

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.<sup>4</sup> 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.

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## 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.<sup>1</sup> 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-

sumer-driven decisions related to their own treatment.”<sup>2</sup>

Personal responsibility is a laudable goal with intuitive appeal and an established place in the lexicon of American culture and values, but used in this context, it is at odds with current models of the doctor–patient relationship. Physicians and patients negotiate treatment, taking into account the dynamic tension between desirable behaviors and achievable ones. Failure leads to renegotiation. Reasons for missed appointments are many — sick children, depression, business meetings that run late, and just plain forgetfulness. An exploration of the reason may improve future behavior, whereas humiliation and punishment may result in decreased adherence to treatment. Treatment negotiations are both individual and ever changing. The West Virginia plan is a blunt instrument that takes the therapeutic contract outside of the medical encounter, and there is a paucity of evidence to support this approach to improving health-related behaviors.

The plan also raises fundamental issues of fairness. First, it places responsibility on patients for factors that may be out of their control. Persons who depend on public transportation or transportation provided by Medicaid can attest to the unreliability of these systems. Primary care offices have limited evening and weekend hours, forcing patients to visit emergency rooms. And at least 75 percent of the beneficiaries who may be affected are children, who will have to depend on their parents or guardians for adherence to the rules.

Second, the plan holds Medicaid patients to a standard of behavior that is not required of oth-

er patients. An editorial in a West Virginia newspaper said, “All the state is asking is that patients take their medications, follow their doctors’ orders, and show up on time for their appointments.”<sup>3</sup> As physicians, we know how rare such behavior is. Even under the ideal circumstances of a clinical trial, the rate of compliance with medication ranges from 43 percent to 78 percent, and there is no consensual standard for what constitutes adequate adherence.<sup>4</sup> Privately insured patients may reject their physicians’ advice without losing their health benefits — and they may have the confidence to express that disagreement overtly, leading to renegotiation — whereas poorer and often less well-educated Medicaid patients may simply choose silently not to comply.

There are well-understood reasons why Medicaid beneficiaries have poorer health indicators and higher rates of noncompliance than many other patients. Poverty results in reduced access to child care, transportation, healthful foods, and exercise facilities, as well as lower literacy, more life crises, and higher rates of untreated psychiatric illnesses. People with fewer experiences of success are less likely than others to believe that they can change their health status. This plan asks the most vulnerable population to do more with less ability to accomplish what we ask of them.

The plan makes explicit the belief that persons must behave according to set norms in order to deserve health care and health insurance. What physician has not sighed in frustration over the patient who continues to smoke after angioplasty? Yet while promoting healthful behaviors, we continue to offer care. The West

Virginia plan risks the application of an actuarial value to every behavior. Is riding a bicycle to work good for your health because of exercise or bad for your health because of the risk of accidents? Is it irresponsible to refuse to take a medication if it makes you ill and you cannot reach your physician to ask for advice?

The plan asks physicians to violate all three fundamental principles enumerated in the Physician Charter on Medical Professionalism: the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice.<sup>5</sup> It raises potential conflicts by placing physicians in a reporting situation in which the public health is not at issue, possibly asking them to harm their patients or their relationships with patients. As physicians become agents of the state, poor patients’ distrust of the medical system can only increase. Although the plan’s member agreement mentions the patient’s right “to decide things about my health care and the health care of my children,” it does not recognize that noncompliance can be an expression of disagreement with the physician. The plan promotes discrimination not only on the basis of socioeconomic status, but also on the basis of diagnosis: surely, people with mental illnesses who have trouble managing activities of daily living such as keeping appointments will be discriminated against under a plan that rescinds their mental health benefits because of such lapses.

It is unclear what steps will be taken if physicians do not comply with reporting requirements. The four indicators require data collection from physicians’ offices. This requirement for additional documentation is an unfunded ad-

ministrative mandate that could actually decrease physician participation in the Medicaid program.

In the face of both increasing health care costs and numbers of uninsured persons, states will continue to seek ways to control Medicaid costs. Clinicians often abstain from policy discussions until it is too late for them to have an impact. But who is better able to provide evidence of the misguided nature of such plans? What physician would recommend that a person with diabetes who misses appointments lose the ability to attend diabetes education classes? What physician wants to be

faced with a child with asthma whose benefits have been reduced to four prescriptions per month when she gets pneumonia and an antibiotic makes five? In an era of “personal responsibility,” physicians must assume the responsibility of speaking out about how such policies affect their practices and their patients' health.

**An interview with Dr. Bishop and Nancy Atkins, commissioner of the Bureau for Medical Services, West Virginia Department of Health and Human Resources, can be heard at [www.nejm.org](http://www.nejm.org).**

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#### FOCUS ON RESEARCH

## Overweight and Mortality among Baby Boomers — Now We're Getting Personal

Tim Byers, M.D., M.P.H.

See related articles, pages 763 and 779

I am a baby boomer, and my body-mass index (BMI) is 27.3. I am also an epidemiologist, so for both personal and professional reasons, I have closely followed the sometimes divergent conclusions about the health risks associated with growing older and being a little overweight. As reported in this issue of the *Journal*, trials involving more than half a million Americans (Adams et al., pages 763–778) and more than a million Koreans (Jee et al., pages 779–787) are the latest in a series of cohort studies published in recent years on the risks associated with excess adiposity. Now that studies are beginning to describe the risk of death associated with even modest levels of adiposity among baby boomers, this issue is getting more personal for me.

At first glance, the new study involving members of the AARP (formerly the American Association of Retired Persons) looks reassuring for those of us who are not obese, but only overweight. Among the entire cohort of AARP members, the risk of death seems to be substantially increased only for those whose BMI is over 30, the cutoff defining obesity. However, we have learned in recent years that only studies of the relationship between adiposity and the risk of death that properly account for tobacco use and chronic medical conditions can be truly informative about the risk caused by lesser degrees of adiposity. The AARP study clearly shows that if the effects of smoking are set aside, at age 50, when the prevalence of chronic disease is low, there is also an elevated risk of

death for persons whose BMIs are well below 30.

The study of adiposity and mortality among Korean adults also shows a graded relationship between BMI and death from atherosclerotic cardiovascular disease across a very wide range of BMI levels, including what would be regarded as only modest levels of adiposity in the United States. This finding is a sobering reminder that because obesity is now a worldwide problem, the phenomenon of “global fattening” will contribute to a pandemic of chronic diseases for many years to come.

What are we to do about the epidemic of adiposity, both collectively and personally? As health care providers, we are all touched by the personal dimensions of the problem, sometimes because we