State Health Watch

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Wash. state turns down $47 million for kids program

Legislators concerned about 'crowd-out,' covering those above 200% FPL

To the dismay of children's advocates, the Washington state legislature has passed up the chance for the state to tap into $47 million in federal dollars available to it under the Children's Health Insurance Program (CHIP).

The legislature adjourned March 12 without appropriating even the nominal amount of money that could have "held" or reserved the state's $47 million allocation for expanding coverage to children. States must file a plan with the federal government by July 1 or lose their right to the money.

Washington legislators gave a thumbs down on the federal dollars partly because of concerns about crowd-out and about subsidizing insurance for families with higher incomes. The state's Medicaid program already covers children up to age 19 from families with incomes up to 200% of the federal poverty level (FPL)—approximately $32,000 a year for a family of four. Under the heading of "no good deed goes unpunished," one lobbyist said Washington has been penalized because it took aggressive steps to insure more of its population before passage of CHIP.

Republican legislators opposed Democratic Gov. Gary Locke's request to include $1.5 million in the state's budget to cover an estimated 10,000 uninsured children whose families earn between 200% and 250% of FPL. Although the money would have drawn down only a small portion of the federal 2-for-1 match dollars, it would have at least made it possible for the state to access its allocation at some later date.

Republican leadership and fiscal committee chairs were adamant that incomes approaching the 250% mark were too high to warrant receiving any subsidies from the state — especially in rural and lower-cost areas. At 250% of FPL, a family of four earns about $38,000 a year.

The state had hoped that CHIP money could be used for outreach to the estimated 60,000 to 90,000 children in the state who are eligible for Medicaid but not yet enrolled. Efforts fizzled last year to make changes in the federal law so that states such as Washington, which already cover many of their poor children, could

Continued on page 4

In This Issue

New Jersey hospitals put brakes on plans for managing care of state's uninsured

Doubtful that a new state plan will control charity care costs, New Jersey hospitals are pushing legislation that would make it voluntary rather than mandatory for them to develop managed care networks for uninsured residents.

Recently approved by the Health Care Financing Administration (HCFA), the innovative plan would be the first attempt by a state to have hospitals manage the care of uninsured residents. Hospitals would be required to develop networks if they wanted to collect uncompensated care subsidies from the state .

"There's overwhelming support for this legislation because it's not wise to implement something statewide when you don't know what the effects will be," said Suzanne Ianni, executive director of the Hospital Alliance of New Jersey, a group representing 18 mostly urban hospitals.

"Seventy–five percent of the members of the Assembly and Senate are sponsoring this legislation," said Peter Lillo, vice-president for government relations of the New Jersey Hospital Association, "and we expect that it will pass and that Gov. Whitman will sign it."

Legislators are expected to vote by the end of March on an amendment that would turn the mandatory and statewide program into a voluntary regional demonstration project. State officials likely would designate a region or county for the demonstration project, based on interest by local providers, said Anne Weiss, senior assistant commissioner for the New Jersey Department of Health and Senior Services.

Continued on page 7

PSO solvency standards approved for Medicare

Federal agency will accept comments, issue interim final rule April 1

It's not the Big Chill, but it isn't the Big Easy either.

Walking the fine line between protecting consumers from insolvencies and yet encouraging provider-sponsored organizations (PSOs) to form, a 14-member negotiated rulemaking committee reached final agreement March 3 on solvency standards for PSOs that will participate in the Medicare+Choice program.

The Health Care Financing Administration (HCFA) will issue an interim final rule on the solvency standards April 1. Comprehensive rules for PSOs will be issued June 1.

"Some organizations, when the topic of PSOs come up, think (the federal requirements) will be a very simple and easy way to get into the Medicare risk business," said Jim Burnosky, a senior consultant for Medimetrix. But, the federal solvency standard, when you "look at it directly in the light of day," recognizes that PSOs are HMO look-alikes.

"The bottom line is that the regs are a little easier to comply with than full HMO regs, but, that's not saying a lot. PSOs are still strong risk-bearing entities that will need a lot of cash, a lot of infrastructure and a good financial plan. PSOs still have a lot to do to operate," he said, and they will need "parents with deep pockets."

The 14-member committee, composed of representatives from consumer and provider groups as well as government regulators, was charged with reaching a consensus on the solvency standard for PSOs.

"A fallback system"

Jack Ehnes, Colorado's insurance commissioner and a member of the committee, emphasized that the approval process for Medicare+Choice PSOs is not a "federally regulated" system, it's a "fallback system." PSOs apply to the federal government for approval only if state regulators take more than 90 days to act on their application or if state requirements far exceed federal requirements. After three years of operating with federal approval, the PSOs would be back in the state regulatory systems.

Among the major gains for providers in the Medicare+Choice solvency standard is that all tangible health care delivery assets (hospitals, medical facilities, equipment, property) will count in determining net worth. Some analysts believe the standards favor hospitals since it would be easier for them to meet the minimum net worth requirement than it is for doctor groups. But major physician associations reacted favorably to the requirements.

Providers would have liked a broader definition of sweat equity, Mr. Ehnes said. However, the committee did agree that "subordinated liabilities" would not count in calculating net worth. "Subordinated liabilities" are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors," a committee statement said.

The committee decided not to adopt the more "forward-looking" risk-based capital (RBC) approach to solvency matters, one "regret" for insurance regulators, said Mr. Ehnes.

Already used in other lines of insurance such as property/casualty and life/health, a risk-based capital formula establishes minimum capital requirements based on the degree of risk taken by the health organization. RBC also provides for flexibility in regulating rapidly evolving and emerging healthcare organizations. This sliding-scale approach to establishing capital requirements is expected to be adopted by many states in the near future. "The beauty of it is that it sets appropriate capital requirements true to the nature of the risk that is being assumed," said Mr. Ehnes.

Maureen Mudron, Washington counsel for the American Hospital Association (AHA) and another member of the committee, said the feeling was that RBC had not yet been tested with these type of organizations. However, HCFA will continue to evaluate the formula.

The federal solvency requirements for Medicare+Choice are less than, more than or equal to the HMO or PSO requirements used by the individual states. National organizations such as the AHA, the National Association of Insurance Commissioners, and the American Medical Association, are likely to conduct analyses that compare how individual state requirements stack up against the federal requirements, said Mr. Bernosky. In some states, it may be easier to meet HMO requirements than the federal PSO requirements.

"With the backlash against HMOs, there may be a benefit to calling yourself a PSO," he said.

Keith Mueller, director of the Nebraska Center for Rural Health Research, noted

Continued on page 11

PSO Solvency Standards
(For Medicare+Choice plans upon application with HCFA)

Minimum net worth requirement: $1.5 million
At HCFA's discretion, if PSO has administrative infrastructure that will reduce start-up costs, net worth can be reduced, but to no lower than $1 million.

Minimum net worth requirement to be met by cash or cash equivalents: $750,000

Calculation of net worth: Tangible assets—Health care delivery assets can be counted at 100% of book value.

Intangible assets: If at least $1 million of net worth requirement is met by cash or cash equivalents, these assets can be counted for up to 20% of net worth requirement; if less than $1 million in cash or cash equivalents, then up to 10% can be counted.

Funding for projected losses: In financial plan, PSO must explain how it will meet projected losses until the break-even period. In the first year, the guarantor must provide the PSO with cash or cash equivalents to fund losses.

Five states to subsidize employer coverage for children, but HCFA warns of crowd-out with these programs

At least five states, Massachusetts, Colorado, Oregon, Minnesota and California, hope to use some of their Children's Health Insurance Program (CHIP) dollars to subsidize employer-sponsored coverage for children. They will offer subsidies of employer-sponsored coverage in addition to insurance through a state-sponsored children's program.

Officials in California said the state decided the HealthyFamilies program should offer subsidies for employer-sponsored coverage as well as a state-sponsored insurance pool for children partly to lessen crowd-out. Crowd-out occurs when public funds replace private funds to finance health coverage.

"It seems to us that if you work for an employer and have been unable to take advantage of the coverage provided by that employer, it would be less disruptive to the market for you to take advantage of it rather than redirecting you into a purchasing pool," said Leslie Cummings, associate director for health policy at California's Department of Health Service. "That would help to sustain the employer market."

To the surprise of at least some state officials, however, the Health Care Financing Administration (HCFA) said last month that it planned to subject plans for employer-sponsored coverage to "particular scrutiny" for potential crowd-out. In a Feb. 13 letter to the state officials, HCFA said "we believe there is a greater potential for substitution of public for existing private spending on health insurance in these types of arrangements."

Companies with low-wage workers, for example, might decide to reduce or eliminate their premium contributions for dependents. And if families with children already enrolled in their employers' plans are able to take advantage of the subsidies, government funds would be used to replace existing, private coverage instead of to cover more uninsured.

HCFA says states need to include five provisions in their plans for subsidizing employer-sponsored coverage (see page 8), to prevent "crowd-out." These include requiring that employers contribute at least 60% of the cost of family coverage and limiting the subsidies to children who have been uninsured for at least the previous six months (known as a "look-back" period.)

Most states have set the employer contribution requirement at 50%, according to Lee Partridge of the American Public Welfare Association. She noted, however, that HCFA has indicated that the 60% contribution level should be considered "preliminary guidance" and that it may be flexible on this point.

Massachusetts, which is launching its Insurance Reimbursement Program (IRP) in July, includes no look-back period. The state also has decided to provide subsidies even to employees and their families who currently have insurance through their employers if they meet the income guidelines.

IRP was planned before CHIP and was approved by HCFA several years ago in a Section 1115 Medicaid waiver.

The question of whether to subsidize premiums for employees who are already insured by their employers was a major part of the debate over IRP. Out of fairness to employers who have been insuring their low-income workers, the state decided to include them in the program, according to Mark Reynolds, deputy commissioner of the MassachusettsMedicaid program.

Like the Massachusetts program, the Oregon program also was planned before CHIP and can be launched without CHIP funding. Both plans will cover the entire family, not just children.

"We don't expect the entire (Oregon) program to qualify" for CHIP funding, said Bob DiPrete, director of the Oregon Health Council, which advises the state legislature on health policy issues. He noted that adults do not qualify for CHIP funding and he does not expect HCFA to allow the state to subsidize all employer benefit packages because some do not

Continued on page 8

Many employees in ERISA plans are afraid to complain, Oklahoma insurance chief says

Many employees covered by ERISA health insurance plans are afraid to pursue complaints about their employer's health coverage because of "fear of retribution or job loss," according to Oklahoma Insurance Commissioner John P. Crawford.

The conclusion is contained in a report about his office's first year experience under a two-year pilot project with the Department of Labor (DOL) which authorizes the insurance department to follow-up complaints about health coverage from consumers in those plans.

Oklahoma insurance officials say only about 10% of employees covered under ERISA plans who call in with an inquiry or complaint about their employer's health coverage are submitting written complaints that can be followed up.

"With a private carrier, consumers are dealing with an entity that is separate from their employer," the statement reads. "However, with an ERISA plan, the plan and employer are one. Consumers fear retribution if they appeal or fight their ERISA plans over coverage and benefits."

The landmark agreement with the DOL authorizes the Oklahoma commissioner's office to assist consumers covered by self-insured health plans that are governed by the Employee Retirement and Income Security Act (ERISA) of 1974. While ERISA preempts state regulation of employer plans, under Oklahoma's agreement with the DOL, plans must respond to the regulator when there are consumer complaints. Oklahoma is the only state that has made such an arrangement with the DOL.

Overall, Mr. Crawford's office received 508 written complaints during 1997 from Oklahoma residents covered under an ERISA plan:

• about 28% were resolved with benefits being paid; the most common reason for delay in payment was "foot dragging" on the part of the plan;

• about 3% were referred to the DOL for possible violations of ERISA; and

Continued on page 6

Washington state turns down $47 million for kids

Continued from page 1

use the federal funds for outreach. To hold the state's money in place in case the federal government allowed such uses of the money in the future, advocates began meeting last fall to develop a strategy for a campaign to support expanding coverage to up to 250% of FPL.

Although advocates generally preferred a Medicaid expansion, Gov. Locke proposed a modified version of the Basic Health Plan as the vehicle for expansion. BHP is the state's subsidized insurance program. Gov. Locke touted his proposal as an easier sell to cost-conscious legislators, because families would be required to cost-share and the benefits would be scaled down. "It wouldn't be as rich as Medicaid, but it wouldn't be substantially different," Sue Crystal, the governor's policy adviser, told advocates in January.

Both Gov. Locke's proposal and a bill sponsored by Democratic Sen. Pat Thibaudeau to expand Medicaid to 250% died in the fiscal committees.

Taking a different tack, advocates then began lobbying for $431,000 to expand coverage to the estimated 1,200 children in the state with special health care needs. But amendments failed in both the House and Senate, largely along party lines.

Republican Rep. Tom Huff, chair of the House Appropriations Committee, said during the session that the state can't pay for the health care programs it currently offers low-income children. Sen. James West, chair of Senate Ways and Means, warned against further spending in view of an estimated $92 million shortfall in next year's Health Services Account, which finances the Basic Health Plan and the current Medicaid expansion for children.

According to health policy analysts, in years past, the federal funds never would have been left untapped by the state. Some observers privately comment that legislators were already unhappy with expansions to 200% of FPL and had strong resistance to further increases, especially because of the political fallout that would result from any efforts to trim them back in the future.

The governor, advocates and state agency officials are now turning their efforts to lobbying Congress to give states more leeway in how they can use the money. State Medicaid Director Jane Beyer was in Washington, D.C. last month to meet with advocacy organizations, committee staff members and the state's Congressional delegation to drum up support for making changes in the federal law.

A draft bill — with bipartisan support from the state's delegation — is expected to be introduced by Rep. Jennifer Dunn (R-WA). The amendment would allow states that already cover up to 200% of FPL to use the federal funds for outreach, said Ms. Beyer. Washington, Minnesota and possibly Vermont would be covered by the amendment.

"It's not going to be a slam-dunk," said Ms. Beyer. Both parties have concerns about reopening CHIP — Republicans worry that further expansions will be made to the program, while Democrats are afraid that coverage will be reined in.

Decision may have repercussions

This year's legislative action could come back to haunt the state, predicted Ms. Beyer. Congress is considering whether to require some indication of a state's financial support of expansions to 250% of FPL before allowing it to use funds for augmenting their current efforts to cover populations under 200% of FPL.

And lawmakers on both the state and federal level remain deeply concerned about "crowd-out" — families dropping private coverage to enroll in subsidized insurance. But Ms. Beyer noted that it is sometimes only luck that separates uninsured and insured families under 250% of FPL, with the insured families having the good fortune to be able to access dependent coverage through an employer. Families with insurance can sometimes afford only high-deductible coverage, which she said could create barriers to getting children the preventive care they need.

Medicaid outreach survives

Some Medicaid funding did survive in the budget, said Ms. Beyer. Legislators retained a measure that provides that will make it possible for the state to access some of the $10 million of federal funds available to it for outreach to Medicaid-eligible children not enrolled. The funds, which come from a $500 million pool set up under the welfare reform law, require a 10% state match. Ms. Beyer said the matching funds will be put up by local communities, not centrally directed by the state. "I want to go to the people who have the profound knowledge of their community's needs and give them the dollars," said Ms. Beyer.

—Shauna Brown. Ms. Brown is editor of Washington Health, a monthly publication covering health policy issues in Washington state.

Contact Ms. Beyer at 360- 902-7806; Rep. Tom Huff 360-786-7802.

NASHP launches clearinghouse for CHIP programs

The National Academy for State Health Policy has established a clearinghouse to help states plan, implement and refine their Children's Health Insurance Programs.

With the aid of funding from the David and Lucile Packard Foundation, the center will provide a range of services to states including:

- small meetings on key topics;
- policy papers ("A Policymaker's Guide to the State Children's Health Insurance Program" is now available);
- case studies/best practices;
- technical assistance, including on-site expert team visits to individual states;
- teleconferences;
- a web page and interactive forum called "CHIP CHAT" (available at www.nashp.org);

an annual survey and analysis of state progress in implementing CHIP; and

- other activities in response to requests from state officials.

A special preconference in San Diego before NASHP's annual meeting will focus on the challenges of implementing CHIP.

For more information, go to www.nashp.org, or call 207-874-6524.

Despite flood of new state laws on conversions, community interests still 'at risk,' study says

In response to a "tidal wave" of restructurings in the health care market, states have passed a rash of laws that try to protect the public interest in conversions, mergers and acquisitions. Within the last two years, 19 states have passed a total of 21 new laws in this area, says a recently released study by Community Catalyst, Inc. a Boston-based advocacy group and formerly part of Families USA..

While commending legislators for their quick response to the phenomenon, "not even the best of the new laws is comprehensive enough to protect the many community interests at risk in a nonprofit conversion or merger," the report says.

Among the highlights of the report:

Community Health Services:

Only nine laws require a regulator to consider the community health impact of a conversion. Of these nine laws, all but two govern hospital conversions only. Generally, conversions of health plans or nonprofit insurers are excluded from these reviews

Only seven laws (in GA, LA, NB, OH, RI and WA) give the regulator authority to monitor and enforce agreements on essential community services, free care and community benefits after the transaction. Only three states (CA, ME, RI) require the buyer/acquirer to submit a community benefits plan.

Rhode Island's law is praised by Community Catalyst because it accomplishes three goals: It places the burden of proof on the buyer/acquirer that free care and community benefits are being provided to underserved populations in the community; it mandates a statewide standard of uncompensated care for both nonprofit and for-profit hospitals and regulators can conduct annual reviews of how each hospital is meeting the standard and can also determine if the standard continues to be adequate.

Charitable Foundations

About two-thirds of the laws require that the value of the nonprofit be transferred to a foundation if there is a conversion to safeguard the public's financial interest in these conversions, which involve organizations that are not only tax-exempt but which have benefited from donations, grants, volunteer time and "community goodwill." Many of the provisions on setting up foundations focus on valuation issues and other financial issues.

They often fail to otherwise regulate these newly-created foundations and to establish public accountability, the report says.

"What these new laws generally lack is sufficient recognition of the community's unique role as donor in a conversion foundation," the report says. "Every member of the affected community by virtue of his/her residence has contributed to the assets accumulated in local nonprofit charitable entities."

Without increased accountability, Catalyst cautions that there is a real danger that the funds will not be used appropriately. It cites a 1996 *Wall Street Journal* article, which reported that a conversion foundation in Tennessee used its endowment to purchase airplanes so that students at the local school could take flying lessons.

A debate has emerged over whether these funds should be used to pay for health services or insurance for the uninsured or whether there should be a broader mission aimed at shaping the system for improved access. The Community Catalyst report states that "at a minimum, it is important to put some language in the legislative provision that guarantees an emphasis on vulnerable populations as opposed to medical research and education, for example."

Vulnerable populations should be represented on the board of directors, Catalyst says. The foundation should be independent of both parties in the transaction and should have access to expertise concerning the health care needs of the community.

Broad range of restructurings

The sale of a nonprofit organization to a for-profit is by no means the only kind of restructuring occurring in the marketplace today. Nonprofits are merging and consolidating with each other and so are for-profit corporations. Associations and joint ventures and mergers across state lines are some of the other transactions. Each of these transactions has different implications. New laws need to use broad definitions of conversions.

One of the key issues to watch is the development of new mutual holding company laws.

"Citing the need to raise capital, mutual insurers have successfully lobbied state legislatures to enact mutual holding company legislation," the report says. New legislation, which varies somewhat from state to state, enables mutual insurance companies to create a series of holding companies, which can sell stock to outside investors.

Only nine laws require a regulator to consider the community health impact of a conversion. All but two govern hospital conversions only.

"Consumer advocates charge that the new mutual holding company laws represent an end-run around the demutualization process because they permit mutual insurance companies to convert to stock companies with compensating their current owners."

At least 15 states and the District of Columbia have passed mutual holding company laws.

The public interest must also be closely guarded when nonprofits spin-off for-profit subsidiaries, says the Catalyst report. Some nonprofits have transferred their most profitable lines of business into for-profit subsidiaries without contributing the value of charitable assets. The nonprofit is left as a shell corporation. According to Catalyst, "conversion legislation passed in Maine and in California enable a nonprofit Blues plan or HMO to transfer virtually all of its business into a for-profit subsidiary, even if that subsidiary plans to offer stock, without triggering the charitable set-aside requirement."

The Community Catalyst report is being published in the March/April issue of the Clearinghouse Review. To obtain a copy, contact the National Clearinghouse for Legal

Employees in ERISA plans call but don't write OK regulator

Continued from page 3

• in 50% of cases, the employer/plan position was "upheld."

The fact that half of complaints were settled in favor of companies is deceptive, said Stacy Martin, spokeswoman for the Oklahoma Insurance Department. While employers were complying with the law, consumers may have submitted complaints because their benefits offered less coverage than traditional plans or because they may not have included state-mandated benefits, which is allowed under ERISA. Plans also do not have to follow standard practices or benefits followed by private sector carriers and they may drop benefits without prior notice to the insured. ERISA plans only need to notify the insured within sixty days after the fact, according to the commissioner's statement.

> "Consumers have far fewer rights under these (ERISA) plans. We are very concerned about this as insurance regulators."—Crawford

"Consumers have far fewer rights under these (ERISA) plans. We are very concerned about this as insurance regulators, Mr. Crawford said in his statement. "The good news is that the Oklahoma Insurance Department has been able to help many consumers individually with their ERISA complaints. The bad news is there are many fundamental problems with ERISA plans which cry out for reform," Mr. Crawford said.

Some of the primary weaknesses of ERISA, he said, include:

• No requirement for plans to post reserves to back up payment of claims. Without this cushion, employers are vulnerable to large claims or bad claims years. This not only puts consumers at risk of unpaid claims but also places employers at financial risk. If an employer goes bankrupt, there is no guaranty fund protection. Employers can simply file for bankruptcy, then reopen with a separate Federal Identification Number.

• Plan benefits can be changed at will. ERISA plans do not have to maintain a standard of benefits. As medical costs escalate, Mr. Crawford said employer-sponsored plans may be "increasingly taking back benefits."

• No punitive damages or bad faith exposure. If plans deny benefits, consumers cannot collect punitive damages or compensation for costs such as lost wages, need for additional services, etc. Liability for these costs "may not be the only way to provide accountability; but the point is, there needs to be some," Mr. Crawford said.

Mike Seney, vice-president for State Chamber, Oklahoma's Association of Business and Industry, which represents many of the state's large self-insured employers, said the commissioner's statement seemed like "more of an editorial, with not a lot of detail."

Conclusions questioned

Mr. Seney said he and large employers in the state would like a report that breaks down what kind of inquiries and complaints were received by the commissioner's office and how they were handled. It's "a tremendous jump" for the commissioner to say that only 10% of inquiries result in written complaints because "people were afraid to lose their jobs by filing a written complaint," he said. Callers may have had their questions answered or the problem may have been addressed, he noted.

Mr. Seney said he has heard nothing about the pilot project from employers or from the insurance commissioner's office since the program was launched a year ago. At that time, the commissioner met with self-insured employers and told them he would be in close communication with them, Mr. Seney said.

Bruce Ruud, regional director for the Department of Labor in Dallas, said the federal agency was approached by Oklahoma to do the pilot project. Other states have contacted the DOL about getting similar authorizations to handle consumer complaints, but Mr. Ruud said the agency wants to wait and see how the two-year pilot with Oklahoma works. "They've referred some matters to us but are handling the majority themselves," said Mr. Ruud, who adds that it is too early to take stock of the project.

The insurance commissioner's office used eight internal codes to classify how calls were handled or disposed, but this information was not released with the statement. Mr. Crawford was also not available for an interview.

Because callers often didn't know if they were covered under an ERISA plan, Ms. Martin said it frequently was up to the commissioner's staff to make this determination with the aid of a directory from the DOL's Pension and Welfare Administration, which lists all such plans. Another challenge for the commissioner's staff, she said, has been distinguishing between third-party administrators and self-insured plans.

"We're breaking ground," said Ms. Martin. "We're the first state regulatory agency to crack the federal veil and provide local assistance to local constituents."

Contact Ms. Martin at 405-522-4644.

AHA will favor vendors that offer insurance to workers

As part of a national effort to expand coverage to as many people as possible, the American Hospital Association (AHA) and the National Association of Public Hospitals & Health Systems (NAPH) have notified contractors that they prefer to do business with companies that provide health insurance to employees.

The initiative, dubbed Health Competition, was first developed and implemented in New York by the Healthcare Association of New York State and local labor leaders.

AHA spends an average of $45 million on vendors annually. NAPH spends about $750,000 on vendor contracts.

Contact Carol Schadelbauer of the AHA at 202-626-2342 or Kathleen Song at NAPH at 202-408-0223.

NJ hospitals object to mandatory plan for uninsured care

Continued from page 1

HCFA approved the state's Medicaid 1115 waiver for the Managed Charity Care Demonstration last month. New Jersey legislators, struggling with the issue of how to finance charity care in the state, passed legislation calling for hospital-centered managed care for charity patients two years ago. But, federal approval was needed before the plan could be implemented.

Mr. Lillo said hospital and state officials alike were wary of the plan when it was first proposed because they were not sure how to accomplish the intent of the bill.

Working poor

"Most of our charity patients are actually the working poor who do not have health insurance coverage," Mr. Lillo said. "It's hard to figure out how to manage their care when we may only see them once a year."

Hospitals also have been concerned that setting up networks of providers to serve charity patients potentially could result in higher costs, Mr. Lillo said. "Hospitals have been underpaid historically (for charity care)," he said, "and this proposal could end up costing more."

"The legislature doubled the cigarette tax to provide more money for charity care and we don't want to see more spent than necessary," the hospital association official said.

"Last year, the state documented $463 million in charity care provided by hospitals," Ms. Ianni said, "but only $320 million has been appropriated."

The problem with the original legislation and the waiver on managing care for the uninsured, Ms. Ianni said, is that hospitals are viewed as the appropriate financial entities to be responsible for bills of charity care patients.

"This proposal really isn't managed care because the only rules apply to providers. The beneficiaries have no rules they must follow," she said.

Under terms of the state's waiver, 75% of the state's hospitals would be required to develop networks of physicians, substance abuse treatment centers, community clinics, laboratories, pharmacies, and other providers to manage the care of those whose conditions could benefit from a coordinated approach.

Hospitals would be required to provide care for those with substance abuse problems and with a dual diagnosis of substance abuse and mental illness. They also were to identify other sub-groups of the uninsured that would benefit from managed care. In plans submitted for state approval last fall, hospitals often targeted populations that needed respiratory, cardiovascular or prenatal services.

Under proposed regulations published in the New Jersey Register in January 1998, only hospitals that receive less than $500,000 a year in charity care subsidies and do not serve as the only acute-care facility in their county would be allowed to opt out of the program. Hospitals that opt out would be ineligible for charity care funding, but still would be required to care for charity patients and submit demographic and audit data to the state as they do now.

Ms. Weiss said department staff established a task force of hospitals, physicians, HMOs, community representatives, and others to find a way to implement 1996 legislation on financing care for the uninsured. The task force recognized that no HMO in the state would be willing to manage all the care needed by one million uninsured people and so we "came up with the idea of asking hospitals to identify subpopulations of the uninsured that could benefit from managed care.

Substance abuse

She said a continuing point of contention between hospitals and the department is over the financial burden of providing services to those with substance abuse problems or a dual diagnosis of substance abuse and mental illness. While the regulations say hospitals would be financially liable for up to 45 behavioral health visits a year, Ms. Weiss said the department has indicated that hospitals could set criteria for the managed care services and accept financial responsibility only for patients who meet the criteria.

For instance, hospitals could limit the program to patients who come to the emergency room for detox three times in a year. She notes that a task force on hospital-centered managed care found that the majority of charity care services do not involve substance abuse.

Currently, uninsured individuals with family incomes up to 200% of the federal poverty level qualify for fully subsidized inpatient and outpatient care and those with incomes between 200-300% of the poverty level qualify for partial subsidies. For New Jersey residents, participation in hospital-centered managed care would be voluntary.

Caution urged

Because this is the first state proposal of this nature in the country, Ms. Ianni said, it makes sense to "use a little caution before taking it statewide." Mr. Lillo agreed, saying, "We are not opposed to the concept of managed care, but want to try this proposal voluntarily first to see if it can work. If it works, then it can be expanded. If it doesn't work, we've learned something without a lot of problems being created."

He expects that some of the larger health care systems in the state would volunteer to participate in a demonstration. However, there may be a problem with a provision in the draft regulations that appears to require a system to submit a separate plan for each of its hospitals and not allow movement of charity patients from one hospital in the system to another.

Besides provider networks, hospitals participating in the program also must have an appropriate information system to track charity care patients and services, quality assurance programs, and utilization management programs.

Ms. Weiss said the department has taken no stand on the amendment in the legislature. The department has worked hard to fulfill the 1996 legislative mandate, she said, but will conduct a demonstration program if that is what the legislature now wants. The effective date of the regulations has been delayed until April. Hospital representatives believe implementation was delayed because state officials wanted to wait to see if the legislature amended the program to make it a demonstration.

—John Hope

Contact Ms. Ianni at (609) 989-8200; Mr. Lillo at (609) 275-4201; and Ms. Weiss at (609) 984-7639

Five states to subsidize employer coverage for children

Continued from page 3

meet CHIP requirements.

Initially, Oregon expects to cover some 5,000 children through the subsidy of employer insurance and an additional 15,000-20,000 children through the state-sponsored insurance program for children. The Oregon legislature has already funded the program that will subsidize employer-sponsored coverage.

Mr. DiPrete said Oregon plans to require the same six-month 'look-back" period for its state-sponsored insurance program as for subsidized employer coverage. This will help prevent migrations from employer plans to the state program. While many experts doubt that families with employer coverage would voluntarily switch to a Medicaid-type program, because of the stigma, Mr. DiPrete believes that Oregon's state-sponsored program could indeed attract people. It offers the same managed care plans as the private market.

HCFA encouraged Minnesota to subsidize employer-sponsored because the state had already done so much to cover children up to 275% of the federal poverty level (FPL), according to Pat Callaghan, a member of the health care administration staff for the Minnesota Department of Human Resources.

"HCFA helped us brainstorm on this," Ms. Callaghan said. Currently children are locked out from participation in the state-sponsored MinnesotaCare program if they have access to insurance through an employer, even if that insurance is too costly for their families to afford.

The Minnesota legislature is considering several bills that would set the structure for the program. The MinnesotaCare program currently uses a four-month look-back period.

Colorado, which recently became the first state to win approval of its state-sponsored non-Medicaid CHIP program, is also planning to offer subsidies of employer-sponsored coverage beginning in July, said Laura Tollen, manager of health-care initiatives in the Colorado Department of Health Care Policy and Financing.

Ms. Tollen said the state hopes to negotiate with HCFA to allow some flexibility in the requirement that an employer pay 60% of the premium. Under the Colorado program, Colorado families with uninsured children would have a choice of whether to buy coverage through their employers or through the Children's Basic Health Plan, which covers children through age 17 up to 185% of FPL. There is currently a three-month "look-back" period for the Basic Health Plan

Children need to be uninsured for three months before they can join California's Healthy Families program. However, subsidized employer coverage (called the purchasing credit plan) has been put on hold temporarily because of a drafting error in the state statute, Ms. Cummings said.

As written, the statute makes the subsidized employer insurance package a far more favorable option than coverage through the purchasing pool because no cost-sharing is allowed under the employer plan.

Contact Ms. Callaghan at 612-215-9448; Ms. Tollen at 303-866-6092; Mr. DiPrete at 503-378-2422; Mr. Reynolds at 617-210-5670; and Mr. Curtis at 202-857-0810.

HCFA requirements for subsidies of employer health plans

• With the exception of newborns, children in a family will not be eligible for subsidies through an employer-sponsored group health plan if the family had employer-sponsored group coverage for these children within the previous six months. By establishing this provision, HCFA hopes to prevent families from dropping their children from the company plan and signing them up for a less-expensive state-run program.

• To discourage employers from lowering their existing contributions for dependent coverage, states will only be permitted to subsidize employer coverage if the employer contributes at least 60% of the cost of family coverage.

• To ensure that subsidies through employer plans is cost-effective, a state's payment can be no greater than it would be if the children were enrolled in a separate CHIP program operated by the state.

• Families receiving assistance through an employer-sponsored group health plan must apply for the full premium contribution available from the employer.

• To demonstrate cost effectiveness, the state will be required to collect information and conduct an evaluation that examines the amount of substitution (if any) that has occurred under the program and the effect of these provisions on access to the program."

Agencies collaborate in oversight of managed care

A growing issue in many states is interagency collaboration for oversight of managed care. A recent report by the National Academy of State Health Policy in Portland, ME examines the experience of Virginia and Colorado in this area.

Grievances/complaints is one function where agencies could coordinate their efforts. The issues to be addressed include designating different agencies to handle certain types of complaints and developing a system for referring complaints to the proper agency.

In both states, the agencies developed Memoranda of Understanding so they could better understand their roles and functions."The difficulty of this task should not be underestimated," the report states. Traditionally, departments of Health and Medicaid have had two very different sets of guiding principles and goals. As the focus moves more to consumer protections or to serving small businesses without the resources to demand or monitor quality the way large purchaser can, these differences in perspective can diminish.

On-site periodic reviews was one of the most difficulty areas to achieve collaboration. "The complexity of the task is such that it takes a long time to sort through exactly what each agency does in its review," states the report. In Virginia, the departments of Health and Insurance have begun to go on-site together.

Copies of the report "Quality Assurance in Practice—Report on a Two-State Demonstration: Interagency Collaboration for Quality Care in Medicaid Managed Care for Low Income Mothers and Children," can be obtained for $15 by calling the National Academy for State Health Policy at 207-874-6524.

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.

California legislators say Healthy Families contract creates conflict-of-interest for administrator

SACRAMENTO, CA—California's contract with Wellpoint Health Networks, Inc. for administering its new Healthy Families program creates "an unacceptable conflict of interest," according to four California congressmen. Two of the congressmen, Bob Matsui, (D-Sacramento), and Rep. Pete Stark (D-Hayward), recently asked the Health Care Financing Administration (HCFA) to block the contract.

Wellpoint's dual role as an administrator of the program and a provider "could lead to some self-dealing," Rep. Matsui said. "All parties may start to act in good faith, but the real problem is you can't control employee behavior. There obviously will be some cases where bias will be shown."

Cynthia Coulter, a spokeswoman for Wellpoint, said the contract contains several provisions to ensure that the company does not benefit from its dual role. These include an independent audit and the monitoring of telephone calls with potential customers. She added that Wellpoint has played both roles in other state contracts.

Rep. Matsui said if HCFA does not reject the contract, he is prepared to file a lawsuit to invalidate it.
Sacramento Bee, March 5, 1998

Pharmacy retailers drop pharmaceutical mailings after outcry over confidentiality concerns

BOSTON—CVS Corp. and Giant Food Inc. of Landover, Md. promised to suspend mailings of pharmaceutical literature to their customers after the *Washington Post* published a report about the practice and the companies received a flood of complaints.

While the two retailers did not supply customer information to pharmaceutical companies, they did give customer data to a Massachusetts firm called Elensys, Inc. which sends out mailings in order to improve drug compliance or to introduce customers to new drug products.

Giant and CVS officials defended their programs, saying customers benefit from the reminders to refill prescriptions and the information from drug manufacturers. However, pharmacy regulators say the practice may violate confidentiality rules governing the release of medical information.

CVS signed on with Elensys in September to track customers who take a heart medication called Posicore. Giant was using the company to send customers information about hay fever.

The mailings are part of a move by drug manufacturers and pharmacies to make greater use of medical information, new technology and sophisticated marketing to sell more drugs. Rather than promoting medications to doctors, companies are increasingly going directly to patients.

One Virginia legislator has introduced a bill that would strengthen rules prohibiting pharmacists from releasing prescription data. James M. Jeffords (R-VT) also delayed introduction of a final version of legislation on medical privacy protections, citing the report about CVS and Giant Food. Rep. Jeffords said he wanted to make sure the bill addressed the selling of medical information.
Washington Post, Feb, 15, 1998 and *Boston Globe*, Feb. 19, 1998

Massachusetts will use number identifiers rather than names in HIV reporting system

BOSTON—For the first time, Massachusetts health care providers will soon have to report all cases of HIV infection to the state. But Massachusetts, unlike most other states with HIV reporting systems, will use identifier numbers rather than names.

Maryland and Texas are the only other states using identifier numbers rather than names. California and New York, states with some of the biggest numbers of HIV and AIDS cases, are in the midst of a name vs. number debate.

Massachusetts' policy would go into effect after the state develops a reporting system, perhaps using a combination of several digits from a person's Social Security number, date of birth, and some other coded demographic information.

Some AIDS activists have long objected to HIV reporting, either by name or number. The importance of taking new drug treatments early in the infection has led many of them to change their minds. Other activists, particularly from minority communities, support HIV reporting so that public health officials can respond more quickly to the epidemic.
Boston Globe, Feb. 24, 1998

New York could use surplus to reduce premiums for individual policyholders facing big hikes

ALBANY, NY—New York plans to use the surplus from two pools funded by the insurance industry to keep insurance premiums from skyrocketing for individual policyholders. Empire Blue Cross and Blue Shield and Oxford Health Plans, which cover many individual policyholders, have requested a 46% increase and a 69% increase in their rates, respectively.

Eighteen health maintenance organizations recently requested and were granted permission to increase the rates they charge so-called "direct-pay" customers.

On a one-time basis, Gov. George Pataki has proposed using nearly $100 million to help bring down anticipated increases. Empire claims to have lost $300 million on individual policies from 1988 to 1997 and Oxford lost $17 million in 1997. Empire's president, Dr. Michael Stocker, said individual policyholders require hospitalizations twice as often as members of commercial plans. The governor said he would work toward finding a long-term solution for the rapidly escalating cost of individual policies.
The Record, Hackensack, NJ, Feb. 17, 1998, *New York Times*, Feb. 16, 1998 and *Times Union*, Albany, NY, Feb. 18, 1998

Two behavioral health contractors owe $40 million to five Tennessee mental health institutes

NASHVILLE—Tennessee's five state-operated regional mental health institutes are owed back claims of $40 million by the two behavioral health contractors managing the state's mental health program. A special report by the Comptroller's Office and the Department of Commerce and Insurance found that one of the

Continued on page 10

Clip file / Local news from the states

Continued from page 9

contractors, Tennessee Behavioral Health (TBH), has refused to process any claims from the state's mental health institutes since last July.

The report also verified the complaints of private mental health providers who say they're often paid late or not at all.

While acknowledging that the state's billing system is flawed, acting Mental Health Commissioner Ben Dishman said TBH is "in violation of the contract big-time."

The special report, which reviewed TBH billing and claims processes, showed that the company has wrongly denied 28% of its claims from mental health providers.

The state pays the two contractors $27 million a month minus a 10% penalty for their violations of the contract. Because Premier Behavioral Systems has about 60% of the enrollees, the money is split 60-40 between the two companies.

The Commercial Appeal, Memphis, TN, Feb. 12, Feb. 15, 1998

Minnesota plans cover tobacco cessation treatment

ST. PAUL, MN—Blue Cross Blue Shield of Minnesota is the third insurer in the Twin Cities to announce in the last few months that it will now cover prescription smoking cessation treatments.

Medica was the first to announce in December that it will pay for the treatments and HealthPartners plans to begin offering the coverage this summer. This means that three health insurers covering 80% of Minnesota residents will offer nicotine patches, gum and the anti-depressant Zyban.

The insurers' cost estimates for providing the new benefit vary widely. Blue Cross, which is suing tobacco companies along with the state to recover medical costs attributable to smoking, projects its annual costs for the benefit will be $11.2 million annually. Medica said it expects to spend about $500,000 for the 120,000 to 140,000 members likely to take advantage of it.

Minnesota's Veterans' Administration says it spent $152,000 in 1997 on nicotine patches and gums to treat a small percentage of its patients who smoke. The VA said about 18% of its 45,000 outpatients smoke.

St. Paul Pioneer Press, Feb. 19, 1998

OxfordHealth leaving some Medicaid programs

NORWALK, CONN—Oxford Health Plans, Inc. has told New Jersey and Connecticut state officials it will no longer participate in their Medicaid programs. The company said it hasn't decided whether it will stay in the New York program. Oxford will stay with Pennsylvania's state Medicaid program. However, it will hand over management of the operation to another firm, Minneapolis-based Health Risk Management Inc.

The company's stock has plunged as a result of rising medical costs and highly publicized problems with paying its bills. In December, Oxford said it was thinking about quitting government health programs for the poor and focusing on more profitable lines of business.

Getting out of Medicaid programs "is something you can do easily" to improve the financial situation, said Robert Hoehn, an analyst at Furman Selz LLC.

Oxford has 40,000 members in New Jersey's Medicaid program and 33,000 members in Connecticut's program. The company has 67,500 members in Pennsylvania's Medicaid program and 42,000 in New York's program.

Chicago Tribune, Feb. 28. 1998

FL lawyers sue over compensation for tobacco suit

TALLAHASSEE, FL—Lawyers who helped Florida sue tobacco companies and win an $11.3 billion settlement are now suing the state over the fees they will collect.

Under the settlement between the state and the tobacco companies, the lawyers are to be paid "reasonable" fees to be determined by an arbitration panel, instead of the 25% contingent that had been agreed to previously.

Bob Montgomery, the lawyer filing the suit on behalf of the state's so-called Dream Team, claims the state and tobacco companies conspired to keep the lawyers' fees down .

Attorney General Bob Butterworth said lawyers would be better off under the settlement than under the contingency fee because that was only supposed to apply to a small portion of the settlement, about $1.3 billion. The contingency fee only applies to Medicaid reimbursements because that's what the lawyers were hired to pursue.

Sun Sentinel, Fort Lauderdale, FL, Feb. 18, 1998

Arizona PHO folds after seven years in operation

PHOENIX—After struggling for nine months to put the 600-member St. Joseph's Physician Hospital Organization (PHO) back on track, the board of the seven-year-old organization announced the PHO will officially close in May.

The PHO will only be able to pay claims from medical providers at a rate of 50 cents on the dollar after Feb. 1.

About a dozen or so managed care companies will have to make other arrangements for the care of 23,000 plan members who are being treated by the St. Joseph network. Physician members and owners of the PHO also must negotiate new contracts with insurers, either individually or through newly formed independent practice associations.

St. Joseph's PHO was organized in 1992 so that local providers could more effectively negotiate with managed care companies. As managed care plans became a bigger force in the health care industry, the PHO was forced to negotiate lower and lower rates for its services. With more seniors moving into managed care from traditional Medicare, the PHO had to provide more complex care for the same fees.

To try to stem the PHO's losses, the board hired a new medical director and a third-party administrator in June.

The St. Joseph's physicians group is not the only physicians' health organization in the Phoenix area that has had problems. Late last year the 330-member Arrowhead Physicians Alliance at Baptist Hospitals and Health Systems' Arrowhead Community Hospital disbanded. About the same time, the 220-member PHO at Chandler Regional Hospital scrapped its internal management and affiliated with Medpartners of Birmingham, Ala., the largest publicly held practice management firm.

Arizona Republic, Feb. 19, 1998

States can avoid challenges to Medicaid contract awards

Greater use of competitive bidding in Medicaid managed care along with state personnel's lack of experience in this new procurement process are among the reasons for the "relatively high number" of legal challenges to behavioral health contracts in Medicaid managed care, according to a recent study commissioned by the American Managed Behavioral Healthcare Association (AMBHA).

The dollar value of these contracts and the bidder's already significant investment in its proposal makes "the incremental costs of contesting the procurement" look relatively minimal, write the authors, Colette Croze of Croze Consulting and Wendy Krasner of McDermott, Will, and Emery.

"Public mental health systems are moving from distributing grants of half a million dollars to each of 100 community mental health agencies to procuring services through single contracts of $50 million to $150 million.

Vista Behavioral Health Plan, for example, spent $1.2 million on its bid for a contract awarded by the Montana Department of Human Services valued at $400 million. The company challenged the state's award to another bidder. According to the AMBHA report, the company ended up reaching an out-of-court settlement with the winning bidder in which it received a settlement equal to half of its proposal development costs.

Of the 12 competitive procurements studied, there were five challenges to the awards, with three of those challenges resulting in litigation—in Montana, Iowa and Ohio.

Costs of contesting the procurement are relatively minimal when contrasted with the enormous value of winning the contract.

Still, the authors stress that "the majority of public procurements of managed behavioral healthcare have gone smoothly and unchallenged," that "health care procurement protests are not limited to behavioral health," and that "litigation is a way of life in the public sector.

Lawsuits didn't start with for-profit organizations getting into the public mental health business. "Government is continually sued around its provision of health and mental health services."

The AMBHA report cites several other key factors that appear to have precipitated the procurement challenges:

• most state offices of behavioral health are not familiar with all of the requirements of the Federal Procurement Act;

• changes in the rules of the game during the course of the procedure;

• and deficiencies in the procurement process, such as unclear design features, hastily developed evaluation processes, uneven knowledge base of review participants, conflicts of interest, and the use of a consensus approach in which everyone's opinion is treated as equal.

The report offers several recommendations for reducing the risk of litigation and improving the procurement process. They include using:

•reasonable time frames for issuing and receiving proposals;

•RFIs (Requests for Information);

• pre-qualifications and effective evaluation criteria, site visits, clear appeals procedures, and a single point of contact for bidders;

• experienced personnel and legal counsel during evaluations;

• a neutral third party observer to oversee procurement process;

• alternative dispute resolution techniques to settle disagreements;

• a public process for advising on rates, methodologies, and justifications; and

• a federal assistance process, such as the Medicare competitive procurement federal advisory committee.

Copies of the report are available for $50, payable to AMBHA, 700 Thirteenth St., NW, Suite 950, Washington, DC 20005, 202-434-4565.

Solvency standards approved for Medicare PSOs

Continued from page 2

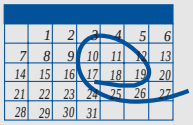
that the committee has left the door open to reducing solvency requirements for rural PSOs. HCFA will seek public input on this issue in coming months. In rural areas, where as much as 40% of the population is on Medicare, Medicare+Choice plans could greatly improve the benefit package for consumers, he said. PSOs would also help preserve the health infrastructure in rural areas. When residents join health plans in nearby urban areas, they often stop using local providers.

There's a perception inside the Washington Beltway that PSOs would prefer to bypass local regulators and deal with with federal regulators, said Mr. Ehnes. Often underestimated is the role state regulators play in helping "solve problems with them (healthcare organizations) when they're operating." It is difficult to "replicate the value of that relationship" at the federal level, Mr. Ehnes said. Recently, some healthcare executives came into his office to explore whether the PSO concept "can work in our state."

As federal and state regulators prepare to work together on approving PSOs that offer Medicare+Choice coverage, NAIC officials stress the importance of coordination on such issues as when the clock should start ticking on state applications and on when an application should be considered substantially complete. NAIC maintains there is potential for gaming the system if , for example, applicants delay providing information until the the day before the 90-day review period runs out.

NAIC officials also hope that HCFA will not just accept the applicant's reasons for delays when the 90-day review period is exceeded. The agency should get the regulator's explanation as well, NAIC believes. There could be a question about compliance with consumer protection standards or other standards that might have a bearing on solvency. For example, the NAIC says a case could be made that network adequacy standards are a solvency issue.

Contact Mr. Bernosky at 216-523-1300, Mr. Ehnes at 303-894-7499, Ms. Mudron at 202-838-1100, or Mr. Mueller at 402-559-5260.



DEADLINES

JUNE 1, 1998

Comprehensive rules for PSOs to be issued by the Health Care Financing Administration. HCFA is scheduled to issue an interim final rule on solvency standards April 1. The standards could be applied to provider-sponsored organizations participating in the Medicare+ Choice program. (See story, page 2).

On line access / Index

Back issues of *State Health Watch* may now be searched on line for a fee at www.newslettersonline.com. Information may be searched by keyword and by date of publication. Also, the 1997 index of articles is now available by mail without charge to current subscribers. *For a copy of the index, please fax us at 1-800-842-3081 or e-mail us at SHWInc1@aol.com*

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State Health Watch News Briefs

California's 6.5 million uninsured often forgo necessary medical care

LOS ANGELES—The 6.5 million Californians who lack health insurance are much more likely to delay or forgo necessary medical care than those with coverage, according to a study issued in February by the UCLA Center for Health Policy Research.

The gap in accessing care cuts across all nonelderly age groups, both men and women, and applies to all types of medical care, including treatment of an acute problem, monitoring of a chronic illness or preventive screenings.

Among the most significant findings:

• Nearly one-third of uninsured children (29%) lack a usual source or provider for medical care, a rate seven times higher than for insured children.

• Four out of 10 uninsured children (41%) did not make a physician visit within the last year, compared with 20% of insured children.

• During a one-year period, 13% of uninsured children delayed or didn't get needed medical care. In contrast, only 2% of insured children delayed or didn't get needed medical care.

• Some 51% of uninsured adults report that they have no usual source of care, compared with 10% of insured adults. A separate policy brief issued by the UCLA Center last month reports that 2 million California men ages 18-39, 34% of all men in this age group, are uninsured. That compares with an uninsured rate of 23% of women in the same age category and is nearly double the uninsured rate for men ages 40-64.

To obtain a free copy of Policy Brief 98-2 on uninsured men or Policy Brief 98-3 on the consequences of being uninsured, fax your request to 310-825-5960.

LA, NY, Miami, Philadelphia, Chicago best areas for Medicare risk

MINNEAPOLIS—The most attractive markets for continued Medicare managed care-expansion are likely to be in those areas in which managed care competition, including development of Medicare programs, is well established, according to a new report by Interstudy Publications. Based on current penetration, AAPCC rates, and size of eligible population, the top five areas for expansion of Medicare programs are Los Angeles-Long Beach, New York, Miami, Philadelphia and Chicago. Interstudy also found that areas that have low managed care penetration, recently had increases in AAPCC rates, may also be attractive markets. This group includes Greenville, NC; Jackson, MS; Montgomery, AL; Sheboygan, WI; and La Crosse, WI-MN. *To purchase a copy of The InterStudy Competitive Edge: the Regional Market Analysis, call 1-800-844-3351.*