State Health Watch

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Lawmakers in 21 states expected to consider bills that make it easier for consumers to sue their plans

Some 21 states are expected to debate legislation this year that could make it easier for consumers to sue their health plans when they are injured by a denial of health coverage, according to a just-released survey by the national Blue Cross and Blue Shield Association.

Legislators in many states have shown a willingness to test the Employee Retirement Income Security Act (ERISA) over the issue, which they see as a vital consumer protection.

A growing criticism of ERISA is that many consumers covered by employer-sponsored plans are not benefitting from the multitude of other managed care protections that have been put into place by state legislatures in recent years. The 1974 law, which has become an important part of the debate over health plan liability, has been interpreted by the courts as preempting most state regulation of employer-sponsored plans.

Many lawmakers believe the millions of consumers in employer-sponsored health plans (an estimated 48 million are in self-funded plans) should have the right to sue their health plans for inadequate care just as they can sue doctors and hospitals.

At presstime, Texas, which passed the landmark Texas Health Care Liability Act (SB386) last year was waiting for a decision from a federal court judge in Houston on a suit by Aetna, which is challenging the law on the grounds that it is preempted by ERISA.

Patricia Butler, a Colorado-based lawyer, explains in a recent analysis of managed care legislation for the Henry J. Kaiser Family Foundation, that the Texas Liability Act opens the door to an ERISA challenge because it goes beyond removing the corporate practice of medicine defense which has made it difficult for all consumers to sue any health plan.

Corporate Practice of Medicine laws, which prohibit organizations not owned by physicians from employing physicians, have been interpreted by many courts as barring suits against HMOs and other health plans because they are prohibited from "practicing medicine." They are considered to be merely administering

Continued on page 4

In This Issue

States simplify Medicaid applications, offer presumptive eligibility to improve outreach

Under pressure to improve outreach to uninsured children who may qualify for Medicaid or new child health insurance programs, many states are moving to make the Medicaid application process more user-friendly.

Several states, including Florida, Massachusetts and Connecticut, also plan to take advantage of a new opportunity to give children presumptive eligibility for Medicaid so that they can bring them into the system more quickly once they apply for benefits.

The Center on Budget and Policy Priorities (CBPP) reports that, as of February, 38 states had dropped the assets test for Medicaid, 30 have developed short application forms and 25 were allowing mail-in applications.

"Having an assets test is a tremendous barrier to Medicaid applications, and eliminating it is an important step," said Donna Cohen Ross, director of the Start Healthy, Stay Healthy Project at the CBPP.

Eliminating the assets test makes it possible to take another very important step—simplifying and shortening the application form, she said.

"Some states have applications over 20 pages long, posing an often insurmountable challenge for families," states a Jan. 23 letter sent to state officials by the Health Care Financing Administration (HCFA). The letter informs state officials of steps they can take to improve outreach to the millions of uninsured children in the country who are eligible for Medicaid, but not enrolled.

Continued on page 7

New York budgets $24 million in grants to help nonprofit providers create HIV/AIDS care networks

New York's long-awaited special needs plans (SNPs) for Medicaid recipients with HIV/AIDS appear to be closer to reality. In his budget proposal, Gov. George Pataki announced plans to set aside $24 million in grants to help SNPs get off the ground.

Well-capitalized, for-profit HMOs would not be eligible for the grants. Only non-profit health care providers and community groups serving those with HIV/AIDS would be eligible for the grants if they decide to create managed care networks. Every dollar in grant funding would have to be matched, however, by a dollar of private capital.

"The governor's proposal ... puts for-profits at a disadvantage unless they have very deep pockets, which of course some of them do," said Dr. George Clifford, administrator of the AIDS program at the Albany Medical Center, one of the hospitals looking into the possibility of forming a SNP. "It creates an unlevel playing field."

Many observers think the state is trying to do just that, to make sure that the groups already providing services don't get squeezed out of the new system.

"At this point we are getting ready to issue an RFP, which we expect to do this spring," said Department of Health spokeswoman Frances Tarlton. "Then we're looking at three months for the applications to come in. Our goal is to be able to license some SNPs by the end of the year."

The federal government waiver under which New York is operating its Medicaid mandatory managed care system requires that "the SNPs have to be in place; viable, up and running before we can mandate managed care for this population," Ms. Tarlton added. As a result, she said, "It's likely that there will be some pilot programs set up."

But likely participants are taking very much of a wait-and-see attitude until the state announces its rate structure, or even how much the total funding package will be.

"We've had conversations with some of those HMOs to see if they're interested in being the parent to a SNP," said Dr. Clifford. "At least two have made it clear they're not interested in getting involved in any more business arrangements of this type with the state."

When the state negotiated its first mandatory managed care contracts, many HMOs complained that they were pressured into accepting less-than-adequate rates. In fact, the department raised many of them after outside auditors appointed by the Legislature reviewed the rates.

"We'd be very concerned about the rate structure before we made any decision," said David Rooney, a spokesman for Kaiser Permanente CHP, one of the HMOs that's been participating in the discussion process with the Health Department and other interested groups over SNPs.

While the state has yet to announce its rate structure, department officials did brief managed care companies, health care providers, community service organizations and consumer groups on some financial and policy issues at a meeting in early February.

"We've heard they're going to base their rates on 1995-'96 utilization data and cost data, which is good," said Susan Dooha, director of Health Care Access for Gay Men's Health Crisis. "Hospitalizations costs were higher during that period, because the new therapies have reduced the need for hospital admissions."

The department also appears not to want to repeat the bidding process that cre-

Continued on page 11

Health-risk adjustment helps ensure consumer choice in markets

Health-risk adjustment of premiums not only promotes fairer compensation among health plans but it also can help ensure that consumers have adequate choice of providers in their markets, experts say.

The Minneapolis-based employer coalition, Buyers Health Care Action Group (BHCAG), is risk-adjusting payments to providers based on the health status of their patients partly because it wants to attract "niche players," the specialty providers, disease management programs and centers of excellence that typically serve high-risk, high-cost patients.

"If we weren't doing risk adjustment, we wouldn't have some of these care systems at the table," said Ann L. Robinow, executive director of care systems and finance for BHCAG. Ms. Robinow spoke at a Jan. 29 meeting on health risk adjustment in Washington, D.C. The meeting, which included reports on health risk adjustment efforts in four states—Minnesota, California, Colorado and Washington—was sponsored by the Robert Wood Johnson Foundation and conducted by the Alpha Center.

Premiums traditionally have been adjusted for age, gender and geographic region, but there's growing interest in adjusting payments for the health status of enrollees, too. The idea is that this more refined risk adjustment will better compensate plans that enroll higher risk or "sicker" populations and reduce incentives for "cherry-picking" healthy enrollees.

Jan Malcolm, system vice president, public affairs, for Allina Health System, said her plan used to offer an open-access product to state employees. While the product was very popular, it became clear that it also attracted higher-risk, more costly enrollees. Because the state did not have a risk adjustment system that compensated Allina for those differences, the health plan was forced to discontinue the product, Ms. Malcolm said.

Better risk adjustment, Ms. Malcolm said, is needed to allay public mistrust of payment incentives under managed care. "Whatever we can do to rebuild those incentives is critical," she said. "We have to demonstrate that we're willing to do risk-adjusted payments."

But there are many obstacles to widespread adoption of health risk adjustment. Many purchasers find the concept of health risk adjustment too difficult to understand and too costly to support. There also are serious data collection issues. Reliable information about patient diagnoses is difficult to get, particularly in out-

Continued on page 11

Vermont targets inconsistent practice patterns in state

Vermont is not alone in having inconsistent practice patterns across the state for middle ear infections, congestive heart failure, complicated pregnancies or other conditions. While significant variations in practice patterns have been documented in virtually all states, Vermont is unique in having a private, non-profit organization working with providers to reduce those variations.

The Vermont Program for Quality in Health Care (VPQHC), an unusual alliance of providers, insurers, employers, consumers and state regulators, analyzes differences in practice patterns and helps hospitals and other providers in the state improve quality of care.

"To get people together to commit to a mutual goal like this is really extraordinary."—Riley

Similar efforts in other states are often carried out by health plans, academic organizations or health systems. One health policy expert says Vermont's collaborative venture in sharing data and using practice guidelines could serve as a model for other states.

"To get people together to commit to a mutual goal like this is really extraordinary," said Trish Riley, executive director of the National Academy for State Health Policy. "Again, all eyes are on Vermont."

VPQHC operates with a staff of six and a budget of $466,000. In its early years, VPQHC relied on hospitals for most of its funding, and providers dominated its board of directors. VPQHC now gets 70% of its funding from a state-imposed tax on health insurers and hospitals and its board now includes employers, state officials and consumers, along with doctors, hospital executives and insurance company representatives.

With an expanded board and a reliable funding source, VPQHC has become bolder -- more willing to publicize its data.

Each year, VPQHC publishes the *Vermont Health Care Quality Report,* which uses maps and charts and plain English to show practice variations for everything from C-section rates to cardiac catheterization. The report also details VPQHC's own efforts to improve health care quality, and, where appropriate, compares Vermont's progress against HEDIS measures, goals for the national Healthy People 2000 initiative and its companion initiative in the state, Healthy Vermonters 2000.

When the legislature considered a bill mandating insurance reimbursement for chiropractic care, the state insurance department contracted with VPQHC to bring chiropractors and MDs to the table to examine appropriate scope of services for chiropractic care in Vermont.

When VPQHC conducts a study, it assembles a steering committee of medical experts in the field to guide the project, develop practice guidelines and offer assistance to other providers.

Anya Rader, VPQHC's executive director, admits the medical establishment isn't always comfortable with the scrutiny.

"I think there's a constant tension, and if there wasn't we probably wouldn't be doing our job right," she said. But overall, she said, doctors are willing, interested participants.

"To the extent they're able to fit it into their busy lives, they really do want to do this stuff," Ms. Rader said. "And intellectually, I think, they're interested in it. You might find exceptions to that rule, but by and large these are people who want to do good work, are smart, are interested in the latest knowledge and want to find ways to incorporate that in what they do."

Ear Infections

In reviewing claims data, VPQHC found that surgery on Vermont children with chronic ear infections varied depending on their health insurer. Children covered by Medicaid had the highest rates of surgery, while children insured with Blue Cross and Blue Shield of Vermont were far less likely to undergo the same procedure. Although there could be any number of explanations for the disparity in surgical rates, VPQHC concluded some children were getting unnecessary surgery while others were not

Continued on page 8

Blue Cross and Blue Shield Association finds legislatures easing up on mandates

The push by state legislators to mandate that health plans offer specific benefits and use specific clinical practice standards eased somewhat in 1997, according to the Blue Cross and Blue Shield Association's annual report on state health legislation trends.

In 1996, 30 states passed laws mandating 48-hour maternity stays for vaginal deliveries. Mandatory hospital stays for women undergoing a mastectomy appeared likely to be the next big wave of health plan legislation to sweep across the nation. But in 1997, only 14 states passed laws requiring a minimum hospital stay for women undergoing a mastectomy.

In fact, last year several states decided to defer action on mandates for coverage of services such as prostate cancer screening and breast reconstruction surgery until information was available on the financial impact of these mandates. Virginia, Kansas, Wisconsin, Pennsylvania and South Carolina now have mechanisms in place to assess the fiscal impact of state mandates.

Last year, Virginia legislators declined to act on requiring minimum hospital stays for mastectomy patients, and mandating coverage for reconstructive breast surgery, acupuncture, prostate cancer screening and hemophilia services. Instead, legislators referred bills to a special advisory commission set up several years ago to do cost-benefit analyses of mandates. Legislators are now reviewing that panel's recommendations.

Louisiana, too, passed legislation which requires submission of a cost-impact report before any bills proposing mandates make it to the floor. That action was taken after lawmakers passed, and the governor signed, several bills mandating coverage for emergency care, prostate cancer screening, diabetic self-management training, and off-label use of drugs for cancer treatment.

Blues' State Services Research Director Susan Laudicina said that given the political appeal of these measures she doesn't expect them to completely evaporate from

Continued on page 6

Lawmakers open door to lawsuits against health plans

Continued from page 1

benefits.

Besides removing the corporate practice of medicine shield, the Texas Liability Act also puts out a challenge to ERISA plans by creating a new cause of action, an "explicit new legal claim that managed care plan participants may use as the basis of a lawsuit," Ms. Butler says. Plans may be sued if they do not use "ordinary care" in denying or delaying payment for care recommended by a physician or other provider.

New York and California

Several proposals to amend ERISA are likely to be debated in Congress this year, but many state legislators aren't waiting for Congressional action. In New York, the Assembly has overwhelmingly passed a liability bill (A1816) which, like the Texas legislation, sets up a new cause of action. Sponsored by Richard Gottfried, the bill requires that managed care organizations "exercise reasonable care" when "making decisions that affect the diagnosis, care or treatment of an enrollee." In "selecting and exercising influence or control" over providers or other agents, plans must respect decisions which may affect the quality of the diagnosis, care, or treatment provided to its enrollees, the legislation states. The bill faces a tough battle in the Senate because of opposition from HMOs and business groups.

In California, Assemblyman Martin Gallegos (D), a member of the state's Managed Health Care Improvement Task Force, is pushing the legislature to support a statewide ballot initiative on managed care reforms, including the liability issue.

Under his proposal, separate causes of action would be established for quality of care and malpractice, but even some supporters question whether the assemblyman can get the two-thirds vote from the legislature needed to put it on the November 1998 ballot. Several other bills addressing the liability issue also are expected to be introduced this session.

In Congress, Rep. Charles Norwood (R-GA) has won the support of more than 220 cosponsors for his Responsibility in Managed Care Act (HR 2960). The bill would make it easier for patients in self-insured employer plans to sue managed care organizations in state court for personal or financial injury, by waiving the ERISA preemption that has shielded the plans from such causes of action.

Opponents have focused their attention on blocking the bill in the Commerce or Education and Workforce committees. On the Senate side, Sen. Alfonse D'Amato (R-N Y) is hoping to use a parliamentary maneuver to get the Senate version of the bill (S644) onto the floor for debate.

A somewhat different approach to holding health plans accountable was first introduced by congressional Democrats last spring as the Managed Care Plan Accountability Act of 1997. Under that approach, a new federal cause of action would be created that would allow members of employer-sponsored managed care plans to sue an HMO in federal court "even if the HMO was merely administering an employee benefit plan, since the HMO exercises judgment by defining which benefits are permitted."

Employers have joined forces with managed care organizations to fight the legislation at the federal and state levels. Among employers' fears are that they they could be liable themselves and dragged into suits as defendants. Rep. Norwood's bill explicitly prohibits causes of action against an employer unless "the employer or other plan sponsor exercised discretionary authority to review and make decisions on claims for plan benefits" which "resulted in personal or financial injury or wrongful death." But Kim Monk, manager, public policy, for the Washington Business Group on Health, said the bill does the opposite of what it intends by "creating a clearer line to employers than before."

Liability legislation will "make it undesirable for employers to sponsor health coverage," she said. "The first time employers get sued, they will drop coverage." Some fear that employers may drop benefits that could open them to suits.

While liability for managed care plans is a popular consumer protection, it has raised questions that have long surrounded tort laws in general, especially as they apply to physicians and hospitals. Do malpractice suits just raise the costs of health care or do they foster improved quality of care? Ms. Butler questions whether "the process of seeking financial awards for negligence (misconduct) under American tort law is the best way to remedy participants' disputes over plan coverage."

New York may end up taking a middle ground by approving an external appeals process for review of denials of coverage by managed care plans. The Assembly has already approved a bill (A6585) which would establish such a process.

In opposition to A1816 and S2544, the HMO Conference of New York and the American Insurance Association have cited a 1997 analysis by the Barents Group, a health economics firm, which estimated that liability legislation could boost health costs by as much as 5%. The HMO Conference also argues that the legislation "will undermine quality by promoting unnecessary utilization and overburden an already unresponsive judicial system."

Disagreement over caps

A California task force appointed by the governor and the legislature to make recommendations on improving managed care, failed by one vote to include legislation on liability in its recommendations. The recommendation did not carry largely because of disagreement over placing limits on liability similar to those that apply to physicians and hospitals that are sued for malpractice.

Dr. Bruce Spurlock, executive vice president of the California Healthcare Association, which represents hospitals and medical groups, argued that HMOs should be subject to the state's malpractice law, which limits liability of hospitals and physicians. Leaving HMOs without the same protection would encourage plaintiffs to go after HMOs since they would be liable for much bigger damages.

Some providers also worry that a no-caps law could encourage legislators to raise or eliminate the caps for them as well. Trial lawyers argue that only the threat of severe penalties is sufficient to make companies worth as much as $1 billion or more sit up and take notice.

Copies of Managed Care Liability: An Analysis of Texas and Missouri Legislation may be ordered from the Kaiser Family Foundation by calling 1-800-656-4KFF and requesting document #1343. The foundation's web address is www.kff.org

Wash D.C. advocacy group sues to protect assets of local Blues plan from being lost in merger

A lawsuit by a consumer advocacy group against Blue Cross Blue Shield of the National Capital Area has once again focused attention on what happens to Blues' assets when they merge or convert to for-profit status.

In a lawsuit filed last month against Blue Cross Blue Shield of the National Capital area, the Fair Care Foundation, a Washington, D.C.-based consumer group, says it is worried that District of Columbia taxpayers will be cheated out of an asset they helped build if the merger between District of Columbia Blue Cross and Blue Shield and the nonprofit Blue Cross and Blue Shield of Maryland is completed.

The Fair Care Foundation last month sued Blue Cross Blue Shield of the National Capital Area, claiming its assets, gained through years of tax breaks as a nonprofit, will be illegally absorbed by the Maryland plan. At presstime, the District of Columbia Superior Court was considering a motion by BCBS of the National Capital Area to dismiss the suit. Fair Care is seeking a preliminary injunction to block the completion of the Blues' merger until the lawsuit is settled.

Seventh largest Blue

The National Capital Blue and BCBS of Maryland formally consolidated Jan. 16, to form CareFirst Inc., with the merger of sales forces, computer systems, products and networks of health care professionals and hospitals slated to be completed within six months. The combined company will be the seventh largest Blue Cross plan in the country with 2 million members, annual revenues of $3 billion and 5,000 employees. Under the consolidation, the two Blues remain separate entities but CareFirst, a holding company, controls their boards.

John Ellison, an attorney with the Pennsylvania law firm Anderson, Kill & Olick which represents the foundation, believes the consolidation of the Blues is the first step toward becoming for-profit. He noted that the Maryland plan made two unsuccessful attempts to convert the Blue to for-profit status.

In suing the Blue, the Fair Care Foundation joins a fierce, nationwide battle over control of Blues' assets whose estimated value is in the billions of dollars. Opponents in several states, including New Jersey, Georgia, Kentucky and Connecticut, are waging legal wars to keep Blues' assets for public use, arguing that they are charitable,

William Jews, the former chief executive officer (CEO) of the Maryland plan who became president and CEO of the new holding company, said that the consolidation will result in substantial savings. Larry C. Glasscock, president of the National Capital Area plan, is the holding company's chief operating officer.

According to Mr. Jews, the consolidation will improve the Blues' access to capital and boost its chances to prosper in an increasingly competitive health-care marketplace. Currently, the Blue Cross market share in the District of Columbia is 20%, half of what it is in Maryland.

The Fair Care Foundation says that while the two Blues may remain separate entities they will be far from equal. "We think this consolidation means a shift of control of the assets from the District to Maryland," said A.G. ("Terry") Newmyer III, director of the foundation. The new holding company is based in Maryland, which means that "the District will be the real loser," he said.

Blues in other states have converted to for-profit status without setting aside any charitable assets. In Connecticut and Kentucky state attorney generals are suing the merged Blues in attempts to recover their assets for charitable uses.

In addition to the Superior Court lawsuit, the Fair Care Foundation has filed a lawsuit in the District of Columbia Court of Appeals, charging that the group was illegally excluded from discussions by District and Maryland insurance commissioners who later watered down the conditions under which the two Blues were allowed to consolidate.

The foundation particularly objects to the temporary suspension of a requirement that CareFirst, Inc., be licensed as a nonprofit health insurer and the softening of a ban on executive severance packages for officers of the Blues. Mr. Newmyer said the Blues "privately cozied up to the insurance regulators, which we think is disgusting behavior."

Under his contract with the District of Columbia Blue, Mr. Glasscock could have received $3 million worth of severance benefits. He did not return telephone calls concerning his final pay arrangement.

Dennis Carroll, an attorney in Maryland insurance commissioner Steven Larsen's office, said the commissioner postponed the nonprofit licensing requirement until the Blues find out from the Internal Revenue Service if they owe an estimated $20 million in taxes because of their consolidation.

> "We think this consolidation means a shift of control of the assets from the District to Maryland."—Newmyer

Many of the legal battles over Blues' assets involve Anthem Insurance Companies, Inc., which is gobbling up Blues across the country.

Blue Cross and Blue Shield of New Jersey last month lost the last, and probably final round, of its fight to convert to a mutual insurance company without giving an estimated $1 billion to charity. The state Supreme Court Jan. 26 denied the Blue's request to review a lower court ruling that the Blue is a charitable organization.

The Blue had sued the state after the state attorney general found that the Blue was a charitable organization. Shortly after the lawsuit was filed, Anthem dropped its merger attempt with the Blue.

BCBS of New Jersey spokesman Fred Hillman said the Blue has scrapped its conversion plans and will continue to operate as a not-for-profit health services corporation.

In Connecticut, the attorney general last month filed suit in Hartford Superior Court against Anthem, which previously had acquired the state's Blue Cross and Blue Shield, for failure to protect the Blue's charitable assets.

"The Blue Cross has historically operated as a nonprofit, charitable organization,

Continued on page 8

Legislatures easing up on mandates, survey shows

Continued from page 3

the legislative hoppers this year. "The lure of mandated benefits will continue in 1998 because they appear to offer a simple solution to anecdotal health problems and involve limited government expenditures," the report says. Ms. Laudicina said trends indicate, however, that politicians "are beginning to think twice" before rushing to legislate by disease or body-part.

Health plans surveyed by the Blues for its 1997 report say that mandates on practice and coverage are boosting premiums from 5 to 20%. Other pressures on plans as a result of state legislative action include bans on gag clauses in contracts and requirements that enrollees have direct access to specialists and access to emergency room care.

> Politicians "are beginning to think twice" before rushing to legislate by disease or body-part.—Laudicina

Twenty four states enacted bills in 1997 barring health plans from prohibiting or restricting physicians and other providers from discussing certain treatment options with their patients. Although a 1997 General Accounting Office analysis of 500 HMOs concluded that none had contracts with gag clauses, today some 39 states have laws banning their use.

Meanwhile, 14 states passed laws requiring direct access to specialists. Nine (AR, DE, ID, MN, MO, MT, NV, RI, and TX) were designed to make it easier for women to use their obstetrician/gynecologist as a primary care provider but several other provider groups got special notice as well. Florida legislators passed a law allowing direct access to dermatologists; Georgia and South Carolina now allow direct access to ophthalmologists; and, in New Mexico, patients wanting to see an acupuncturist don't need to go through their primary care doctor anymore. Plans expect a flurry of similar proposals allowing enrollees to self-refer to health care specialists in 1998. States to watch: (CA, CO, FL, IL, IN, ME, MO, MS, NE, OK, PA, SC, TN, VT, and WA.

Initial screening exams

Twenty states enacted laws requiring initial screening exams and stabilization services and other services be covered and delivered in an emergency room. Twelve states (CT, GA, ID, LA, MO, NV, NC, OH, OR, TX, VA, and WA) also are requiring that coverage be allowed in emergency cases deemed such by a prudent layperson.

Mental health parity laws also topped legislative agendas in 1997. Eight states passed laws designed to put mental health coverage on an equal footing with physical health coverage. But many of these laws were limited. Colorado, Connecticut and Texas, for example, now require health plans to offer equivalent or similar coverage only for patients with serious, biologically based mental health illness. Laws passed in Indiana and North Carolina only apply to the state employee health plan. But plans are expecting legislators to take up these measures again in1998; 19 states are expected to introduce legislation on mental health parity this year.

One of the newer areas of managed care regulation involves the establishment of external or independent grievance processes to review coverage and claims denials. Nine states, including Connecticut and Missouri, passed these laws last year. Ohio and California have the most restrictive, limiting outside review to only those appeals that involve experimental treatments. Most of the other states allow for external review of any denial. Vermont only allows external review of mental health care treatments. In 1998, 14 states (CA, DE, FL, GA, HI, MD, MS, NH, ND, NY, OK, PA, VT, and WA) and the District of Columbia will push to enact mandatory external grievance review laws.

States took measures last year to bring their insurance market laws into conformance with the federal Health Insurance Portability and Accountability Act of 1996. The majority of states said they will be seeking a federal waiver to set up or use alternative state mechanisms to ensure portability to individuals moving from group to individual coverage. High-risk insurance pools were the most popular alternative mechanism, with 21 states choosing this route. Several states (FL, GA, NM, OH, PA, UT, and VA) have devised other approaches to conform with HIPAA's group-to-individual portability requirement. Georgia created an assigned-risk mechanism, under which individuals can apply for coverage to the insurance commissioner who assigns eligible persons to health plans based on a formula. Utah is using both its high risk pool and its existing guaranteed issue requirement in the individual market to ensure portability. Individuals denied coverage by a health plan are referred to the state's high risk pool, which determines whether the person is eligible. If an individual is found to be "too healthy," the health plan has to provide coverage.

For-profit conversion laws

Gretchen Babcock, executive director of state services at the Blues, said despite moves by Blues plans in New York and Colorado to convert to for-profit status, she doesn't think there is feverish activity and that it's a major trend. Still, 10 states passed for-profit conversion laws last year intended to protect the public's interest in the assets of tax-exempt organizations. Blues plans are much more interested in merging among themselves or affiliating with other providers such as hospitals, she said. Last year, 10 states passed laws regulating merger and acquisitions and consolidations.

—Janet Firshein

For copies of "State Legislature Health Care and Insurance Issues, 1997 Survey of Plans," contact the Blue Cross and Blue Shield Association at 202-626-4780.

States offer presumptive eligibility to improve outreach

Continued from page 1

HCFA's letter reminds state officials that they can keep verification to a minimum because there are few verification requirements under federal law, said Ms. Cohen Ross. Asking families to assemble lots of documentation to verify income, etc. can create a significant barrier to families, she said. So can requiring that parents apply for benefits in person. Allowing applications to be mailed in lifts a "tremendous obstacle" for parents who have child care or transportation problems or who are "not in position where they can leave work for a few hours to apply at a Medicaid office," she said. Some states require a telephone interview, which is a "suitable compromise," she said.

Screen and enroll

For states that set up separate insurance programs under last year's historic Child Health Insurance Program (CHIP), simplifying the Medicaid enrollment process will make it easier for them to meet the new "screen and enroll" requirement. Families that apply to children's health insurance programs must be screened for their Medicaid eligibility and enrolled if they qualify. Merely referring them to Medicaid does not meet the requirement, said Ms. Cohen Ross. "A complicated Medicaid program is going to bog down their efforts," she said. "You want to be able to make it simple for every family that's applying."

HCFA has developed a four-page model application which can be used for both Medicaid and state child insurance programs. A single application form, a single point of entry and a unified message are some of the ways states can coordinate the programs, she said. "It shouldn't be up to families to figure out where the child belongs," said Ms. Cohen Ross.

"With short applications, no asset test and ability to mail you can begin to think about how community-based organizations can really use these as tools to conduct effective outreach," said Ms. Cohen Ross. In Virginia, where there is a two-page application for Medicaid, community-based organizations that do home visits help their clients fill out the forms in their own homes.

Presumptive eligibility for Medicaid is a new option provided by the 1998 Balanced Budget Act that will help states improve outreach to their uninsured children. Presumptive eligibility has been proven to be an effective tool for bringing pregnant women into Medicaid programs. Being able to access services right away helps motivate families to follow through with the application process.

Presumptive eligibility

Currently, traditional Medicaid providers, including federally qualified health centers (FQHCs), and entities that determine eligibility for Head Start, WIC and child care subsidies under the Child Care and Development Block Grant, can grant presumptive eligibility to children.

The president's proposed budget for 1999 expands the number of entities that can grant presumptive eligibility to include schools, child-care resource and referral centers, child support agencies and CHIP eligibility workers.

This is a "huge expansion and an important one," Ms. Cohen-Ross said. Child care and referral centers are well-positioned to do presumptive eligibility for Medicaid, she said, because besides helping parents to find affordable child care, they offer other assistance such as determining whether the family qualifies for earned income tax credits. "They are wonderful organizations" that look "at the total package of benefits," she said. She said schools could help capture older children who are now eligible for health care coverage.

Under the president's budget proposal, costs for covering children during the presumptive eligibility period would come from Medicaid, according to Jennifer Baxendell, director of health legislation for the National Governors' Association. The current requirement that states subtract the costs of presumptive eligibility for Medicaid from a state's CHIP allotment has made it a less attractive option to state.

Connecticut will start giving children presumptive eligibility for Medicaid in May, said David Parella, director of medical care administration. Children will be issued numbers that they can use to access services on a fee-for-service basis for 60 days. Mr. Parella said the state is looking at using school health centers, Head Start sites, WIC programs and child care providers to do outreach and give presumptive eligibility.

Connecticut has a separate child insurance program called Husky Part B. Medicaid has been renamed Husky Part A. Allowing CHIP eligibility workers to give presumptive eligibility for Medicaid, as proposed in the president's budget, "could speed up the process (of enrolling into Medicaid) and reduce costs," Mr. Parella said. In addition to using the Husky name for both programs, the state also will use the same application form. (The current Medicaid application form is 14 pages long, but is being simplified.)

Schools could help capture older children who are now eligible for health care coverage.

Massachusetts plans to use presumptive eligibility for children beginning in March when children with family incomes below 200% of the federal poverty level (FPL) will be eligible for Medicaid. Sharon Torgerson, director of external relations for the Department of Medical Assistance, said legislative approval will be needed before the state can move ahead.

Massachusetts has already been using presumptive eligibility for its children's insurance program, the Children's Medical Security Plan. The same application form will be used for both programs in the future. The state is now in the process of simplifying its Medicaid application for the second time in less than a year, Ms. Torgerson said. There will be a core four-page form with supplemental pages for children with disabilities or with other health insurance coverage.

About 12,000 children who are now on the Children's Medical Security Plan are eligible for Medicaid, but moving those families over to Medicaid has been difficult, Ms. Torgerson said.

Children with family incomes up to 133% of FPL became eligible for the Medicaid program last summer. While state officials have been promoting the more comprehensive benefits of Medicaid to

Continued on page 10

Vermont targets inconsistent practice patterns

Continued from page 3

getting treatment they needed.

Acknowledging the controversy in the scientific literature about the best treatment, VPQHC convened a 12-member study group of Vermont providers and insurers to establish guidelines.

Key elements of the guidelines, said Cyrus Jordan, VPQHC's medical director, include emphasizing use of pneumatic otoscopy to confirm presence of fluid in the middle ear and use of the narrowest spectrum antibiotic so that organisms won't develop resistance to agents. The guidelines have clear recommendations for when children need evaluation for surgery. VPQHC also produced a brochure for parents on ear infections.

Cesarean sections

VPQHC found that too many Vermont babies were being delivered by Cesarean section. A woman having a baby at Southwestern Vermont Medical Center in Bennington, VT, for example, was more than twice as likely to deliver by C-section than a woman giving birth at Porter Hospital in Middlebury.

VPQHC holds regular conferences for Vermont doctors and national experts to share their knowledge about how to reduce C-section rates. Local physicians and nurses sometimes visit hospitals with high rates to offer their expertise. VPQHC sends hospitals quarterly reports on C-sections so that they can compare their performance to those of other hospitals.

Vermont's overall C-section rate was16.5% in the first half of 1997, which is well below the national average of 20.8% reported by the National Center for Health Statistics for 1995 (the preliminary figure for 1996 is 20.6%). The goal is to have a Cesarean-section rate of 15% of all births by the year 2000, VPQHC reports.

Congestive heart failure

VPQHC found that Vermonters were being hospitalized for congestive heart failure at wildly differing rates.

Vermonters age 65 and older living in the northwest corner of the state, for example, were nearly three times as likely to be hospitalized for congestive heart failure in 1995 than Vermonters of the same age living in the upper Connecticut River Valley along the New Hampshire border.

The project's steering committee, which includes some of the state's most respected cardiologists, reviewed the literature and developed a consensus on standards of care and sent it to every cardiologist in the state.

Karen Meyer, executive vice president at the Vermont Medical Society, said physicians are far more receptive to quality improvement efforts when they come from VPQHC rather than a health plan. "It's educational and it's about improvement of patient care," she said. "A health plan always feels like it's about money."

The Medical Society strongly supports VPQHC not only because it provides physicians with data and guidelines to help them improve, but also because it fosters collegiality among Vermont doctors, many of whom work in rural areas far from large medical centers, Ms. Meyer said.

In the past, VPQHC concerned itself largely with cost and clinical practices: Did the surgery work and what did it cost? But the congestive heart failure project will add a new dimension to VPQHC's work: patient satisfaction. VPQHC can get a better measure of value in the health care system once it examines the patient's sense of satisfaction with the service and his or her physical and mental well-being after surgery or hospitalization, Ms. Rader said.

Can a heart patient go shopping for groceries or play with grandchildren without feeling weak? Was the medical staff nice to family members? How is the patient's mental health?

The state Division of Health Care Administration is a partner in VPQHC's efforts. The Division itself has begun a data-collection initiative, and plans to share information with VPQHC and consumers.

Theresa Alberghini, who heads the division, said the state will provide information to consumers about insurance-company practices and making choices in health care, while VPQHC continues to work in its area of expertise -- with medical professionals on quality improvement.

"We're not just collecting data because we like to collect data," she said. "We're collecting it because it's going to help us protect consumers."

—Bryan Pfeiffer

Advocacy group sues to protect assets of Blues' plan

Continued from page 5

and, as such, it has amassed large assets which belong in a charitable trust, said Robert Shields, Jr., a special counsel to the attorney general.

Anthem said it will vigorously contest the lawsuit. "The company never was a charity, never received charitable contributions or donations, and never provided free coverage or health benefits, said Harry Torello, president and CEO of Anthem Blue Cross and Blue Shield of Connecticut.

Anthem is using the same argument in Kentucky, where the state attorney general last year sued the company to recover charitable assets estimated to be as high as $700 million. The unusual twist in this litigation is that the lawsuit was filed nearly five years after the Kentucky Blue Cross and Blue Shield merged with Anthem.

Georgia is one state where Anthem is not involved. Eight small nonprofit groups filed a class action lawsuit last year against the Georgia commissioner of insurance and the Blue Cross plan for failing to protect the charitable assets when the plan converted into a privately held for-profit corporation.

The nonprofit groups Jan. 12 scored a victory when the Superior Court of Fulton County put aside the Blue's request to dismiss the case, giving the plaintiffs time to prepare their case. The groups are arguing that the state legislation which allowed the conversion is unconstitutional, said their attorney, David Pope, a partner in the firm of Carr Tabb & Pope. The suit asks that all of the Blue's assets, which Mr. Pope said are estimated at $500 million, should be used for charitable purposes.

—Mary Klein

Contact: Mr. Newmyer III at 703- 775-3738; Mr. Ellison at 215-568-4710; Mr. Jews at 401-581-3000; Mr. Carroll at 410-468-2030; Mr. Hillman at 973-466-8755; Mr. Shields at 860-522-8338; Mr. Torello at 203- 239-8381; and Mr. Pope at 404-876-7790.

Clip file / Local news from the states

Each month, this page features selected short items about state health-care policy digested from newspapers around the country.

Tennessee legislators rebuke state officials for failure to release external quality report

NASHVILLE,TN— Angry over news that the Department of Health did not promptly release an external review of the state's troubled mental health and substance abuse program, Tennessee legislators called for an independent monitor and an independent consumer advocate to be placed in a different department, such as the attorney general's office.

The state's external quality reviewer, First Health, Inc., identified serious problems with TennCare Partners, the state's Medicaid managed behavioral health care program, in two reports completed last fall. Legislators only obtained a copy recently.

The reports found that behavioral health patients were not given reasons for denials of service and were not informed of their rights to appeal. Among other findings: use of case managers is "sporadic," there are no preventive mental health care services and one behavioral health firm only authorizes 24 hours of intensive treatment at a time, regardless of the patient's condition.
The Commercial Appeal, Memphis, TN, Feb. 1, 1998

Pennsylvania Medicaid managed care rates too low for disabled and chronically ill recipients, report says

HARRISBURG,PA—A long-awaited report on the adequacy of Pennsylvania's Medicaid managed care rates has concluded that plans are being underpaid for disabled and chronically ill beneficiaries. Arthur Anderson LLP, which produced the report, said the Department of Public Welfare underestimated rates for these beneficiaries by 3%.

The accounting firm said rates are sufficient to cover most Medicaid recipients including mothers and children. In fact, the state probably overpaid plans with its inflation factor of 5%, the firm's actuaries said. The national rate of inflation was 1.7%. Profits and administration for HealthChoices plans amounted to 13-15%, higher than the 11% estimated by DPW.

HealthChoices plans all lost money last year, but state officials note that, in previous years, the plans reported substantial profits. Plan executives say the state has offered plans an increase of payments in the 7% range.
Inquirer, Philadelphia, PA, Feb. 8, 12, 1998

Chicago employers join to purchase health care

CHICAGO—In a first for the Chicago business community, eight large employers are banding together to purchase medical services from managed care plans.

The buying group will design a model HMO benefits package, with different options employers may choose. A single request-for-proposal will be issued and bids will be scored by the buying group. The Healthcare Purchasing Group will collectively negotiate prices on behalf of its members. HMOs will be asked to report regularly on employee satisfaction and health care quality and to meet performance requirements.

The Healthcare Purchasing Group's eight initial members are ABN AMRO, First Chicago NBD, Ford Motor, the State of Illinois, the Jewish Federation of Metropolitan Chicago, Northern Trust, the University of Chicago and Zenith Electronics. They employ 97,000 people in the Chicago area.

Although that's a relatively small number, the move has "enormous symbolic significance," the newspaper reports.
Chicago Tribune, Jan. 15, 1998

Cook County Hospital's patient load drops 13% leading county officials to rethink building plans

CHICAGO—A 13% decline in patients spending the night at Cook County Hospital has county officials rethinking their plans to build a new hospital. The Bureau of Health Services, which oversees the county's hospitals and clinics, released its report on the decline just as county officials were preparing to open another round of bids on new construction.

Hospital officials said the reason for the decline include shorter hospital stays and greater use of the county's outpatient clinics. The average number of people spending the night at Cook County Hospital dropped from 475 in 1996 to 415 in 1997. The aged hospital has 695 beds.

The 464-bed hospital now planned for construction has an estimated price tag of $551 million including equipment. With the reported decline, some officials have proposed a smaller facility or an alternative plan that would tap the excess capacity of existing hospitals rather building a new public facility.
Chicago Tribune, Jan. 13, 1998

After hiatus, California legislature considers fresh batch of managed care legislation

SACRAMENTO, CA—Armed with recommendations from a 30-member HMO task force, Democratic lawmakers are pushing once again for stricter controls over HMOs.

Last year, nearly 80 managed care reform bills were either vetoed by Gov. Pete Wilson, who said he wanted to wait for the task force recommendations, or put on hold because of his veto threat.

Among the legislative proposals:

- require HMOs to cover drug treatments for a patient with an ongoing health problem, even if the HMO removes that drug from its list of covered treatments;
- require HMOs to cover glucose monitors and test strips for diabetes patients;
- require insurers to cover prostrate cancer exams for men;
- require health plans to justify authorizations or denials of care, and allow for independent reviews whenever a health plan denies service to a consumer;
- allow women who have undergone mastectomies to remain in the hospital for 48 hours after surgery; and
- transfer oversight of HMOs from the Department of Corporations (DOC) to a newly created agency that will focus on regulating the managed care industry. The DOC, which oversees the securities industry, has been criticized for not having enough expertise in health care. Republicans want the new regulator to be appointed by the governor; Democrats want a full board with diverse interests.

Continued on page 10

Clip file / Local news from the states

Continued from page 9

Other Democrat proposals include giving patients the right to choose their own doctor, requiring second opinions, and protecting the confidentiality of medical records.

Many Republicans appear willing to go further than the governor in support of new regulations, but say they want to stay away from mandates that could drive up premiums, such as a plan to require HMOs to pay for contraception for women.
Sacramento Bee, Sacramento, CA, Feb. 3, 1998

Missouri considers broadening attorney general review of nonprofit hospital sales and mergers

JEFFERSON CITY, MO—As Attorney General Jay Nixon nears a decision on the pending $309 million sale of St. Louis University Hospital to Tenet Healthcare Corp., the second largest for-profit hospital chain, legislators are considering proposals to broaden the attorney general's authority in reviewing sales or mergers of nonprofit hospitals.

A bill by Sen. Betty Sims would formalize procedures under which the attorney general reviews such transactions. The reviews would focus on three broad questions: whether the price offered for the nonprofit entity is fair, whether the transaction involves no conflicts of interest and whether the proceeds will be used in keeping with the purposes spelled out in the nonprofit entity's charter.

The attorney general would have 60 days to approve or reject a sale. Sales also would be cleared by the Missouri Department of Health and there would be an appeal process for consumers and others who might oppose the sale.

Consumer health advocates in Missouri say they are worried that the poor and uninsured would not receive the same level of care if Tenet acquires the hospital. Under a bill sponsored by Sen. Franc Flotron, a for-profit buyer would not have to offer any more medical services than is specified in the nonprofit hospital's charter . Mr. Flotron said he wants to prevent the attorney general from trying "to shake somebody down" in return for approving a sale.
St. Louis Post-Dispatch, Feb. 2, 1998, Jan. 28, 1998

Medical directors accountable to state board of medical examiners, Arizona Supreme Court rules

PHOENIX—Medical directors of insurance companies are accountable to the Arizona Board of Medical Examiners, the Arizona Supreme Court has ruled.

The state Supreme Court upheld a decision against Blue Cross and Blue Shield of Arizona which challenged the right of the medical examiners board to discipline its medical director. The case revolved around the insurer's refusal in 1992 to pay for a Phoenix woman's gallbladder surgery.

The medical examiners' board tried to discipline Dr. John Murphy, Blue Cross' medical director, for his decision not to approve surgery of the diseased gallbladder. Blue Cross argued that the board lacked the authority to review its decisions.
Arizona Republic, Phoenix, AZ, Jan. 26, 1998

New Jersey health plan fined for cancelled surgeries

TRENTON, NJ—Backed by its new HMO regulations, the New Jersey Health Department fined First Option Health Plan at least $200,000 when patient surgeries were cancelled as a result of contract disputes with anesthesiologists.

When anesthesiologists refused to sign contracts which called for an average 22% reduction in fees, operations scheduled at two hospitals were cancelled, the state said.

First Option's actions resulted "in the disruption of physician-patient relationships, disruption of services, continuity of care problems, as well as undue inconvenience and stress to its members with surgical needs who were already under significant pressure," Health Commissioner Len Fishman said in a letter to First Option officials. First Option was acquired in January by Foundation Health Systems of California.

The head of the New Jersey State Society of Anesthesiologists said the dispute caused at least a couple dozen operations to either be canceled, temporarily postponed, or moved to other hospitals in recent weeks. He said the reduction in fees for Medicare and Medicaid HMO patients was considerably higher than 22%.
The Record, Hackensack, NJ, Jan. 23, Jan. 24, 1998

States offer presumptive eligibility to children

Continued from page 7

these families, Ms. Torgerson said many are not motivated to make the switch if their children have had few health problems and they are happy with CMSP. They simply do not see the need to switch to another program, she said. She acknowledged that the more complicated enrollment process for Medicaid may also have discouraged switching.

"People will enroll in the program it's easiest to enroll in," said Kim Shellenberger of Health Care for All, a consumer advocacy group, adding that the "stigma" of Medicaid also could be a factor in why people aren't switching.

The president's budget includes a proposal that would expand states' access to a $500 million fund for outreach. The fund, set up under welfare reform, was established so states could do outreach to families affected by welfare reform. It provides an enhanced federal matching rate of 90% for certain outreach activities, but few states have "taken advantage of this fund so far, in part, due to the difficulty of targeting outreach only to a subset of Medicaid-eligible children," states the Jan. 23 letter from HCFA. States could use the money to do outreach to all uninsured children.

However, the budget also proposes to reduce the federal matching rate for states' administrative expenses from 50% to 47%, leading state officials to say the president's budget is taking away money for outreach. Jennifer Baxendell, director of health legislation for the National Governors' Association, said this is a "significant reduction" that would affect not only outreach but other activities such as policing for fraud and that the cut would be vigorously fought by governors.

Contact Ms. Cohen Ross at 202-408-1080 or Ms. Torgerson at 617-210-5680.

NY to help nonprofits establish AIDS care networks

Continued from page 2

ated such a furor among managed care plans in the past. "DOH will set the rates," said Sarah Smith, director of managed care for the Greater New York Hospital Association. "They will not be put out to bid. There probably will be no negotiating."

But Ms. Smith said it will be no small trick to figure out an appropriate rate using the cost experience of treating HIV/AIDS patients on a fee-for-service basis. "It will be a highly controversial endeavor."

According to several participants in the February meeting, the state is also leaning toward creating "risk corridors" which would encourage both cost containment and maintaining adequate care. The department's current thinking is to have a 2% risk corridor; that is, if costs were more than 2% above a SNP's capitated rate, the state would share the extra expense. If they were more than 2% below the rate, the state would share in the savings. The state also discussed setting up a reinsurance program to protect SNPs from "the million-dollar-cases"—those individual patients who require very expensive, intensive care.

Despite the wariness of many of the organizations that would be expected to form SNPs, Dr. Clifford thinks there will be intense competition for the contracts, especially in New York City, "unless the rate is set so low you just can't make any money."

"These are franchises in New York City," he said. "You're looking at a potential 60,000 enrollees. That's so large you can spread the risk."

Dr. Clifford is concerned that it may be impossible to form adequate networks upstate, where there are about one-tenth the number of HIV/AIDS Medicaid recipients, clustered mainly in Buffalo, Syracuse and Rochester.

But in metropolitan New York, groups ranging from the public and non-profit hospitals to community organizations like Gay Men's Health Crisis all are expected to see forming SNPs as financially viable—especially with start-up grants.

GMHC's Ms. Dooha remains cautious, however: "We're waiting to see the money."

—Harvy Lipman

Health-risk adjustment helps ensure consumer choice

Continued from page 2

patient settings, where it frequently isn't recorded in the claim at all. There is also the daunting statistical challenge of trying to reliably risk-adjust for small populations as well as accounting for comorbid diseases and geographic variations.

The "next generation" of risk adjustment will measure declines and improvements in health outcomes and adjust payments accordingly, said Richard V. Anderson, vice-president of health policy for Kaiser Foundation Health Plan in Oakland, CA. BHCAG hopes to create incentives for providers to improve their management of enrollees with chronic disease, said Ms. Robinow.

Before risk adjustment can be used in this way, though, coding of chronic diseases in outpatient settings will have to improve, said Craig Christianson, MD, medical director of U-Care Minnesota.

Here are brief summaries of experience with health risk adjustment in four states:

The California Health Insurance Purchasing Collective (HIPC), a state-run small group purchasing alliance that includes 20 insurance carriers enrolling 120,000 beneficiaries, uses only certain high-cost inpatient diagnoses to risk-adjust, partly because of data limitations. The HIPC set a "tolerance" band of 0.95 to 1.05, so that risk adjustment is triggered only when a carrier's risk assessment is 5% above or below the average for the HIPC.

The California HIPC reported that 1% of total premiums was transferred during the first year of health risk adjustment and 0.15% of total premiums was shifted the second year. The small shift in the second year may be due to a more even mix of risk among insurers or from better data reporting. Two HMOs that withdrew after implementation scored below 0.95.

In Minneapolis, BHCAG, which contracts directly with 25 provider care systems for health care coverage of 115,000 beneficiaries, implemented health risk adjustment in January 1997. BHCAG makes fee-for-service (FFS) payments to care systems which are adjusted quarterly, based on how actual payments to each system compare with a risk-adjusted, per-member-per-month (PMPM) claim target. Daniel Dunn of Integrated Healthcare Information Services, Inc. noted that the largest adjusted increase was about $22 PMPM and the largest adjusted decrease was $20 PMPM. Relative risk among care systems varied from 0.78 to 1.25 for the first quarter of 1997.

Colorado's Medicaid program moved toward risk adjustment in two phases because of data issues. In 1997, Colorado adjusted premiums based on prior fee-for-service costs for a large sampling of Medicaid recipients. This year, it will use a diagnosis-based grouper system to predict costs and adjust premiums.

Colorado Medicaid contracts with five managed care plans that enroll 70,000 Medicaid recipients (about 28% of the total enrollment). Interestingly, the state has found found that the population in HMOs is sicker and costlier than the population in fee-for-service. About 2.7% of total premiums was shifted in the first year of health risk adjustment, and the bulk of that transfer involved a 2.15% increase in HMO payments relative to FFS.

The Washington State Health Care Authority (HCA), which administers benefits for 240,000 state employees and dependents in 17 health plans, is starting a phased-in approach to health risk adjustment this year. The HCA ran a hypothetical simulation of how its risk adjustment models would have affected 1997 premiums. Under full-fledged health risk adjustment, 6.5% of total premiums would have been shifted. About 5% of total premiums would have been transferred, under the phase-in approach being used in 1998, which will be based on enhanced demographic data and health status.

— Mary Darby

For more information, contact the Alpha Center, which conducted the conference, at (202)296-1818.

DEADLINES

MARCH 30, 1998

Cut-off date for uninsured children 18 and under to enroll in TennCare. The cut-off does not apply to children in families with incomes below 200% of the federal poverty level with no access to commercial insurance. The governor set the date to encourage parents to enroll their children before they get sick.

On line access / Index

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State Health Watch News Briefs

NJ wins HCFA approval to develop hospital-based managed care

WASHINGTON, D.C.—New Jersey has won federal approval for its Managed Charity Care Demonstration program, which will emphasize the use of coordinated care systems rather than expensive hospital and emergency room treatment for low-income, uninsured individuals.

Under the Section 1115 waiver approved Feb. 13 by the Health Care Financing Administration, hospitals will be required to develop "hospital-centered managed care networks." New Jersey hopes the approach will allow it to serve more uninsured low-income residents through the more efficient use of disproportionate share hospital funds and by using less costly and intensive care settings.

Participation in the new program is voluntary and eligibility standards will remain the same as they are under the current program. Currently, individuals with family incomes up to 200% of the federal poverty level are entitled to fully subsidized inpatient and outpatient care, while those with incomes between 200% and 300% of the poverty level are eligible for partial subsidies.

Rather than offering a specific benefit package, hospitals will offer services that are tailored to the specific needs of their own patients. However, substance abuse and mental health services must be offered as well as care for any other conditions that would benefit from care coordination such as diabetes and hypertension.

Columbia/HCA sells Value Behavioral Health for $230 million

NORFOLK, VA—FHC Health Systems, parent of OPTIONS Health Care, Inc., announced Jan. 29 that it was purchasing Value Behavioral Health (VBH) from Columbia/HCA Healthcare Corporation for $230 million.

The move is the latest in a wave of mergers to hit the increasingly consolidated behavioral health-care industry. VBH is a division of Value Health, Inc., which was just acquired by embattled Columbia/HCA last August. Columbia's desire to sell the behavioral health firm was well known.

The combined company will become the second largest managed behavioral healthcare company in the country, with approximately 20 million covered lives in the public and private markets and projected 1998 annual revenue of more than $580 million. Magellan Health Services Inc.'s recent acquisition of Merit Behavioral Care Corp. created the largest firm in the field with more than 60 million covered lives in the public and private sectors.