State

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Despite HCFA's help, federally qualified health centers struggling to get cost-based Medicaid reimbursement

Many states include reimbursements in managed care payments, shifting responsibility

Some federally qualified health centers (FQHCs) claim they still are not being paid money owed them by state Medicaid programs, despite the Health Care Financing Administration's (HCFA's) attempts to rectify the situation. Seeking millions of dollars in cost-based reimbursement, the FQHCs say they are caught in a limbo in which neither the states nor managed care plans will take responsibility for making the payments.

Under longstanding federal law, state Medicaid programs are required to pay FQHCs their reasonable costs. In an attempt to wean federally qualified health centers from cost-based reimbursement and prepare them for operating in a managed care environment, the requirement begins to ratchet down to 95% of reasonable costs in the fiscal year ending in 2000, 90% in 2001, 85% in 2002, and 70% in 2003.

Some centers have been able to get paid, reflecting the intervention of HCFA in 1998. For example, South Carolina managed care contracts that once explicitly gave health plans the job of cost-based reimbursement assign that role to the state Department of Health and Human Services, effective October 1998.

Key to the successes, say center officials, is a series of arm-twisting letters from HCFA affirming that state Medicaid programs must pay centers the difference between what the providers receive from managed care contracts and their full costs. Importantly, HCFA also outlines how those costs should be paid.

But just because a state says it pays doesn't mean the FQHCs see the money. For example, FQHC officials in Ohio say their state is one of those in which the Medicaid program pays their costs in such a way that the center never sees the money.

"We're still living in the desert of finances here," says Katherine Kunk,

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Insurance reforms succeed without rocking markets, says analysis of initiatives in 7 states

State health insurance reforms have not brought soaring prices and upheaval to the marketplace, except for some notable exceptions in the individual market.

That is the general conclusion of an exhaustive review of insurance market reforms in Colorado, Florida, Iowa, New York, North Carolina, Ohio, and Vermont. A Wake Forest University study of insurance availability, prices, and enrollment found that guaranteed issue, community rating, and similar reforms have largely achieved the goals of spreading risk and stabilizing the market for employer groups of 50 or fewer workers.

The reforms weren't without problems in the individual market. While community rating and guaranteed issue did make coverage available to more higher-risk individuals buying insurance on their own, the study found prices generally rose as a result and enrollment consequently dropped. But in none of the states studied did the reforms cause the notorious "death spiral" — the complete collapse of the market for insured individuals due to an accumulation of progressively higher risk and rates.

"For the small-group market, generally it's true that even the strongest reforms don't cause major damage to the market," says the study's principal investigator, Mark A. Hall, an attorney who teaches health care law and public policy at Wake Forest in Winston-Salem, NC.

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deputy director of the Ohio Primary Care Association. "Ohio doesn't care about its federally qualified health centers."

In the same vein, Kathy Wood-Dobbins, the executive director of the association representing Tennessee's primary care centers, reports that efforts to get the state to supplement the centers' payments have stalled. "We are paid whatever the managed care organization wants to pay us. [Our] position is that the payments are in no way cost-related," says Ms. Wood-Dobbins.

Under HCFA's model reimbursement scheme, states make up the difference between an FQHC's managed care revenues and the center's costs through quarterly supplements and an annual reconciliation. In order to prevent the possibility of "sweetheart" deals between HMOs and health centers, the FQHCs must be paid no less than what other community providers receive for similar services.

Standing hat in hand

But there's still uncertainty over who is going to decide what that payment will be and how it will be made. Some states apparently continue to include the payment in their reimbursements to managed care plans, despite warnings not to do so from federal regulators. Balanced Budget Act (BBA) provisions that became effective in October 1997 took away states' latitude to delegate to their managed care contractors the responsibility for meeting a health center's costs. Moreover, there's no question of the legitimacy of the FQHC claims to cost-based reimbursement, as the BBA also removed the freedom of FQHCs to waive their right to recover their full costs.

For now, FQHCs are standing hat in hand at the door of state Medicaid programs, trying to secure the difference between their managed care payments and the costs of providing Medicaid care. The claims range from hundreds of thousands to millions of dollars.

Some Medicaid programs say FQHCs should recover their costs from the managed care organizations because the additional amount already is figured into managed care capitation rates. Apparently, some states have been slow to comply with the federal prohibition against this methodology, leaving the FQHCs with little or no leverage with the MCOs.

"The managed care companies told us to pound sand," says Patti Deitch, executive director of Philadelphia Health Services. "It was a nightmare."

Ms. Deitch says the so-called "wrap-around" payment for her organization represented about $100,000 per month in unmet costs in an annual budget of about $7.4 million. When it appeared in October 1998 that negotiations between state officials and the state association of community health centers were sputtering, Ms. Deitch's center and four other organizations in Philadelphia sued Pennsylvania's Department of Public Welfare for Medicaid costs not covered in their Medicaid managed care payments. The centers and state officials settled in November on a reimbursement process modeled after one suggested by federal officials.

"We were in a critical situation here. No one else in the state was affected like we were," says Ms. Deitch, referring to Pennsylvania's mandatory Medicaid managed care rollout that started in the Philadelphia area. The centers received half of the disputed amount in late 1998 and will receive the remainder after a reconciliation in early 1999, Ms. Deitch says.

Officials at the Pennsylvania Department of Public Welfare will not comment on the reason for the delay in the payment. "It just took a while for us to figure this out," department spokesman Jay Pagni says.

An Oct. 23, 1998, letter from Sally Richardson, director of HCFA's Center for Medicaid and State Operations, explicitly prohibits states from folding the FQHC's additional payment into the capitation rate and then requiring managed care organizations to turn over the payment to the centers.

"This clarification is intended to ensure that MCOs do not perceive or incur any undue burdens when contracting with FQHCs . . . versus other providers of care thus creating unintended barriers or disincentives to contract," Ms. Richardson wrote.

That letter, and earlier ones in April, tilted the issue in favor of the FQHCs. "I thought it was great," says Ms. Deitch. "It couldn't have been better if I wrote it myself."

The conflict seems to be most acute among the 14 states with Section 1115 waivers, which allow implementation of Medicaid managed care. While HCFA recognizes that some 1115 states explicitly have waived the FQHC reimbursement requirement, the federal government is holding other states to the letter of the law and demanding details on how the Medicaid program will comply.

Ohio's first explanation didn't pass federal muster, says Ms. Kunk, and a more detailed explanation was due to HCFA in late January.

Florida eyes HMO payments

Officials in Florida, another waiver state, say they have built the supplemental payments into the capitation rate they pay to all HMOs but have allowed the marketplace to determine whether that additional payment ever reached the federally qualified health centers. The amount varies by county and averages about $2.50 per member per month (PMPM).

"A lot of the HMOs have contracted with the federally qualified health centers," says Bruce Middlebrooks, spokesman for the Florida Agency for Health Care Administration. "That's just something we included in the cap rate."

The executive director of the association representing Florida's 26 community health centers estimates that about half have HMO contracts, and that a "very rough" estimate of costs due to community health centers is $500,000.

"We're making progress. I wouldn't say we're delighted," says Greg Glass, executive director of the Florida Association of Community Health Centers.

Mr. Glass' association is negotiating the mechanics of the reimbursement with the state and is hopeful the issue will be resolved quickly. At the same time, association members are assessing themselves to build a war chest for a possible legal fight over the issue.

Florida's Medicaid program requested permission from HCFA in early January to eliminate the additional amount it

pays PMPM to HMOs to cover the centers' higher costs, effective Feb. 1.

"I'm not saying they're happy about it," observes Mr. Middlebrooks.

The Florida Association of Managed Care Organizations, an association of Medicaid HMOs, estimates that removing the FQHC line item from the Medicaid capitation rate will have a $9 million impact on Medicaid HMOs in the state.

"The HMOs, not surprisingly, are in an uproar," says association counsel Gary Clarke. Association and state officials are meeting to work out a resolution to the issue.

HCFA is negotiating with several states to ensure the level and mechanism of the payments is consistent with federal policy.

"Actually, I'm optimistic that HCFA's taking a closer look," says Tennessee's Ms. Wood-Dobbins.

Contact Ms. Deitch at (215) 684-5344, Ms. Kunk at (614) 224-1440, Mr. Glass at (850) 942-1822, and Mr. Clarke at (850) 577-6557. ■

A most dangerous game: Medicaid plans and states rely exclusively on each other for payments, enrollees

Think of it as state Medicaid programs and Medicaid-heavy HMOs putting all their eggs in each other's baskets.

That's what's happening as health plans serving a mix of private and public enrollees withdraw from the Medicaid managed care market, leaving government payers increasingly dependent upon so-called "safety-net" health plans. At the same time, the plans serving exclusively or almost exclusively government-funded enrollees also find themselves in a precarious position.

"These organizations are highly dependent upon a single line of business, a single source of revenue, and that creates enormous vulnerability for them," says Robert Hurley, PhD, an associate professor of health administration at Virginia Commonwealth University (VCU) in Richmond, VA.

The percentage of health plans with a Medicaid membership of 75% or more grew between 1992 and 1996 from 10.8% to 17.8%, according to a recent study Mr. Hurley conducted with Michael McCue and other colleagues at VCU.

The chief of a safety net health plan in New York City recognizes that her reliance on state funding makes her "very vulnerable."

"We have only one payer," explains Maura Bluestone, president and executive director of The Bronx Health Plan. Approximately 80% of the 37,000 members in Ms. Bluestone's 13-year-old plan are covered by Medicaid; 20% are covered by other government programs. Reserves have gotten the plan through deficits in 1996 and 1997 without cutbacks in services, but building a network is challenging with fewer dollars for provider payments.

"We're getting less, so we have to pay a little less," she says.

A separate analysis bears out Mr. Hurley's concern over safety-net plans. Some 70% of Medicaid-only plans lost money in 1997, according to preliminary data from a study funded by the Robert Wood Johnson Foundation. Among the plans that had a mix of Medicaid and other payers, the proportion that lost money ranged from 48% to 57% (see chart, below).

"The ones that are Medicaid-only are in trouble," says Bradford Gray, PhD, a researcher with the New York Academy of Medicine in New York City.

At the same time, Ms. Bluestone misses the "healthy competition" that the commercial plans once brought to the Medicaid market in New York City. In her market, she says, HIP is the only remaining HMO with sizable membership in both the commercial and government markets; remaining plans serving Medicaid enrollees "are staying in because they have to.

"Healthy competition is good for all of us. It does help to have pressure, and it's easy for that pressure to go off if the state doesn't have any alternative good players," Ms. Bluestone says.

The Washington, DC-based American Association of Health Plans recently organized long-time Medicaid managed care plans to call attention to the threat they face from declining reimbursements and increasing administrative burdens.

Diversification of Business and Profitability of Safety-Net Plans, 1997

	Loss	Broke Even	Profit	Total
Medicaid only (n=27)	70%	18%	11%	99%
Medicaid and other non-commercial (n=28)	48	4	48	100
Medicaid and commercial (n=18)	57	0	43	100

Source: Gray BH, Rowe C. Safety-net managed care plans: Results from a national survey. Preliminary data presented at the 3rd Annual Congress on Managed Medicaid & Medicare. Washington, DC; January 1999.

"There's been quite a lot of discussion in the last six months about Medicare and the plans pulling out," observes AAHP spokeswoman Susan Pisano. "There's been relatively little attention to the fact that the same problems are happening to Medicaid."

The Bronx Health Plan officials say they are chafing under reporting requirements, mandates regarding how care should be provided, and "admirable but highly ambitious" service levels in areas such as access, outreach, and education.

"State and federal regulators are turning to managed care to quickly remedy three decades of failed public programs," Ms. Bluestone said in a prepared statement.

Raising the profile of problems facing Medicaid plans does not signal an impending exit if reimbursement and other issues aren't addressed, says AAHP's Ms. Pisano. "They're not saying they're going to pull out this year. They're not saying they're going to pull out next year. They're saying they can't go on indefinitely."

What matters most

A plan's profit/nonprofit status and the proportion of government-funded enrollees probably don't affect the quality of care the plan can provide, Mr. Hurley says.

"What's probably more important and more central, of course, is competence, commitment, and stability," Mr. Hurley told participants at a January Congress on Managed Medicare and Medicaid.

"The organizations that are providing these services have to know what line of business they're in, they have to know what they're doing, they have to be committed to it, and they have to be prepared to be in the line of business for a sustained period of time. Otherwise, they make poor contractors."

Giving capitation to safety-net providers merely raises the stakes in an already dangerous game, says Mr. Hurley. It is up to state officials to ensure that capitated plans have the financial wherewithal to meet their obligations.

"Safety-net providers who bear full risk could in fact fail, and in their failure jeopardize their capacity to be a provider. We haven't seen this happen yet, but it's looming out there on the horizon. It's certainly the nightmare of many public regulators. It also should be the nightmare of many advocates who want to preserve the capacity of these providers to serve the uninsured."

Mr. Hurley is particularly concerned about the viability of provider plans, especially those sponsored by hospitals. He notes that in recent years the proportion of HMOs that are profitable has plummeted while the profitability of hospitals has stayed high.

"I think they continue to be in competing businesses. We have to still continue to ask the question whether or not hospitals can and should be in the HMO business," he says.

The increasing concentration of Medicaid enrollees in plans that cater to government payers makes Mr. Hurley pessimistic about reaching that Holy Grail of a single tiered system. The demographics and geographic dispersion of Medicaid enrollees may make such a goal "impractical, if not impossible," he says.

"I think many of those who thought 10 years ago that Medicaid managed care could be a bridge or a vehicle to achieve a degree of mainstreaming have to come to grips with the fact that this hasn't been the case, and may never be the case."

Contact Mr. Hurley at (804) 828-1891, Mr. Gray at (212) 822-7286, Ms. Bluestone at (718) 733-4747, and Ms. Pisano at (202) 778-3200. Mr. Hurley's study is found at: McCue MJ, Hurley RE, Draper DA, et al. Reversal of fortune: Commercial HMOs in the Medicaid market. Health Affairs *1999; 18:223-230.* ■

Consumers provide the FACCTs on how well provider systems address chronic conditions

A coalition of public and private Iowa employers is going straight to the patient to measure providers' effectiveness in treating asthma, diabetes, and coronary artery disease. The survey will use a self-reporting methodology, bypassing the traditional medical records review, to determine whether there is any difference in care between public and private patients.

The effort, facilitated by the Portland, OR-based Foundation for Accountability (FACCT), is part of a growing effort by purchasers to look beyond a plan's reported clinical outcomes to what the patient actually thought the care did for him or her. FACCT, a standards organization sponsored by large employers representing more than 70 million employees, has become one of the nation's leading advocate groups for analyzing such care at the level of the provider, rather than by health plan.

"In a lot of situations, the health plan is simply an administrative agent," says Ted von Glahn, a consultant for FACCT. "The action, in terms of how people are doing with regard to their health and management of disease, is at the care system level."

FACCT is conducting the survey for a coalition of purchasers in Iowa consisting of the state of Iowa, the Iowa Medicaid program, and the Community Health Purchasing Corporation, a sophisticated group of 30 self-insured employers. The collaboration makes it possible for the survey to find out if the performance of a given set of providers varies by whether the person has public or private insurance.

"We've been doing consumer satisfaction surveys for ages," says Harry Gill, MD, PhD, a physician consultant for the Iowa Medicaid program. "It will be interesting for us to find out how we compare to commercial plans."

FACCT is spearheading a national effort to integrate patient-based information with more traditional reporting methods. Over the past two years, FACCT has worked in concert with the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations and the Skokie, IL-based National Committee on Healthcare Quality to incorporate FACCT measures into the clinical outcomes reporting systems of those two organizations. This coordination of reporting standards acknowledges the push by consumers through their employers for more responsive systems that take into account how consumers

Iowas public- and private-sector purchasers combine forces to reshape health care system

The Foundation for Accountability (FACCT) survey in Iowa is sponsored by the Iowa Health Care Purchasers Collaborative, three purchasers that joined forces to reshape the local health care landscape. Collaborative members are the Iowa Medicaid program, the state's personnel department, and the 30 self-insured employers that make up the Community Health Purchasing Cooperative.

The Collaborative's Mission:
To stimulate the market to foster development of a coordinated, integrated, and innovative health-related program, focusing on health and well-being, in which providers, consumers and payors are educated in all components of health care; are empowered to improve performance; and are rewarded for positive behaviors affecting quality, costs, and outcome.

The Collaborative's Principles:
- Private and public sectors will work together to seek solutions.
- Private and public sectors should become proactive purchasers.
- Payors should be able to respond to and embrace changing health care markets.
- Providers should be held accountable for quality, service, and cost.
- Consistent standards should be applied across the marketplace.
- Consumers should be encouraged to make responsible and informed health care choices.
- Access to health care in rural Iowa should be promoted and stabilized.
- Activity should be in sync with the state health policy as not to desecrate local health care systems.

feel about the care they receive.

The survey is possible only because of the unusual structure of Des Moines' providers and purchasers. The Des Moines provider systems in the survey are comprehensive, fully integrated, and—most significantly—tend to have exclusive affiliations with their primary care physicians. By identifying an enrollee's primary care physician, it is possible to know the full range of providers who serve that person.

It's no longer enough to measure just plan performance, particularly when providers belong to multiple plans, says Community Health Purchasing Corporation president Paul Pietzsch. "Our hypothesis is that when you have plans that have all the providers in a community, what you're measuring is just averages," he says.

Several separate areas will be explored in the survey:

• The Basics: Information on how well plans ensure access to care, communicate with enrollees, and ensure providers are responsive will come from existing and ongoing data collection using Consumer Assessment of Health Plans Study surveys.

• Staying Healthy: Information on how providers and plans help people avoid illness and maintain their health will come from existing and ongoing data collection from the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of standardized measures developed by the Washington, DC-based National Committee for Quality Assurance.

• Getting Better/Living with Illness: The survey for the final area covered by the Iowa initiative has been developed by FACCT. It addresses how the plans or care systems operate when enrollees have either an acute or chronic illness.

The survey will zero in on finding out how the care systems work for people with asthma, diabetes, and coronary artery diseases. Purchasers have a slew of questions about how well the systems are educating patients to take control of these chronic diseases, says Mr. von Glahn of FACCT.

"Did the patients even get the education? No. 2, did they understand it? Did they have a degree of confidence that they can use it? No. 3 is, what are their actual behaviors? What are their outcomes? What are their symptoms? How much work or activities of daily living are they missing?"

Chronic conditions only now are coming into the forefront of quality assessment efforts because, up to now, there has been "fairly poor agreement" among providers on how they should be managed, Mr. Gill says.

Another factor piquing the interest of researchers is the literature suggesting some chronically ill populations, such as asthmatics, fare better in a managed care environment than in fee-for-service plans.

The survey will compare the performance for three care systems—Iowa Health System, the Secure Care/Mercy Health System, and the McFarland Clinic—and the two administrative agents that serve them, Principal Health Care of Iowa and the Medicaid program.

"It's exciting to us to slice it both ways," Mr. von Glahn says.

The so-called FACCT/One surveys are different from previous efforts by the company in that they will rely on self-reported survey data for clinical information, bypassing the cost, confidentiality, and coding issues posed by medical records review, says Mr. von Glahn.

"Part of what we're learning about is whether you can use a patient self-report instrument here in Iowa to do a nice job of reporting on quality."

For Mr. Gill, relying on self-reported data for clinical information is a concern "to some extent," but he is willing to explore how it can be used for quality assessment. Separate University of Iowa analyses of Medicaid care for the chronically ill will be stacked up against the FACCT/One data for a fuller understanding of the program, he says.

Contact Mr. von Glahn at (503) 223-2228, Mr. Pietzsch at (515) 277-1210, and Mr. Gill at (515) 281-5394. ■

Insurance reforms succeed without rocking markets

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"I think the only states with major market disruptions have been those that adopted pure community rating and all-products guaranteed issue in the individual market."

The Wake Forest study, funded by the Robert Wood Johnson Foundation in Princeton, NJ, contrasts with another academic work commissioned by the Washington, DC-based Health Insurance Association of America. In the HIAA study, the Center for Risk Management and Insurance Research at Georgia State University in Atlanta concluded that guaranteed-issue requirements coupled with community rating increased the likelihood people would be uninsured. In small employer groups, the increase was between 15.8% and nearly 29%. Similar requirements in the individual market raised the probability of being uninsured by between 5% and 11%. The HIAA study relied on analyses of the March 1998 supplement to the Census Bureau's Current Population Survey.

Although an HIAA spokesman had not yet seen the Wake Forest analysis, the association maintains that community rating, guaranteed issue, and benefit mandates raise the price of health insurance and therefore cause employers or individuals to drop coverage.

"Our concern has been and continues to be that there is an association between various state mandates and the rising number of uninsured, or precisely the likelihood that one will be uninsured in a particular jurisdiction," says HIAA spokesman Richard Coorsh.

Small-group market stable

The Wake Forest study involved in-depth interviews and insurance data analysis in each state. Although findings are reported separately for each state, taken together they indicate that small group markets remain highly competitive in price, product diversity, and number of carriers, the study authors say.

One key reason for this, Mr. Hall explains, is that there seemed to be no reservoir of severely bad risk waiting to flood the small-group market once the reforms were enacted. And good risk did not flee the market as markedly as people had feared it would.

"So the fear that you drive out the good risk and attract the bad risk just hasn't materialized," Mr. Hall says.

That is not to say the reforms have greatly expanded insurance enrollment. In New York, for example, the study concluded that even though insurance is now widely and readily available to any group regardless of health status, high prices have kept the reforms from generating a huge influx of new subscribers. Indeed, the percentage of New York workers with small-group coverage declined in the years following reforms. Still, the study concluded that the reforms stabilized the marketplace. "At least it can be said that the deterioration in the small group market that preceded these laws has been slowed, and possibly reversed," the study said.

> Reforms have made insurance more available, though not necessarily more affordable.

The greater the reach of the reforms in the individual market, the greater the disturbances to the marketplace, Mr. Hall says. For example, the more a state limited an insurer's ability to vary prices from a community rate, the more likely it was that insurers suffered adverse selection or left the market entirely, he notes.

"It's not that everybody pulls out," Mr. Hall explains, "but most of the commercial indemnity insurers will pull out if you adopt pure community rating."

In Vermont, for example, the study concluded that giving commercial insurers the flexibility to vary rates 20% above or below the community rate has helped keep them in the market and avoid possible adverse selection.

While reforms in the individual market have, on balance, clearly raised prices and lowered enrollment, Mr. Hall says the reforms may nevertheless have achieved some of their goals. They have spread insurance risk, particularly removing bad risk from Blue Cross plans, and made insurance available (although not always affordable) to people previously excluded from the market.

In each of the states, the study found subtle or perhaps illegal attempts to circumvent the reforms, notably "field underwriting," in which insurers encourage agents to screen out applicants known or suspected to be higher risks.

Agents use questionable tactics

Indeed, some of the most revealing reading in the state analyses are quotations from agents or insurance company officials given anonymity. In the Florida report, for example, one agent is quoted as describing how insurers become more cooperative and helpful to agents who send them good risk:

"They get things accomplished for you and in return they unsubtly or subtly ask you to be careful what you send them. . . . It's not anything official. It's nothing written. It's nothing official. It's more or less, I scratch your back, you scratch my back."

The Florida analysis also found that insurers slashed the commissions of agents who enrolled "micro groups," which have one to three employees and are considered higher-risk and more costly to sell and administer. In July of 1998, the Florida Department of Insurance issued a directive prohibiting insurers from lowering commissions based on small group sizes. It also warned against slow processing of applications.

Finally, Mr. Hall notes that many state-level insurance reforms came in the early to mid-1990s, as the economy emerged from a recession and labor market conditions encouraged employers to offer health benefits in order to attract workers.

Full text copies of the Wake Forest analyses will be made available on the World Wide Web at www.phs.wfubmc.edu/insure/. The HIAA report is available at www.hiaa.org/newsroom/custerreport.pdf. ■

Proposed Aetna-Prudential megamerger shows why antitrust is now turf of state regulators

Managed care megamergers have state officials flexing their regulatory muscles, weighing in on matters states traditionally have left to federal officials.

The most recent proposed merger on the radar screen was announced in late December between Aetna U.S. Healthcare and Prudential HealthCare. State officials who were nonplussed by United HealthCare and Humana's ill-fated betrothal last summer were at attention when Aetna and U.S. Healthcare followed suit in late December.

"My sense is that public concern has gotten greater because the bloom may be off the rose with regard to managed care," says Boulder, CO-based health policy analyst Patricia Butler.

Is bigger better?

After the merger proposal between United and Humana fizzled, the National Academy for State Health Policy responded to a concern about how the trend toward such mergers would affect local health care marketplaces. The Academy's report, "Is Bigger Better? Legal and Policy Issues in Health Plan Mergers: A Guide for State Health Policy Makers," was published literally within days of the announcement between Aetna and Prudential.

Ms. Butler, the report's author, chronicled a growing trend of states exercising statutory or common-law oversight over health plan mergers. While some states concentrate on companies incorporated locally, some have a more active tradition of health plan review.

Missouri made antitrust a high priority under former Insurance Commissioner Jay Angoff. During a term that ended in October 1998, Mr. Angoff placed conditions on two HMO mergers and ordered divestiture in a third.

"There's a bit of momentum because states have gotten what they need in these settlements," observes Ms. Butler.

Although an Aetna-Prudential merger would not create "large areas of concentration in Missouri, the state Department of Insurance probably will hold hearings on the proposal," department spokesman Randy McConnell says.

The Aetna-Prudential announcement is so recent that many states have not yet crafted a response. Traditionally, state governments leave primary state oversight to regulators in which the affected plans are domiciled. In this case, the responsibility falls to Texas, home to Aetna U.S. Healthcare Inc., Aetna U.S. Healthcare of North Texas, and Prudential Health Care Plan. In a state HMO market of about 3.9 million enrollees, the two Aetna plans have enrollments of about 117,000 each and Prudential has half a million, Department of Insurance spokesman Jim Davis says.

> "My sense is that public concern has gotten greater because the bloom may be off the rose with regard to managed care."
>
> Patricia Butler

State law in Texas follows typical National Association of Insurance Commissioners guidelines and requires approval of a plan merger unless one of six specific conditions are met, says Mr. Davis:

- The newly formed company would not be able to write business in the state.
- The merger would substantially lessen competition.
- The acquiring party might jeopardize the operations of the acquired company.
- The plans of the acquiring company are not in the public interest.
- The competence or integrity of the acquiring party are in doubt.
- The acquisition would violate state or federal law.

While an approval can be issued without outside comment, state law allows a denial only after a public hearing is held.

The response to a proposed merger will vary according to local market conditions, Ms. Butler says. A comparison of responses to the United-Humana and Aetna-Prudential deals bears her out.

The Illinois Hospital and Health Systems Association vigorously opposed the United-Humana merger, but will sit on the sidelines in the latest debate.

"We did oppose the United-Humana merger because of anti-competitive effects," says association assistant vice president Karen Porter, "but we do not believe this one will have such effects."

The Florida Hospital Association spurred a state-sponsored hearing on the United-Humana merger late last summer, but the Aetna-Prudential proposal doesn't pose enough of a threat to warrant the association's concern, FHA vice president Kim Streit says. Florida Department of Insurance officials have not yet decided whether to hold hearings on the Aetna-Prudential merger.

Define your terms

States looking for a legal leg to stand on in any potential challenge to the merger must understand how the courts are likely to define the market for health insurance. The courts tend to define the market broadly, Ms. Butler says, thus dampening the perceived anti-competitive impact of any health plan merger.

One of the biggest wild cards is how the courts will treat self-insured plans, estimated by the Washington, DC-based Employee Benefit Research Institute (EBRI) to cover one-third of all people nationally with employer-sponsored health benefits. One of the biggest attractions to self-insurance is exemption from state regulation under the federal Employee Retirement Income Security Act of 1974.

In New Jersey, Aetna U.S. Healthcare and the recently acquired NYLCare

Health Plans control about 35% of the state's HMO enrollees. The addition of Prudential would boost HMO market share by a little less than 5% and bring the company's HMO enrollment to about 1 million.

Reliable estimates of the impact of self-insurance aren't available on the state level, but EBRI senior research associate Paul Fronstin suggests New Jersey reaches at least the national average.

The decision of whether to include the huge self-insured market in an antitrust analysis depends upon how readily self-insured employers would give up their plans for a licensed insurance product.

"Part of what we don't know is how willing employers are willing to switch back and forth," Ms. Butler says. "If they're willing to switch, they're part of the market."

Mr. Fronstin argues there's a huge potential for self-insured employers to switch. He says proposals in the first Clinton administration to cap insurance premiums at 7% had a large number of self-insurance employers considering a switch.

In addition, says Mr. Fronstin, megamerger companies can offer uniform benefits throughout the county, eliminating one reason many companies choose to self-insure.

Contact Ms. Butler at (303) 440-0586 and Mr. Fronstin at (202) 775-6352. ■

Kaiser must cover Viagra in its health policies, says California Department of Corporations

Kaiser Foundation Health Plan must cover Viagra in the health insurance policies it writes within California, says a December 1998 order from the state's Department of Corporations.

At the same time, the Oakland, CA-based HMO is making financial and other reparations, under an agreement reached with state officials, for previously restricting access to the drug.

Kaiser may request a hearing on the coverage decision. Meanwhile, the company is implementing a 50% copay for the drug in its 1999 renewal contracts, company spokesman Tom Debley says.

While disappointed with the coverage decision, Mr. Debley claimed a victory in sparking public debate over the coverage of so-called "lifestyle drugs," those that do not address an immediate threat to the life or health of an individual.

"There seems to be a debate, at least based on the number of calls I've gotten this week," Mr. Debley tells *State Health Watch*.

Drug access as a policy issue

The state's order on the coverage question rejected Kaiser's clinical and financial arguments for an exemption for Viagra. A statement from Dale Bonner, Commissioner of the Department of Corporations, maintains that state officials share "the growing concerns regarding rising costs" but says prudent public policy tips the scale "in favor of increased access to prescription drug benefits."

Specifically, Mr. Bonner noted that an HMO's mandate to provide medically necessary drugs could not be waived simply when, as Kaiser argued in the case of Viagra, medical necessity is "difficult" to determine. While upholding the use of certain cost-saving measures, Mr. Bonner said state law regulating HMOs "discourages, and in some cases, prohibits limiting access to care based substantially on financial considerations." Finally, the state rejected Kaiser's claims that Viagra coverage would increase rates and questioned whether a hike in rates would even be sufficient cause to exclude the drug.

HMOs required to pay for nonformulary drugs

A separate order, also announced in late December, outlines the remedial steps Kaiser must take for "certain management decisions" between April 1998 to September 1998 that "may have discouraged physicians from writing Viagra prescriptions in a manner requiring Kaiser to pay for it." Under California law, HMOs are required to pay for formulary drugs as well as nonformulary medically necessary medications. Although the Food and Drug Administration approved Viagra in April 1998 as a treatment for male sexual dysfunction, state officials say Kaiser did not approve the drug and put it on its formulary until five months later.

Under the order, Kaiser will:

• pay the state $250,000, part of which covers the department's costs associated with the investigation;

• resolve all currently pending member grievances related to the coverage of Viagra;

• inform its members of its coverage policy regarding prescription drugs for sexual dysfunction before April 1, 1999;

• before Feb. 15, 1999, inform each of its members who received a prescription for Viagra that was filled by Kaiser's pharmacy between April 8, 1998, and Sept. 21, 1998 (the period from the time Viagra was approved by the FDA until the drug was added to the plan's formulary) about Kaiser's current policy regarding prescription drugs for treatment of sexual dysfunction and resolve any grievances that result;

• maintain Viagra as a covered drug on its prescription drug formulary unless, in the normal course, it would be removed from the formulary.

Kaiser originally estimated the total annual cost of adding Viagra coverage at $100 million for its enrollees nationwide, the majority of whom are in California. Declining demand for the drug lowered estimates to $60 million, with the 50% copay dropping that figure to $20 million to $30 million, Mr. Debley says.

Contact Mr. Debley at (510) 987-3291 and the California Department of Corporations at (916) 323-7120. ■

Robert Wood Johnson Foundation to distribute grants to get kids connected with health coverage

Twenty states will begin projects designed to increase access to insurance coverage for children as part of a $47 million Robert Wood Johnson Foundation grant program.

Grants in the first round of the Covering Kids Initiative range from about $600,000 to $1 million. Eligible activities include streamlining application and eligibility verification processes, formalizing referral systems, and creating statewide education efforts.

"Experience has shown that simply creating coverage programs for children is not enough," foundation program officer Judith Y. Whang said in a statement announcing the grants.

In an effort to encourage coordination among interested organizations, the foundation accepted only one application per state, said project deputy director Vicki Grant, PhD. She said the Covering Kids Initiative will provide up to 51 three-year grants ranging in size from $500,000 to $1.5 million. Of the $47 million available, $42 million is for programs and $5 million is for technical assistance.

Ms. Grant said the project has three goals:

• to find ways to identify and enroll currently uninsured children into available coverage;

• to simplify the application process of existing programs;

• to coordinate existing sources of coverage.

The foundation originally had allocated $13 million with an application deadline of May 1, 1998. The applications "were of such good quality, the board decided to expand the program," Ms. Grant said. In addition, the application deadline was extended to Jan. 15, 1999, to give North Dakota, South Carolina, South Dakota, Vermont, Virginia, and Wyoming an opportunity to apply.

Contact the Covering Kids office at (803) 779-2607. ■

Advocates blame confusion about welfare, Medicaid for increasing number of uninsured children in PA, NJ

The number of children covered by government-funded health insurance declined in Pennsylvania last year, even as almost 13,500 were added to the rolls of the state's Children's Health Insurance Program (CHIP).

The boost in CHIP enrollment wasn't large enough to offset a drop in the number of children participating in Medicaid, down 18,000 to 689,000, reports *The [Philadelphia] Inquirer*.

While children's advocates suspect that welfare reform has deterred parents of eligible children from participating in Medicaid, state officials hypothesize that a healthy economy has brought private-sector health insurance to the families of former welfare recipients.

"I know that we will make every effort to keep everyone on," says Peg Dierkers, policy director for the Pennsylvania Department of Public Welfare.

A more prevalent explanation among health policy analysts is that government officials and former welfare recipients alike often mistakenly believe that federal welfare reform curtailed Medicaid benefits as well as cash assistance.

"There may be more problems coming around as even greater numbers of families lose welfare," says Cindy Mann, a senior fellow at the Center on Budget and Policy Priorities in Washington, DC.

Many parents lack job benefits

Experts cite studies showing it is unlikely that many children who leave Medicaid are getting health insurance through their parents' jobs. If their parents are working, the experts say, the jobs often are low-paying with few benefits.

"The problem is that many families seem to have lost their Medicaid coverage because they do not understand that coverage can continue, in most cases, even when welfare checks stop," says Lynn Yeakel, the Philadelphia-based regional director for the U.S. Department of Health and Human Services.

Neighboring New Jersey also is struggling to keep children covered. The state's CHIP program, called NJ KidCare, signed up about 21,500 children since last year, according to state officials. At the same time, though, the Medicaid program lost about 28,000 children since 1997. The state even expanded the number of children eligible for Medicaid last year, but has continued to see enrollment fall, although more slowly.

About 200,000 Pennsylvania children and 150,000 New Jersey children who currently are not insured would qualify for government health insurance.

State officials in Pennsylvania and New Jersey are stepping up efforts to make sure all eligible children get health insurance. They are mailing out information, increasing television ads, and beefing up efforts to make sure children keep their Medicaid benefits when their parents leave welfare. In addition, each state received a first-round award in a Robert Wood Johnson Foundation program called Covering Kids, an initiative targeted to increasing health insurance coverage among children. (See related story, above.) ■

Wisconsin slows long-term care reorganization; advocates worry about pooling program funds

State officials in Wisconsin are decelerating their plans to funnel millions of government dollars for nursing home and outpatient services through a single point of entry.

"The reason we're slowing down is a political concern, frankly," says long-term care policy analyst Lorraine Barniskis in the state's Department of Health and Family Services. "We're down to the wire, and support is not unqualified."

The massive Family Care initiative would funnel approximately $200 million of the state's $2 billion long-term care budget through "one-stop" shopping entry points at the county level. Information and assistance about available services will be funneled through clearinghouses called Aging and Disability Resource Centers. The heart of the proposal envisions "care management organizations," entities that will receive a capitated amount based on an enrollee's level of functional disability and broker the wide variety of services available to that person. An enrollee's participation in the program is voluntary.

The plan proposed by Gov. Tommy Thompson in his State of the State address in late January lowers the mid-2001 target covered by Family Care from 50% of the state's population to 25%. The revised schedule calls for 12 resource centers serving 14 counties by then.

Two major concerns appeared to slow implementation. Counties have the right of first refusal to serve as care management organizations, and may operate without competition for two years. After that, however, counties will have to compete with other entities for the job.

"They were concerned that they'd come in and work out all the bugs, and then have to turn it over," says Rob Gundermann, public policy coordinator for the Wisconsin Alzheimer's Association Chapter Network.

The Alzheimer's association and many others involved in long-term care services are worried that that the impact of currently restricted funds may be diluted when the money is combined in a larger budget item. For example, the Alzheimer's association is fighting to keep the state's $1.8 million Family and Caregiver Support Program separate.

"It's not a big number, but it's important. We would support Family Care if we could keep the [support] program separate," says Mr. Gundermann.

The revised program calls for $11.8 million in planning, information technology, and other start-up costs in the next two years, Ms. Barniskis says. Approximately 100,000 people are receiving some publicly funded long-term care, according to state estimates.

Contact Ms. Barniskis at (608) 267-5267. ■

Clip file / Local news from the states

Each month, this column features selected short items about state health care policy from publications from around the country.

Connecticut moves to strengthen patient privacy protections

HARTFORD, CT—Connecticut legislators want to "plug the holes" in the state's medical records regulations that allow drug companies or medical supply companies to solicit patients regarding products directly related to their medical conditions.

"What happens to your medical records is enough to make you sick," said state Sen. Kevin B. Sullivan, the Senate's top Democratic leader.

Mr. Sullivan said the plan is to provide strict prohibitions on the commercial sale or transfer of any medical records except when specifically authorized by a patient for medical purposes. Lack of congressional action on the issue has left the states to take up the slack, he said. The proposal is slated for the spring 1999 session.

A former head of the Connecticut State Medical Society, Michael Deren, MD, attributed the widespread use of medical information to the blanket medical information release that many health maintenance organizations and insurance companies now require. The release allows far too many people far too much access to those records, he said.

A spokesman for the Association of Connecticut HMOs challenged the need for additional privacy protection. Health insurers and providers also must meet "very strict guidelines [on maintaining privacy] in order to get and maintain accreditation" from national agencies, said association lobbyist Keith J. Stover.

Estimates on the profits made on the use of medical records or the cost of enforcing stricter privacy provisions were not available.

— *New Haven Register*, Dec. 30, 1998

Managed care, behavioral health top legislative agenda

WASHINGTON, DC—Provider regulation, managed care, and behavioral health top the list of topics expected to be considered by the states and the District of Columbia in their upcoming legislative sessions.

An informal survey of legislative and executive staff members by the National Conference of State Legislatures shows that virtually every legislature will take up one of these three issues. Other hot issues are long-term care and children's insurance.

Pharmaceuticals are likely to be on the agenda in 41 states and the District of Columbia, with a focus on drug formularies in 25 states.

A state-by-state summary of the results is available from the National Conference of State Legislatures at (202) 624-3567.

Clinton backs plan to expand Medicaid for disabled

WASHINGTON, DC—Proposals to help get the disabled back to work by expanding their health insurance options through Medicare and Medicaid received a high-profile boost from President Clinton in his state of the Union address.

Specifics released earlier called for a $2 billion five-year jobs program that would be the most significant legislation affecting the disabled since enactment of the Americans With Disabilities Act in1990.

The centerpiece of the plan is a $1.2 billion "work incentives" initiative. It would provide grants to states that allow disabled people who return to work to maintain eligibility for Medicaid. The disabled whose earnings or assets are above federal income limits would be able to buy health insurance through Medicaid. And, for the first time, Medicare coverage would be extended to people with disabilities who return to work.

About 1.6 million working-age adults have a disability that leads to functional limitations, and 14 million working-age adults have less severe (but still serious) disabilities, including the use of a wheelchair, cane, or walker, or a developmental disability. Many of them can work if there is an incentive to do so, advocates for the disabled said. Officials estimated that the proposal could allow tens of thousands to return to work.

The proposal also includes a program that offers Medicaid to people who have physical or mental impairments that are expected to lead to severe disability.

This plan, which would be tested on a limited basis, would include people with muscular dystrophy, Parkinson's disease, HIV, or diabetes who may be able to function and work with appropriate health care, but who, under current rules, get the care only after their conditions have become severe enough to qualify them for disability coverage, Medicaid and Medicare.

Congressional sponsors of the initiative are Sen. James M. Jeffords (R-VT) and Sen. Edward M. Kennedy (D-MA).

—*Boston Globe*, Jan. 13

States prefer public providers for behavioral health carve-outs

FAIRFAX, VA—All but four states are implementing some type of managed behavioral health care, according to a tracking analysis by The Lewin Group in Fairfax, VA.

The report, completed for the Substance Abuse and Mental Health Services Administration, documents how state strategies for delivering behavioral health differ by whether state officials are providing care through an integrated plan or through a behavioral health carve-out. When states provide behavioral health through an integrated plan—where such benefits are integrated into physical health benefits—the behavioral health provider most likely is in the private sector. When states carve out behavioral health care services, the providers are more likely to be in the public sector.

Of 53 state mental health and/or substance abuse carve-out plans analyzed in the study, 30 are managed by public sector agencies or public/private partnerships. By comparison, 76% of the integrated plans contract with private-sector organizations for behavioral health.

The dominance of public health providers in the state's carve-out plans likely "reflects a greater participation of the mental health and substance abuse stakeholders in the process," Lewin senior manager Gail K. Robinson, PhD, tells *State Health Watch*.

The use of carve-outs appears to have grown in recent years, but Balanced Budget Act provisions mandating choice of provider in public programs may affect that trend, Ms. Robinson says.

"We need to watch very closely how the Balanced Budget Act will be interpreted and implemented," she says.

The report also found that most states placed behavioral managed care entities at risk, even if those organizations are in the public sector. If the providers do not also own the managed care entity, providers are paid fee for service and do not assume risk, the report found.

—Lewin release, Dec. 1, 1998

Contact Ms. Richardson at (703) 218-5602.

Managed care can improve Medicaid dental services

PORTLAND, ME—How states are beginning to measure and improve their dental services under Medicaid is described in a new report from the National Academy for State Health Policy.

"Dental Care in Medicaid Managed Care: Report from a 19-State Survey" details the kinds of services provided under selected state Medicaid programs and how states are beginning improve access to dental care.

"Managed care offers an opportunity for Medicaid agencies to improve the delivery of dental care," concludes the report by Neva Kaye, the Academy's director of the Medicaid Managed Care Resource Center, and policy analyst Cynthia Pernice.

As with medical benefits, states increasingly are turning to utilization data, consumer satisfaction surveys, and financial data to measure the performance of their dental managed care programs. In addition, states are holding plans to standards on such measures as waiting time for dental appointments and providers' ability to communicate in different languages.

While all Medicaid programs must offer dental services to children as part of their Early and Periodic Screening, Diagnosis, and Treatment program, the authors note that 11 of the 19 states surveyed also offer comprehensive adult dental benefits.

A complete copy of the report is available through the Academy at (207) 874-6524.

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Providers sue Ohio officials over failure of Medicaid HMO

COLUMBUS—Physicians and hospitals claiming as much as $15 million in losses from the failure of a Medicaid HMO are suing Ohio officials for inadequate oversight of the plan.

The Ohio State Medical Association and the Association for Hospitals and Health Systems brought the suit in the Ohio Court of Claims over the failure of Personal Physician Care, once the largest Medicaid HMO in Cuyahoga County. It had more than 55,000 subscribers in 1997 and was shut down by the Ohio Department of Insurance in August 1998.

Some providers say that, in addition to the losses they have sustained, they have been asked to return some of what they were paid as part of the company's liquidation.

The plan also operated in Akron and Youngstown. Among the hospitals financially hit by the closure are Rainbow Babies and Children's Hospital in Cleveland and Children's Hospital Medical Center of Akron.

Regulators should have known the health plan was in financial trouble and intervened earlier, the lawsuit alleges.

The state now requires all Medicaid beneficiaries in urban counties (except the disabled) to sign up for a health maintenance plan. The HMO program is voluntary in the rest of Ohio.

This issue of *State Health Watch* brings you news from these states: