State Health Watch

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In This Issue

New administration and taxes are ready for their closeups

Many state health policy-makers see a new day and a new chance to improve the welfare of the disadvantaged in their states. The incoming George W. Bush administration has made much of its pledge to return more power to state and local governments. The potential transfer of more power in health care decision making from Washington, DC, to the states is embodied by Wisconsin's governor, Tommy Thompson.

"If Tommy Thompson makes it, that'll be a good thing," Trish Riley, executive director of the National Academy for State Health Policy, in Portland, ME, tells *State Health Watch*. "He has provided one of the best Medicaid programs in the country. He is an innovative, long-term care leader with a strong, fine program in a state that fought hard with the federal government for more flexibility."

Thompson presides over Wisconsin's Children's Health Insurance Program (CHIP) offering, BadgerCare, and is Bush's nominee to be secretary of the Department of Health and Human Services. BadgerCare is seen by many state policy-makers as one of the more successful children's health insurance

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94% of low-income uninsured children are eligible for Medicaid or SCHIP

The U.S. Census Bureau's 2000 figures show there is near universal availability to health care coverage available for low-income children. Now it's a matter of making sure those who are eligible are properly enrolled. Recent expansions in Medicaid coverage for children and state health insurance programs for them are responsible for the high coverage numbers.

The analysis data — from the Center on Budget and Policy Priorities — show that 94% of all uninsured children with family incomes below twice the poverty line, currently $28,300 for a family of three, qualify for Medicaid or a separate state child health insurance program supported by Children's Health Insurance Program (CHIP) funds. In 1999, there were 7.1 million low-income children in the United States, and 6.7 million were eligible for child health insurance using current state eligibility standards.

The number of children covered through programs supported with CHIP funds more than doubled in 1999, reaching 1.8 million in December 1999. In addition, the total number of uninsured children in the United States fell by more than

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Court battles for money could drive costs up

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Medicaid managed care in NY searches for clues

Administrators at the United Hospital Fund of New York City contend that Medicaid managed care may not be as effective in bringing about changes in facility operations as had been anticipated. At least not until there is a critical mass of enrollees in managed care plans and sufficient reimbursements to enable facilities to afford to make changes. 7

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New administration

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programs in the country. Thompson, 59, is America's longest-serving Republican governor and was a leader in voicing support for cutting welfare rolls.

"Bush sends a signal that he wants state flexibility," Ms. Riley adds. "I don't know what is expected on the Medicare reform issue. It's going to be interesting."

Thompson has many detractors, Ms. Riley says, but "from one narrow perspective, he's a good choice."

Many states got a break from Congress before the new year and new administration showed up. Congress reached a compromise that allowed states to keep the federal CHIP money they had not spent. The unspent dollars from 40 states that had not spent their federal allocations were to be siphoned off to the 10 remaining states that did manage to spent their allotments. Those states who were losing money now have through the end of fiscal year 2002 to use the previously unspent funds. It was unusual for a such a compromise to be reached in a divided Congress.

"The system is in fragile shape. We were assured by supports of the tax cut that there is plenty to fully fund education and human services."

Richard Averbuch

Senior Director of Communications
Massachusetts Hospital Association
Burlington

"Almost everyone came away happy," Greg Haifley, deputy director of the health division of the Children's Defense Fund, of Washington, DC, tells *SHW*. "Our view was that we are in times of record budget surpluses, so we're grateful the money is staying in CHIP."

Mr. Haifley says the near miss for states that had not spent their funding was a warning signal that not spending the money is a risk. But with the Bush administration proposing tax cuts that could lead to the elimination of the budget surpluses, he says the Children's Defense Fund will eye tax cuts in terms of what they do for kids in low-income families. Among the questions his organization will use to frame the debate is: Are such cuts fair to those at the lower end of the economic scale as opposed to those who are well off?

"The second part is that if you get a favorable answer to

Source: Massachusetts Hospital Association, Burlington.

the first question, the right tax cut for the right people, you shouldn't have to worry about other priorities," Mr. Haifley says. "We will question who will benefit and also how much does [a tax cut] spend? Does it interfere with our priority to insure every child? Is it a change in administration, party, philosophies, and politics of power and how that power will be used?

"Will it be different?" he asks. "We will praise or criticize as needed."

The Massachusetts Hospital Association (MHA) in Burlington is dealing with a tax cut that is a done deal. It's from the state, though, not the federal government. The state's hospitals are in a pinch. Two-thirds of them are losing money; more than one in six of the state's nursing homes are bankrupt; home health has struggled so much in the past year that 25% of the state's agencies have closed up shop; and 25% of the state's hospitals have closed in the past 10 years. An income tax cut, approved by voters in November, goes into effect this year.

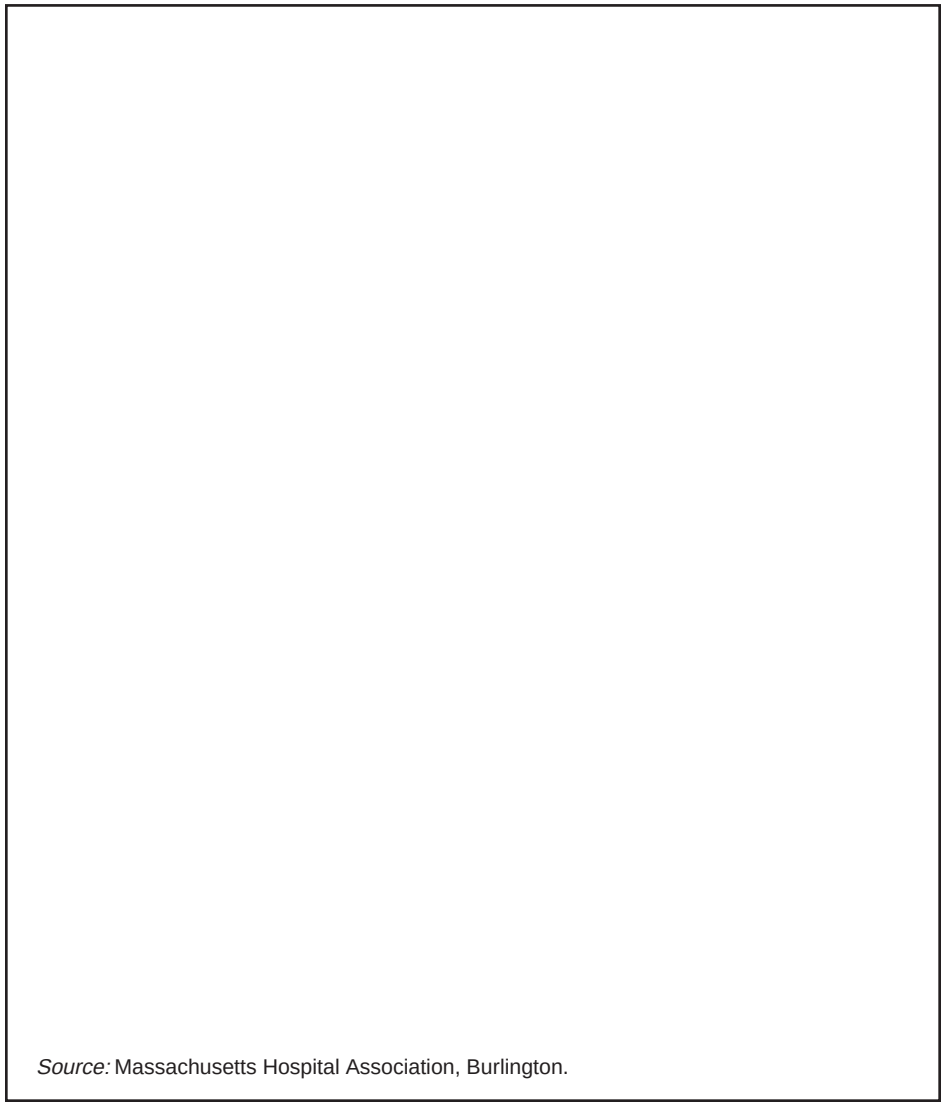
"The system is in fragile shape. We were assured by supports of the tax cut that there is plenty to fully fund education and human services," Richard Averbuch, senior director of communications for the MHA tells *SHW*.

"Now, here we are. The day of reckoning is here. The government will soon issue state budget rules, and funding will the in there. Medicaid will be in there. . . . We look for each party in the system to do its hare. We don't expect the state to make up for federal tax cuts," he explains. "That's not fair. What we need is for Washington to do its fair share for Medicare and the private sector to do its share for employees. The balance has shifted too far out. We need to stabilize the system."

The Balanced Budget Act of 1997 initiated the state's health care crisis, Averbuch asserts, and the health of the state has gone downhill since. The

Reduction in Medicare Payments to Massachusetts Hospitals

Source: Massachusetts Hospital Association, Burlington.



Source: Massachusetts Hospital Association, Burlington.

average hospital operating margin in fiscal year 1999 was -2.8%, the MHA says, so that further losses mean hospitals must start using their reserves, which were intended as seed money for the future.

Also, according to the MHA, the state's Medicaid payment ratios are the 11th lowest in the United States. The Medicare Payment Advisory Commission says that the state's Medicaid margins are the sixth lowest in the country.

"Medicare and the Balanced Budget Amendment are relative to the federal agenda. It is not strictly about DC affecting Massachusetts," Averbuch says. "A lot of the issues will be the same as they have been. A new [presidential] administration may not change things drastically. We favor a bipartisan approach to pulling things together. It will be the continuation of the same policy discussions. But a lot of the action is closer to home in terms of what we can do to get the state government to create a safety net for Medicaid payment and policies, and for state support for hospital care for the unisured." ■

HCFA wants to improve readability, increase comprehension levels of Medicaid materials

The Health Care Financing Administration (HCFA) has awarded two contracts to Maximus, a company with corporate headquarters in Reston, VA, that performs Medicaid outreach in many states. Maximus will be involved in an effort to improve the readability of applications and notices used by states with applicants for Medicaid and the Children's Health Insurance Program (CHIP).

The contracts, worth more than $567,000, will be administered by Maximus' Center for Health Literacy and Communication Technologies.

John Boyer, president of the Maximus Health Management Services Division, tells *State Health Watch* that the Center opened at the beginning of 2000 with a mission to advance an understanding of the relationship between health literacy and health.

"As a result of our work in providing enrollment assistance, we became concerned about the ability of some populations to grasp the written word. Because of our widespread presence in Medicaid and other programs, we saw an opportunity for us to have an impact on health communications," he says.

Christina Zarcadoolas, the center's executive director, says the need for materials to be revised is clear; 60% to 80% of the Medicaid population read below an eighth-grade level, and many may be reading below a fifth-grade level. "Because of their reading level, people are unable to understand and access some very basic information."

She says a national assessment in 1993 showed that 49% of Americans could not read above an eighth-grade level. "We're talking about a profound problem. It's not just an educational problem because it also affects many aspects of day-to-day living."

The new Maximus center works to improve the company's own materials, Ms. Zarcadoolas says, but also competes for contracts in programs where literacy plays an important role.

Under the first HCFA contract, Maximus will look at application forms used by individuals seeking to qualify for Medicaid and state CHIP programs. Center staff will collect applications currently used by the states, evaluate them for simplicity, literacy, and cultural appropriateness, and develop and field-test more user-friendly forms in both English and Spanish. Maximus has already received a 29-page application in use by one state. Some staff at the center with graduate degrees have been unable to categorize some of the Medicaid notices. In some cases, it is difficult to determine what information the notices are requesting.

Don't answer that question!

Ms. Zarcadoolas says one problem identified by HCFA is that states are including items in the application forms that are not required by HCFA regulations, such as asking for the Social Security numbers for all family members, when the requirements only call for a number for the applicant. She says the agency is trying to get word to state Medicaid officials about what is required. Guidelines to be issued as a result of the Maximus study will address the question of required and prohibited information as well.

"Whatever questions are asked," she says, "it's important to look at how the form is designed and the words that are used. If it were easy to do, we'd all be doing it already. We still don't have all the answers."

A key element of the contracts is qualitative field-testing of revised forms. Ms. Zarcadoolas says they will be relying less on focus groups and more on in-depth interviews with individuals and observing people attempting to complete the forms.

Testing will be held at several sites and will go on until the Center staff determine additional interviews will not yield any additional insights. They intend to use community-based organizations to identify and recruit evaluation subjects. Those who participate will be paid for their time and will have travel and child care assistance available.

The second contract requires Maximus to assess and make improvements in the official notices used by state agencies to formally communicate case actions to applicants and beneficiaries.

The center will collect notices commonly used in states, determine the degree to which individuals comprehend them, and develop and field-test new English and Spanish models. Ms. Zarcadoolas says they have found there are many more notices than application forms, but they will apply the same basic methodology and evaluation to the notices as to the applications.

The results of the work will be brought together as guidelines that HCFA will publish and disseminate to state Medicaid directors. The agency already has written to Medicaid directors to tell them of the project and ask them to submit their materials and consider possible evaluation sites. To help ensure that its recommendations will be considered, Maximus says it will not issue a final

report that can be placed on a shelf and ignored. It expects that operations staff in the various states will refer regularly to the guidebook.

The contract also provides for the center's assistance in making Spanish-language documents available. Senior manager Mercedes Blanco tells *SHW* that the center will be working to adapt documents instead of doing a word-for-word translation. Rather than waiting to translate the documents until after they are completed in English, the writers and researchers in both languages work together so they can share insights and better understand what the forms are intended to communicate.

Asked whether opposition to Maximus' enrollment activities in some states could have an adverse impact on the project, Mr. Boyer says he thinks his company often is blamed when people really are opposed to mandatory managed care for Medicaid.

"In virtually every place that we operate, we collaborate with community-based organizations and that has worked very effectively. I think our best work is done in face-to-face relationships over time in which trust can be built."

Texas state Medicaid director Linda Wertz, who also is president of the National Association of State Medicaid Directors, tells *SHW* that states are "willing to participate in any process that will make things more beneficial for clients. . . . It's hard to tell at this stage if Maximus' work will be fruitful, but states will give their best practice recommendations due consideration."

Ms. Wertz says states would prefer that Maximus' recommendations come to them as guidelines rather than as mandates from HCFA.

[For more information, contact the Maximus staff through Rachel Rowland at (888) 941-9549.] ■

Uninsured children

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1 million between 1998 and 1999, in part because of increased enrollment of low-income children in publicly funded programs.

Study author Matthew Broaddus, a health research assistant with the center, tells *State Health Watch* that because 94% of uninsured low-income children are eligible for Medicaid or a state child health program, the nation has largely solved the problem of making low-income children eligible for health insurance. What remains is the challenge of raising enrollment rates among children who are eligible for coverage but remain unenrolled and uninsured.

Mr. Broaddus says many low-income children apparently have not been enrolled because of administrative or other barriers. "The findings of this report suggest the federal government and the states need to take additional steps to implement simpler, more effective enrollment procedures. If the opportunity that the eligibility expansions has created is to be realized more fully, low-income families — especially working families — will need both to be more aware of their children's eligibility for health insurance programs and to be able to enroll their children without facing the burdensome and time-consuming paperwork and office visit requirements that low-income working parents can encounter."

According to the study, Census Bureau data show there has been progress in recent years in increasing insurance coverage among near-poor children, those with incomes between 100% and 200% of the poverty line, but that coverage has deteriorated for children below 100% of the poverty line. Among poor children, Medicaid coverage has fallen since 1995, the year before the federal welfare law was enacted, and the proportion of children who are uninsured has increased. Mr. Broaddus says the drop largely is a result of the sharp reductions in welfare caseloads and ensuing problems in assuring that low-income children and families leaving welfare retain the insurance coverage for which they qualify.

Three measures before Congress

Medicaid litigation adds to lawmakers' woes

The Colorado state agency that oversees Medicaid is asking for a $2.4 billion budget, and lawmakers were warned that court battles could drive costs even higher. Lawmakers were given a 285-page briefing packet on the second-costliest program in the state budget as they prepared for hearings with the Department of Health Care Policy and Financing. Only public education gets a bigger chunk of Colorado's annual budget.

The state might have to come up with an extra $32.5 million as a result of litigation involving the Medicaid program, analyst Alexis Senger told members of the Joint Budget Committee.

"Such litigation may put more pressure on the 6% [spending] limit and/or result in fewer general fund dollars available for other purposes like capital construction and transportation," Ms. Senger told the *Rocky Mountain News* in Denver. The briefing came a day after a hearing in which U.S. District Judge Willey Daniel sharply criticized the state for an $18 million mistake in cutting off Medicaid coverage for more than 40,000 low-income Colorado residents beginning in 1997. ■

that could have increased enrollment by eligible children would:

1. give states the option to allow schools and other organizations to determine "presumptive eligibility" for Medicaid for low-income children;

2. make it easier for welfare-to-work families to retain their health insurance during the transition;

3. allow states to restore coverage to legal immigrant children and pregnant women.

Mr. Broaddus tells *SHW* he thinks there is some interest in extending transitional Medicaid and in allowing presumptive eligibility, particularly through school lunch programs. In addition to potential federal action, states could take these steps to eliminate barriers to enrollment:

• simplify application and redetermination procedures, ensuring that questions asked are only those that are required, are clear, and do not have undue verification requirements;

• make Medicaid and state CHIP policies and procedures similar;

• expand application sites, stationing workers in settings such as clinics and hospitals and providing grants to community-based organizations to help complete applications;

• use school lunch information to help identify eligible children in need of coverage;

• expand eligibility for low-income parents.

"The nature of the programs available to children has changed," Mr. Broaddus says. "States need to send a new message that children can be eligible even if their families are not receiving welfare. The eligibility threshold has expanded with CHIP but many working parents still think they're not eligible." He adds that states have gotten caught up in the fact that they can expand coverage to parents.

[For more information, contact Matthew Broaddus at (202) 408-1080.] ■

Can Medicaid managed care leverage new changes in provider behavior?

Experience in New York City suggests that Medicaid managed care may not be as effective in bringing about changes in facility operations as had been anticipated — at least not until there is a critical mass of enrollees in managed care plans and sufficient reimbursements to enable facilities to afford to make changes.

That's the view of the United Hospital Fund of New York City following its third survey of ambulatory care facilities' response to Medicaid managed care.

Meanwhile, an attorney who represents many safety net hospitals and community health centers says that with the managed care rollout in the city taking longer than expected, facilities receiving fee-for-service payments have no incentive or cash to use to fund improvements. "We thought fee for service would become irrelevant," Deborah Bachrach, an attorney with Kalkines, Arky, Zall & Bernstein in New York City, tells *State Health Watch*, "but it hasn't."

"We thought fee for service would become irrelevant, but it hasn't."

Deborah Bachrach
Attorney
Kalkines, Arky, Zall & Bernstein
New York City

Kathryn Haslinger, vice president for policy analysis at United Hospital Fund, tells *SHW* the organization's survey was started when the state accelerated its policy push for Medicaid managed care. The survey was created to determine how sites have adapted to managed care and the impact it has had on facility finances. Surveyed are hospital outpatient departments and freestanding health centers.

The major finding from the three surveys is that the most important changes in provider operations occurred before managed care really took hold. And key indicators of site readiness, such as the availability of after-hours care, patient tracking, and financial incentives for primary care providers, still have not changed much between the 1997 and 1999 surveys.

All of the primary care sites responding to the survey in both 1997 and 1999 said they had patients who were members of Medicaid managed care plans. But most reported low managed care penetration, with only one in five Medicaid patients seen at the sites enrolled in managed care.

By making primary care services available after hours, providers may be better able to manage their patients' care and reduce costly and avoidable emergency department use. In the 1997 survey, 77% of sites reported being open at least one evening a week, and 56% said they were open some weekend hours. Those levels of commitment to off-hours care remained essentially the same in 1999.

In general, according to the report, sites sponsored by the New York City Health and Hospitals Corporation and Federally Qualified Health Centers were somewhat more likely to offer evening hours, while freestanding clinics were more likely to be open on weekends.

After-hours care also includes assisting patients who seek care when

facilities are closed. Nearly every site reported having an answering service or another provider available, by phone or at another location, where the site could refer patients when it was closed.

Analysts expect that a shift to managed care may encourage primary care practices to adopt operational practices that will help them track patients and make more efficient use of provider time, since missed appointments can reduce productivity as well as disrupt patient care regimens.

The surveys found that the number of sites that called patients to remind them of upcoming appointments did not change significantly from 1997 to 1999, with 46% of sites reporting making such calls most or all of the time in 1997, and 50% doing so in 1999.

Primary care providers also may try to track patient visits and make calls after patients have missed appointments. The number of sites reporting they took such steps rose significantly from nearly 21% in 1997 to 36% in 1999. The Fund says the modest changes overall in patient tracking suggest that sites may be responding to the new managed care environment, with the relatively small improvement due to limited managed care penetration or a belief that the practices are not worthwhile or cost-effective.

A more direct indicator of the influence of managed care may be a site's use of bonuses or other kinds of financial incentives to primary care providers to encourage them to increase efficiency or productivity and to monitor patient utilization or emergency department use. According to the survey, only 16% of sites reported offering such bonuses or incentives in 1997, and the figure only rose to 19% in 1999.

Ms. Haslinger says the survey findings "may suggest that managed care is very difficult to do. There is a real concern that low-income people have access to services and be able to make informed choices, and it may be that we are not able to keep up with what was an ambitious rollout schedule."

The United Hospital Fund suggests that one reason there only have been small changes between 1997 and 1999 is the delay in implementation of mandatory managed care. "Plans and providers focused on the state's shift to managed care with considerable expectation. Managed care plans stepped up their voluntary enrollment activities with Medicaid patients in 1995, anticipating the switch to mandatory enrollment that would come [as part of the Section 1115 waiver demonstration project]. Repeated delays . . . and the long wait prior to mandatory enrollment caused plans and providers to lose momentum in their efforts to prepare for managed care."

"Many primary care providers operate with very small margins and have few reserves to invest in managed care readiness. The shift to managed care often means a loss of revenue for these facilities, and the rising number of uninsured persons imposes additional burdens on many sites."

United Hospital Fund
New York City

Ms. Haslinger notes that the rollout still is in Phase I, which was planned to be a modest beginning and included portions of a pre-existing 1915b waiver project in southwest Brooklyn. "It's still mostly a voluntary program," she adds.

The report says the lack of significant change also may be due to the limited benefits many sites have realized from their efforts to manage care. Many sites had already adopted after-hours care to better meet the needs of their patients. On other indicators, however, providers could see too little return from their efforts to track patients and little reason to offer primary care providers financial incentives to be more productive.

Also, they may have limited resources available to use to further prepare for managed care.

"Many primary care providers operate with very small margins and have few reserves to invest in managed care readiness," the report says.

"The shift to managed care often means a loss of revenue for these facilities, and the rising number of uninsured persons imposes additional burdens on many sites. These financial strains give sites little recourse, and many may be financially unable to make the changes necessary to adapt to Medicaid managed care. As mandatory enrollment continues, . . . monitoring these sites' efforts to adapt to the changing health care environment will be crucial," according to the report.

Ms. Haslinger says that in terms of national policy, it is fair to ask the extent to which Medicaid managed care can be looked to as a means of leveraging changes in provider behavior. She also stresses the financial problems faced by facilities. "It's not reasonable to expect an investment [in information systems, for example] when the income isn't there."

Ms. Bachrach, whose firm represents many safety net hospitals and community health centers, says that with the slow rollout, many Medicaid patients will remain in fee-for-service programs. But those fee-for-service payments don't provide any incentives for facilities to help restructure the

health care system.

She says there is a need for system restructuring to provide "increased continuity of care and increased care management, the hallmarks of any top-notch primary care system. We've seen some movement in that direction under Medicaid managed care, but the fee-for-service payments need to change."

Hospital outpatient rates have been capped at the mid-$60s for more than a decade, Ms. Bachrach says, and the diagnosis and treatment center rate has been frozen for more than eight years.

"The state should reevaluate and adjust the fee-for-service rates to reflect the higher level of care that is being delivered now and will be delivered in the future," she says.

"And the managed care rollout needs to be on a more definite time schedule so facilities can plan. We anticipated an immediate rollout six years ago, but that hasn't happened.

"Plans for changes that institutions made fell by the wayside as other priorities came up. This is an issue that the administration and legislature need to seriously consider if we're serious about improving the quality of care for these populations," Ms. Bachrach explains.

[For more information, contact Kathryn Haslinger at (212) 494-0700 and Deborah Bachrach at (212) 830-7223.] ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

End of litigation results in first reimbursement increase for outpatient care in 15 years

SACRAMENTO, CA—Gov. Gray Davis announced that hospitals in California have settled a 10-year-old lawsuit against the state over Medi-Cal payment rates for outpatient care, leading to the first broad increase in rates in 15 years.

Under terms of the agreement, the state Department of Health Services will also pay California hospitals $350 million, a lump sum that will be divided among hospitals using a formula that has yet to be determined. That sum is designed to compensate hospitals for a decade in which Medi-Cal reimbursement rates were too low, as determined by a federal appellate court in 1997.

The rate increase, a hike of 30% or $78 million, will take effect July 1 and will stand for one year. For each of the following three years, rates will be increased 3.3% annually. After that, a new mechanism for determining fair rates will be established.

"This settlement is critical to the survival of some of California's busiest hospitals and will help keep emergency rooms open," Davis said in a statement. "Hospitals that rely on Medi-Cal reimbursement rates are key links in our health system safety net. The increase in reimbursements will ensure that hospitals in our state will have the resources to provide care to all Californians."

—*Los Angeles Times*, Dec. 6, 2000

Ohio has new organ donation law that overrules objections by family

COLUMBUS, OH—Gov. Bob Taft signed a bill that will allow Ohio's organ, eye, and tissue banks to seize the gift of life over the objections of surviving relatives if an individual has designated intent to be a donor on a driver's license or state identification card. The new law, which included an emergency clause, took effect immediately.

Lawmakers said they were passing the legislation both to honor donors' wishes and to help offset a daunting national trend faced by recovery agencies. Although more than 73,000 people are waiting to receive an organ, fewer than 22,000 transplants were performed last year, with the number of recovered organs remaining flat in most regions or increasing only slightly. The new law makes designation of an intent to donate legally binding, going so far as to authorize procurement organizations to sue survivors in Common Pleas Court to enforce the donation.

The law also creates an organ-donor registry to be operated by the Bureau of Motor Vehicles and disbands the Second Chance Trust Fund Board in favor of an advisory committee answerable to J. Nick Baird, Ohio's health commissioner.

Sniping between organ banks and eye and tissue banks in central and southern Ohio nearly derailed the bill. Just moments before the Ohio Senate was to vote on the measure in September, a power play by organ bank lobbyists to disproportionately increase the representation of organ bank members on the advisory committee stalled the bill until after the election. The organ banks eventually withdrew their demand.

—*The Plain Dealer*, Cleveland, Dec. 14, 2000

Lousiana considers financing the abortion pill for state employees

BATON ROUGE, LA—Louisiana's health insurance program for state workers is looking into whether to include the abortion pill on its list of covered prescription drugs. The State Employees Group Benefits Program board of trustees briefly debated the idea of banning coverage of RU-486, known as the abortion pill, but delayed any decision until its benefits committee can review the issue.

Board member Russell Culotta, who represents state retirees, said he doesn't want group benefits to pay for any abortion-inducing drugs or any medical consultations that would result in prescribing the drug. Culotta said he is pro-life, but that is not his motivation for trying to exclude coverage of RU-486.

—*The Advocate*, Baton Rouge, LA

Pharmaceuticals go to court to block cut-rate prescriptions

MONTPELIER, VT—The pharmaceutical industry has sued the federal government in a bid to block Vermont from offering cut-rate prescriptions to a broader range of people through Medicaid.

Vermont was scheduled to begin signing people up for the new program on Jan. 1, but the industry asked a federal judge in Washington, DC, to suspend it while the lawsuit is pending. Pharmaceutical Research and Manufacturers of America (PhRMA), a trade group representing the industry, has opposed the program since its

conception but was unsuccessful in persuading Health and Human Services Secretary Donna Shalala from approving it.

Now PhRMA has taken the same arguments made to Shalala's staff to U.S. District Court. "The cost and financing of prescription drugs for lower income individuals is an issue of national importance and has been the subject of extensive debate in the legislative and executive branches of the federal government and many state governments," PhRMA's lawsuit states. "While the debate continues, however, the secretary of the Department of Health and Human Services and the state of Vermont have, in effect, made an 'end run' around existing federal law by creating a new 'government' program with no government cost, but paid for solely by private manufacturers."

Vermont's program relies on Medicaid to help reduce prescription drug prices for thousands of people who otherwise wouldn't qualify for Medicaid coverage. State officials asked the federal government for a waiver of existing rules so as many as 70,000 more people could qualify for the discounted prescriptions that the state gets, through rebates granted by the industry, for traditional Medicaid beneficiaries.

—*Rutland Herald*, Rutland, VT, Dec. 14, 2000

Report: Study blames California's weakened anti-smoking rules for 8,300 deaths

SAN FRANCISCO—Some 8,000 people have died of smoking-related heart disease in California as a result of the state's weakened anti-smoking campaign, according to a new study. Medical researchers from the University of California, San Francisco (UCSF) found that anti-smoking campaigns prevented about 33,300 deaths from 1989 to 1997, but that number could have included another 8,300 people if the state's voter-approved program had continued the fervor it began with in 1988.

"The state needs to start again working aggressively," said Stan Glantz, author of the study and a professor of medicine at UCSF. "In the mid-90s, the former governor was closely allied with Philip Morris . . . and as a result, people died."

The initial campaign focused on older smokers, while today's program mainly targets children, Glantz said. His study, published in the Dec. 14, 2000, issue of *The New England Journal of Medicine*, found that the smoking-related deaths correlated to cutbacks in the state's 1992 campaign. But government health administrators disagree, saying California's anti-tobacco campaign is on the mark. According to another recent study, the state's lung cancer rate has dropped 14% in the past decade.

—Associated Press

Rising Medicaid costs create havoc for Indiana's state Medicaid officials

INDIANAPOLIS—Indiana's cost of providing health care for the needy is soaring and threatening to squeeze out other budget needs. Prescription drug costs, an increase in recipients, and a commitment to providing more in-home care to the disabled all have contributed to a jump in Medicaid costs over the past two years that has exceeded the amount budgeted for the program.

State Medicaid officials told a budget-writing committee recently that they need a $71.2 million state appropriation to make up the shortfall in this year's budget and at least $446 million more in the next two-year budget just to offer the same level of care. "It is eye-popping," said Kathleen Gifford, state Medicaid director.

But State Budget Committee Chairman Rep. B. Patrick Bauer (D-South Bend), urged Gov. Frank O'Bannon's administration to go back and "mold and shape" the program so costs and benefits are slashed before higher spending jeopardizes other programs and the state's bank account.

In addition to Gifford's report to the committee, officials in the state's Family and Social Services Administration laid out their spending plans. They were the latest state bureaucrats to deliver pitches to the panel.

Mr. Bauer issued a note of caution. "I don't think reality has set in here — not only in this room, but across the state," he said.

Indiana is one of at least 11 states where tax revenue collections have fallen behind expectations. So far this budget year, which ends June 30, the state has collected $123.2 million less than forecasters expected, which could cut into its projected surplus of $1.2 billion.

—*Indianapolis Star*, Dec. 14, 2000

Kentucky's Medicaid is facing projected $12 million shortfall

FRANKFORT, KY—Kentucky faces a projected budget shortfall of at least $12 million in its Medicaid program that could result in reduced health care benefits to the needy or a cut in reimbursements to medical providers.

Crit Luallen, cabinet Secretary, said the state is still trying to determine the total shortfall in its estimated $3 billion Medicaid program. Kentucky provides about 30% of its Medicaid budget from state funds, then gets the rest from a federal government match.

Mr. Luallen said the shortfall is in state funds. Early estimates of it range from $12 million to $14 million in 2001, and $50 million to $70 million in 2002.

But not having the state money means losing out on

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Vice President/Group Publisher: ***Brenda Mooney****, (404) 262-5403, brenda.mooney@ahcpub.com.*

Editorial Group Head: ***Coles McKagen****, (404) 262-5420, coles.mckagen@ahcpub.com.*

Managing Editor: ***Lee Landenberger****, (404) 262-5483, lee.landenberger@ahcpub.com.*

Production Editor: ***Ann Duncan****.*

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federal dollars, threatening services even more. If the state estimate holds true, Kentucky's total Medicaid loss could be $40 million to $47 million in 2001, and $167 million to $233 million in 2002. Officials said the problem arose because they underestimated growth in the Medicaid program and the impact from soaring medical costs and prescription drugs. But so have other states, according to a report released by the National Governors' Association and the National Association of State Budget Officers.

The budget survey of states, released twice a year, found that other states will face tough choices over the next two years. Of 29 states, about half estimate that Medicaid spending will go over budget.

—*Lexington Herald Leader*, Dec. 19, 2000

Rising pharmacy costs make it difficult for states to keep pace

Northeastern states trying to lower prescription drug costs met for the fifth time recently and expressed hope that their efforts will pressure Congress to act too. "The states are really carrying a tremendous burden," said Jane Kitchel, the secretary of the Agency of Human Services in Vermont. She said pharmacy costs are increasing by 18% while the economy is growing at only 4%, making it difficult for states to help people with their health care costs.

"We're going to be cannibalizing a lot of state governments," she said, something not lost on federal lawmakers. "I think in the upcoming (congressional) session, health care is going to be right at the forefront of legislation," she told about 28 lawmakers from eight northeastern states.

Others weren't so sure. State Sen. Mark Montigny of Massachusetts helped pass a bill designed to lower costs in his state, but it has never been put into effect because of opposition by pharmaceutical companies, he said. He sees the same opposition lobbying in Washington, where pharmaceutical companies contribute millions of dollars to election campaigns.

"Perhaps some day something will be done on a federal level," he said, then added, "I doubt it."

—Associated Press, Dec. 13, 2000