and rules of the Medicaid Program.
5. I can contact Medicaid or my health plan with any questions about my health care.
6. I have a right to be sent a written notice when West Virginia Medicaid decides to deny or limit my Medicaid eligibility. I have a right to appeal a decision about my eligibility.
7. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

Member Acknowledgement

The information in this paper has been explained to me and I agree to follow this Medicaid Member Agreement.

part of Medicaid enrollees and the criteria beneficiaries must meet to remain in the enhanced plan, as well as program regulations and implementation details. Although there is no limit on the number of eligible beneficiaries who can receive the enhanced benefits, the percentage who do receive them will not be known for several years. According to the Washington-based Center on Budget and Policy Priorities, which monitors policies and programs affecting low- and moderate-income Amer-

icans, West Virginia's assumption that Medicaid beneficiaries will change their behavior in such a way as to improve their health (and maintain their eligibility for enhanced benefits) as a result of signing a member agreement is "unproven and untested."⁴

There are many reasons why patients might not comply with medical recommendations. These include poor physician-patient communication; side effects of medication; advice that is impractical to follow for reasons that in-

clude job responsibilities and difficulties with transportation or child care, psychiatric illness, cost, the complexity of the recommendations, or the language in which they are communicated; and cultural barriers.⁵ Patients who may benefit from additional services, such as diabetes care, education in nutrition, or chemical-dependency and mental health services, include many who might have difficulty with compliance, thus increasing the likelihood that they will not be eligible for these ser-

vices under the West Virginia program. Moreover, as compared with elderly Medicaid beneficiaries and those with disabilities, healthy children and adults are inexpensive to cover. Any savings for these groups could be offset by the costs of administering the changes in Medicaid or by increased costs for mandatory services for patients who remain in the basic plan.⁴ In their Perspective article in this issue of the *Journal*, Bishop and Brodkey raise additional questions about the plan (pages 756–758).

Although personal responsibility for health and for obtaining

health care may seem intuitively attractive, the design and implementation of specific insurance initiatives may be complicated. Before such plans are implemented, it would be best to evaluate them rigorously in a controlled trial conducted by an independent group. If they do not improve health or save money, or have unanticipated negative effects, they can be discarded or revised.

Dr. Steinbrook (rsteinbrook@attglobal.net) is a national correspondent for the *Journal*.

1. Wall Street Journal Online/Harris Interactive Health-Care Poll. Many Americans back higher costs for people with unhealthy lifestyles. July 19, 2006. (Accessed August 2,

2006, at http://online.wsj.com/article_print/SB115324313567509976.html.)

2. Center for Medicare and Medicaid Services. Roadmap to Medicaid reform: new options to improve and expand insurance coverage for acute care needs. March 31, 2006. (Accessed August 2, 2006, at <http://www.cms.hhs.gov/smdl/downloads/Rvacutecare.pdf>.)

3. West Virginia's Medicaid State Plan Amendment (SPA) 06-02, approved by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, May 3, 2006. (Accessed August 2, 2006, at <http://www.wvdhhr.org/bms/>.)

4. Solomon J. West Virginia's Medicaid changes unlikely to reduce state costs or improve beneficiaries' health. Washington, D.C.: Center on Budget and Policy Priorities, May 31, 2006 (Accessed August 2, 2006, at <http://www.cbpp.org/5-31-06health.htm>.)

5. Osterberg L, Blaschke T. Adherence to medication. *N Engl J Med* 2005;353:487-97.

Personal Responsibility and Physician Responsibility — West Virginia's Medicaid Plan

Gene Bishop, M.D., and Amy C. Brodkey, M.D.

Mary Jones is your 53-year-old patient with diabetes and obesity. These conditions developed after she began to take an atypical antipsychotic drug for schizophrenia. Jones signed a treatment contract stating that she will keep all her medical appointments, attend diabetes education classes, and lose weight. She attended one class but became paranoid and left halfway through it, and she has gained 5 lb. You gave her educational materials to read, but you have discovered that she doesn't understand them. She has just missed her second consecutive appointment with you; last time, she didn't have bus fare. Neither her glycated hemoglobin nor her blood lipids are at target levels. You are now legally obligated to report this information to your state Medicaid agency, and Jones may lose her mental health

benefits and some of her prescription coverage as a result.

This scenario is no Orwellian fantasy: West Virginia is planning to ask residents who are eligible for Medicaid because of low income to sign documents outlining “member responsibilities and rights.” By signing these documents, they agree, among other things, to take their medications, keep their appointments, and avoid unnecessary emergency room visits. Patients who don't uphold their end of the bargain will have some benefits reduced or eliminated. In the first year, the state will track four indicators: whether patients participate in health care screenings and adhere to health improvement programs as directed by their health care providers, whether they keep their medical appointments, and whether they take their medica-

tions.¹ The plan does not specify standards for determining successful adherence to these criteria.

As part of a trend emphasizing “personal responsibility” for health status, the plan has implications far beyond its effects on needy West Virginians. This strategy will have important consequences for practicing physicians. Its speedy approval by the Centers for Medicare and Medicaid Services (CMS) demonstrates the agency's enthusiasm for such an approach. Under the Deficit Reduction Act of 2005, Idaho and Kentucky have submitted plans with similar philosophies. When the West Virginia plan was approved, CMS administrator Mark McClellan stated, “Medicaid enrollees in West Virginia will now become part of an emerging trend in health care that empowers patients to make educated, con-