State Health Watch
The Newsletter on State Health Care Reform
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The tangled web of Medicaid and the states: Both may need fixing

The best short-term solution for Medicaid's financial problems is a significant infusion of additional federal funds, according to Alan Weil, New Federalism program director at the Urban Institute in Washington, DC.

Long-term improvement, he added, means the structural reform of the Medicaid program.

Speaking in Washington, DC, at a Jan. 7 Robert Wood Johnson briefing on "Forum on Health Care Spending and Medicaid: The Challenges Facing Medicaid," Mr. Weil said, "The real problem with Medicaid is that there is a fundamental mismatch between what we ask it to do and what it costs to do it. In addition, there is a design flaw in asking states with cyclical revenues but balanced budget requirements and shrinking sales tax bases to bear the cost of a program that has grown and inevitably will continue to grow faster than the economy."

Mr. Weil, who once directed Colorado's Medicaid program, said Medicaid can't save very much money by relying on the traditional cost-saving techniques used in private plans, such as increasing copayments and deductibles, and scaling back services. For instance, he said,

*See **cover story** on page 2*

Though tempting, many say not cutting costs is the road to economic recovery for the states

While most agree that the impact on the health is the biggest ramification of state Medicaid cuts, a Families USA study points out that cuts in Medicaid spending hurt state economies because of the "multiplier effect."

Fiscal Fitness: How States Cope

Kathleen Stoll, associate director of health policy analysis for Families USA in Washington, DC, defines it as state actions to cut Medicaid that would cause significant reductions in their state's jobs, wages, and business activity.

"Cuts to the Medicaid program are shortsighted," says Families USA executive director Ron Pollack. "Medicaid is a powerful stimulus to state economies, and Medicaid cutbacks will exacerbate states' economic problems."

Ms. Stoll says that while many people are aware of the health impacts of Medicaid cuts, less understood is the unique role that Medicaid plays in stimulating state business activities and state economies.

*See **Fiscal Fitness** on page 4*

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Cover story

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85% of Medicaid prescription drug costs are associated with elderly and disabled enrollees, many of whom have multiple chronic conditions requiring multiple medications. Eligibility thresholds for these enrollees generally are below the poverty line for those who aren't in nursing homes, he said, and most Americans "would agree that these vulnerable populations have limited resources and cannot afford to pay substantially more for their drugs."

Likewise, according to Mr. Weil, Medicaid can't save much by cutting eligibility in areas where cuts are normally considered. "If you want to save larger sums, you must cut eligibility for the elderly and disabled where the costs are higher, but the consequences of such cuts are more obvious and more grave."

And, he said, cuts in Medicaid ultimately may not save states very much money at all because they have used the program to refinance many costs that were historically borne entirely by states or local governments, bringing them under Medicaid and thus sharing their costs with the federal government. "Cutting a person or service out of the Medicaid program likely means that the cost associated with that person or service will be shifted to another state program, to a county indigent care system, to a service provider struggling to survive."

While Mr. Weil said it's likely that most states will again do what they've always done in tough times — cut provider payments and use some combination of eligibility and benefits cuts to save enough money to get through — the only real fix should be substantial additional federal funds, not as a bailout but "simply to avert grave hardship among the poor, elderly, and disabled, which in my view is an appropriate fiscal priority for the national government."

While some would look at Medicaid's problems and say the program is broken, Mr. Weil said it is working exactly as designed. "It has its flaws, but on the whole, it provides access to health care services to tens of millions of the most economically and medically vulnerable Americans; it has low administration costs, pays low market rates to providers, and provides substantial funding to those who serve the uninsured. . . . States are not to blame for a Medicare program that fails to meet the basic needs of elders and shifts those costs to the states, and they are not to blame for the complete absence of a national system of financing the cost of long-term care in a country where medical improvements have increased life expectancy for people with a range of disabilities and increased the burden of the health care system."

In the long run, according to Mr. Weil, Medicaid would benefit from fundamental reforms in the overall health care system that yield better efficiency on quality, better coordination of care, universal coverage, and direct support of the health care safety net. "It would also benefit from a fundamental restructuring of fiscal responsibilities between the states and the federal government."

Another program panelist, Ray Scheppach, executive director for the National Governors Association in Washington, DC, said problems facing states are very different from those states have dealt with in the past. "The reason that the situation is so bad even though the economy isn't that bad is that the problems are mostly structural in nature. We have a huge structural problem on the revenue side and a huge structural

problem on the spending side."

Mr. Scheppach said the problem on the revenue side is that states have tax systems geared to the manufacturing economy of the 1950s, and not to the high technology, service-oriented economy of the 21st century. The largest tax source for states usually is the sales tax, which generally is applied on transactions involving goods, but not on services, even though goods are not growing very rapidly and services are. In addition, he said, Internet sales are increasing but they and mail-order sales undercut the sales tax because states can't compel out-of-state sellers to collect sales and use taxes. A third revenue problem he identified is the drop in corporate profits from 8% of total revenue to about 4%.

He said he has traced statistics back to World War II and has been unable to find another year in which state revenue numbers were negative for the entire year. And yet in 2002, he said there was a reduction in state revenues of 6.3%, and "that's a pretty traumatic change."

Problems are structural

Even when the economy comes back, things will get slightly better, but not a lot better because the problems are structural in nature. Mr. Scheppach said he expects states to start reevaluating what their core services are, which may lead to more consolidation of agencies and more downsizing. He also noted that tax reform is difficult at the state level, although there may be some efforts to expand taxes on services.

"Even if states fixed their tax systems and did some serious downsizing, they still are not going to have the fiscal capacity to handle Medicaid. And the basic problem, I think, is that a lot of costs that should be part of Medicare essentially have been shifted to the states." Mr. Scheppach also called for additional federal money to help states get through the current problem and then a long-term shift of responsibility for dual eligibles and long-term care back to the federal government.

Congress may tackle Medicaid

Congressional staff members who spoke on background at the presentation offered a cautious view of how Congress is likely to react to the recommendations made by Mr. Weil and Mr. Scheppach. There was a suggestion that since Medicaid serves diverse populations, there needs to be a multipronged approach to looking at how best to use available resources. One effort might be to pursue the notion of offering different kinds of waivers so that resources can be better spent. And it seems clear that a lot of attention will go to enactment of a Medicare prescription-drug bill, with the possibility that dual eligibles could be federalized in that bill.

There has been talk in Washington of appointment of a Medicaid commission, but it is recognized that a commission could not complete deliberations and make recommendations in time to have a positive impact on state budgets now being developed. However, the congressional staff thought it might be a useful vehicle for looking at long-term structural changes.

Those present indicated that simply throwing more money at Medicaid would not be a valid solution, but they also indicated there may be recognition that Medicaid issues have not been addressed for a long time and the state financial problems are so great that there need to be efforts at a bipartisan solution.

That discussion of Medicaid financial problems was put into perspective a week later when the Kaiser Commission on Medicaid and the Uninsured released its latest state survey detailing state budget problems. Commission executive director Diane Rowland told a Jan. 13 briefing in Washington, DC, that Medicaid's 12.8% increase last year is comparable to the 12.7% increase in private health insurance premiums in the same time period, meaning that what we're seeing is a "return to rising costs that now will be absorbing more and more of the program's resources." She said that 60% of the growth in federal Medicaid expenditures from 2001 to 2002 occurred on behalf of the elderly and disabled populations.

John Holahan, director for the Health Policy Center at the Urban Institute, reporting on several case studies, said states have responded to fiscal pressures by protecting K-12 education, cutting higher education a bit, and making a number of one-time fixes such as across the board reductions in agency budgets, salary freezes for state employees, reductions in state work forces, cuts in aid to local governments, and delay in capital construction. On the revenue side, he said, there was little in the way of tax increases. Rather, states used rainy-day funds or other reserves, as seen in the fact that nationally reserves have fallen from 10.4% of state expenditures in 2000 to 2.3% in 2003, and in many states are very close to zero.

There are significant differences today, he said, from conditions during the recession in the early 1990s. Then states cut payment rates and optional benefits, much as they are doing today, but they also discovered disproportionate share payments and ended up bringing in a lot more federal dollars with no state contribution. And eventually they increased taxes.

"This recession is pretty different for a number of reasons," he said. "One, revenue declines the states are

facing are much greater than they were back then. One estimate has them as a shortfall of 9% in FY 2003, and nothing like that was seen in a previous recession. Compared to back then, education, particularly at the K-12 level, is a much higher priority. And it's also protected by law. Further, the opposition to tax increases is incredibly strong."

Vern Smith, PhD, principal for Health Management Associates in Lansing, MI, reported on a survey of state Medicaid directors that indicated their spending is now increasing much faster than the rate of growth authorized by their legislatures. Although there was a 12.8% spending increase nationally last year, the program has only been authorized for a 4.8% boost this year, but Medicaid directors told Mr. Smith they were expecting to see a 9% increase.

"One reason for the higher spending increase is that Medicaid enrollment is going up faster than had been anticipated," Mr. Smith said. "Since the beginning of FY 2003, 37 states have taken midyear budget reduction actions in Medicaid. These 37 states include 32 that did not have specific Medicaid cost reduction actions in the FY 2003 budget, but are now undertaking them."

The largest group of states, he said, was taking action to try to control the rate of growth in prescription drugs. Many added additional classes of drugs to their preferred drug list, or additional classes of drugs subject to prior authorization, or reduced the price that they would pay for the products. And a couple of states increased copays. Twenty-one states took action to freeze or reduce provider payments, and 15 undertook further actions to restrict or cut Medicaid eligibility. Sixteen states reduced the benefits that were covered, with dental coverage for adults getting most of the attention. Four states looked at beneficiary copayments.

"In every way that states can cut Medicaid or control the rate of growth in Medicaid, there are more states undertaking that action now than a year ago," Mr. Smith declared.

But even with all the steps states are taking to cut costs and maximize Medicaid revenue, he said that most states contend it will not be enough to keep Medicaid spending within its legislative authorization. "Forty states told us they now expect a Medicaid shortfall in this fiscal year," he declared. When Mr. Smith asked the Medicaid directors to look ahead to FY04, they were not optimistic.

"The expectation is that there will be further cuts in benefits, eligibility, and provider rates," he said. "Even on the heels of the cutting that has taken place over the last year or two and even though Medicaid providers may not have had a rate increase for two or three years, . . . Medicaid directors communicated a sense that next year will be very difficult, but that Medicaid is just one of the programs in state government that will be constrained because of the state budget situation. As one Medicaid director said, 'What we have is not just a Medicaid problem. What we have is a problem of an economic downturn and a revenue shortfall.'"

[Contact Mr. Weil and Mr. Holahan at (202) 833-7200, Mr. Scheppach at (202) 624-5300, Ms. Rowland at (202) 347-5270, and Mr. Smith at (517) 482-9236.] ■

Fiscal Fitness

Continued from page 1

"Every dollar a state spends on Medicaid pulls new federal dollars into the state — dollars that would not otherwise flow into the state. These new dollars pass from one person to another in successive rounds of spending. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of the auto dealership, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. Economists call this the multiplier effect."

The magnitude of the multiplier effect varies from state to state, depending on how the dollars will be spent initially and on the economic structure of, and conditions in, the state, according to the report. And because of the multiplier effect, the aggregate impact of Medicaid spending on a state's economy is much greater than the value of services purchased directly by the Medicaid program.

Ms. Stoll used an input-output model created by the Department of Commerce to capture the specific economic conditions in each state and calculate the new economic activity that will be generated by Medicaid spending in business activity (the increased output of goods and services), employment (the number of new jobs created), and employee earnings (wage and salary income associated with the new jobs created).

Among the key statistics revealed in the report:

- In fiscal year 2001, the 50 states spent a combined total of nearly $97.7 billion on Medicaid and

(Continued on page 6)

Economic Losses* for Each $1 Million Cut in State Medicaid Spending, FY2003

State	Business Activity Lost Per $1 Million Cut in Medicaid Spending[1]	Jobs Lost Per $1 Million Cut in Medicaid Spending	Employee Wages Lost Per $1 Million Cut in Medicaid Spending
Alabama	$ 4,930,000	54.66	$ 1,830,000
Alaska	2,570,000	24.70	940,000
Arizona	4,220,000	44.79	1,600,000
Arkansas	5,410,000	64.64	1,980,000
California	2,380,000	20.75	870,000
Colorado	2,290,000	24.02	860,000
Connecticut	2,110,000	18.66	790,000
Delaware	1,960,000	16.51	640,000
Florida	3,060,000	34.35	1,180,000
Georgia	3,350,000	32.66	1,220,000
Hawaii	2,900,000	28.55	1,100,000
Idaho	4,520,000	56.25	1,740,000
Illinois	2,440,000	22.05	850,000
Indiana	3,340,000	36.19	1,200,000
Iowa	3,460,000	42.35	1,280,000
Kansas	3,130,000	35.10	1,090,000
Kentucky	4,590,000	49.14	1,610,000
Louisiana	4,870,000	55.20	1,770,000
Maine	3,730,000	45.67	1,430,000
Maryland	2,270,000	21.86	800,000
Massachusetts	2,190,000	19.14	780,000
Michigan	2,510,000	25.99	930,000
Minnesota	2,200,000	23.75	840,000
Mississippi	6,250,000	71.78	2,280,000
Missouri	3,430,000	33.52	1,120,000
Montana	4,900,000	63.88	1,830,000
Nebraska	2,960,000	34.49	1,080,000
Nevada	2,070,000	19.96	810,000
New Hampshire	2,030,000	20.25	720,000
New Jersey	2,270,000	18.20	790,000
New Mexico	5,720,000	67.03	2,140,000
New York	2,090,000	17.41	720,000
North Carolina	3,640,000	38.80	1,320,000
North Dakota	3,880,000	47.58	1,400,000
Ohio	3,120,000	33.69	1,130,000
Oklahoma	4,980,000	61.78	1,810,000
Oregon	3,060,000	32.14	1,130,000
Pennsylvania	2,740,000	26.39	960,000
Rhode Island	2,420,000	24.65	860,000
South Carolina	4,780,000	50.95	1,740,000
South Dakota	3,570,000	45.28	1,350,000
Tennessee	3,990,000	38.35	1,420,000
Texas	3,570,000	35.37	1,290,000
Utah	5,270,000	59.67	1,920,000
Vermont	3,090,000	36.80	1,150,000
Virginia	2,280,000	22.73	800,000
Washington	2,080,000	20.36	770,000
West Virginia	5,160,000	56.70	1,770,000
Wisconsin	2,810,000	32.83	1,090,000
Wyoming	2,790,000	34.70	1,060,000
Average of 50 States	**$ 3,387,600**	**36.85**	**$ 1,235,800**

*Losses were calculated by employing economic impact multipliers that incorporate both the federal matching multiplier and the RIMS II economic output multiplier.

[1] "Business Activity Lost" predicts the total change in economic activity, measured in value of goods and services produced, per one million dollar change in state Medicaid spending.

Source: Families USA, Washington, DC.

that investment generated an almost three-fold return in state economic benefit — $279.3 billion in increased state-level output of goods and services from increased business activity.

- The 10 states with the highest rate of return for every state dollar spent on Medicaid in FY01 were:
  - — Mississippi ($6.34 in new state business activity per dollar of Medicaid spending)
  - — New Mexico ($5.76)
  - — Oklahoma ($5.46)
  - — Utah ($5.35)
  - — West Virginia ($5.25)
  - — Montana ($5.14)
  - — Arkansas ($5.11)
  - — South Carolina ($4.97)
  - — Alabama ($4.82)
  - — Kentucky ($4.71)
- In FY 2001, the average value of increased business activity generated from state Medicaid spending was nearly $6 billion per state, ranging from $33.9 billion in New York to $298 million in Wyoming. The 10 states with the largest increase in business activity attributed to state Medicaid spending were:
  - — New York ($31.5 billion)
  - — California ($31.5 billion)
  - — Texas ($17.8 billion)
  - — Pennsylvania ($14 billion)
  - — Ohio ($11.5 billion)
  - — Florida ($11.1 billion)
  - — Illinois ($10.2 billion)
  - — Michigan ($8.9 billion)
  - — North Carolina ($8.8 billion)
  - — New Jersey ($8.4 billion).
- FY 2001 Medicaid spending generated almost 3 million jobs with wages in excess of $100 billion. The jobs included Medicaid personnel, other employment in the health care sector, and jobs generated as Medicaid dollars circulated through different sectors of the economy. The 10 states with the largest number of jobs created were:
  - — New York (300,352)
  - — California (291,439)
  - — Texas (187,901)
  - — Pennsylvania (143,110)
  - — Florida (132,215)
  - — Ohio (132,028)
  - — North Carolina (100,353)
  - — Michigan (98,754)
  - — Illinois (98,435)
  - — Tennessee (81,675).

"Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another."

Kathleen Stoll
Associate Director of Health Policy Analysis
Families USA
Washington, DC

- The average increase in employee wages attributable to state Medicaid spending was $2 billion per state. The 10 states with the largest increase in wages attributable to state Medicaid spending were:
  - — New York ($11.7 billion)
  - — California ($11.4 billion)
  - — Texas ($6.5 billion)
  - — Pennsylvania ($4.9 billion)
  - — Florida ($4.3 billion)
  - — Ohio ($4.1 billion)
  - — Illinois ($3.6 billion)
  - — Michigan ($3.3 billion)
  - — North Carolina ($3.2 billion)
  - — New Jersey ($2.9 billion).

The report suggests that as policy-makers consider their spending choices, they should be aware that increases or cuts in state Medicaid spending result in a gain or loss of federal dollars, which will have significant implications for the state's economy.

To generate new business activity, jobs, and wages in a state economy, money must be received from outside the state, such as through visits by out-of-state tourists or the sale of manufacturing products to customers outside the state. Buying health care services through Medicaid brings new money into states in the form of federal matching dollars. Ms. Stoll suggests that Medicaid spending provides a uniquely positive, counter-cyclical stimulus to a state's economy during a recession or downturn.

"State Medicaid spending has a greater economic impact than other state spending," she says. "Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another."

The table on p. 5 demonstrates an estimation of the impact of a hypothetical reduction in state Medicaid spending, by multiplying the amount of the cut by a state's figures for lost business activity, jobs, and wages. So, for example, a cut of $250 million (5%) in Texas' Medicaid budget would result in a loss of more than $892.5 million in state business activity, 8,843 jobs, and $322.5 million in wages paid to workers in the state. Stoll says that many states are considering state Medicaid reductions that are greater than the 5% in this example and thus could have an even greater loss.

[Contact Ms. Stoll and Mr. Pollack at (202) 628-3030. Down-load the report and information on specific state impacts from www.familiesusa.org.] ■

More questions raised about smallpox vaccinations

As the Institute of Medicine (IOM) called on the Centers for Disease Control (CDC) to address major concerns about the nation's planned smallpox vaccination program and reports circulated that states were not as ready to start Phase 1 vaccinations, two major unions representing health care workers asked for a delay and said they could not recommend that their members volunteer to be vaccinated until major issues were resolved.

In a Jan. 17 Letter Report to the CDC, the IOM's smallpox study committee said the CDC should continue pursuing opportunities to deliberate and analyze outstanding issues and concerns to ensure that the campaign is carried out as safely as possible. The committee urged the CDC to address remaining concerns about the program, such as how people who are vaccinated will be compensated for medical expenses and other losses that might be incurred through vaccination, to the extent allowed by the rapid time frame, and to spell out more clearly both the risks and benefits for vaccine recipients.

The committee said that broader vaccination of health care workers should begin only after adequate evaluation of the immunization of the first round recipients has occurred.

"While we recognize that CDC has been asked to initiate the immunization campaign rapidly, it's important to remember that recipients of the vaccine are voluntarily assuming its risks for the greater public good," said committee chairman Brian Strom, professor and chair of the department of biostatistics and epidemiology of the University of Pennsylvania School of Medicine in Philadelphia.

"We agree with President Bush and the CDC that safety is paramount, and we support efforts to minimize those risks. Learning from experience, making midcourse corrections on every aspect of the program, and maintaining constant communication with the public are integral to developing the safest program possible," he added.

In its report, the committee called on the CDC to:

- highlight the unique nature of the smallpox vaccination program as a public health component of a national bioterrorism preparedness policy, focusing on delivery of clear, consistent, science-based information;
- proceed cautiously, allowing continuous opportunity for adequate and thoughtful deliberation, analysis, and evaluation, and embarking on Phase 2 only after adequate evaluation of Phase 1 has occurred;
- use a wide range of methods for proactive communication, training, and education, and customize it to reach diverse audiences, including potential vaccinees, all health care providers, and the general public;
- designate one credible, trusted scientist as key national spokesperson for the campaign and sharpen and expand communication plans and strategies to ensure rapid, transparent, and sustained contact with the media through implementation.

Compensation the biggest issue

It appears that the biggest stumbling block is likely to be the issue of compensation for those who have an adverse reaction to the vaccine.

The IOM committee said the CDC should address compensation questions because "the currently stated plans for compensation for adverse reactions could seriously affect achievement of the stated goal of the program — to increase the nation's bioterrorism preparedness. A number of hospitals have said that they will not participate in the pre-event vaccination program until these issues have been resolved. The committee believes that resolution of the adverse reaction compensation issues is important for the informed consent process. . . . Implications of the pre-event vaccination program for issues related to health insurance, disability insurance, and life insurance should also be considered."

Limits to compensation

While the Homeland Security Act of 2002 provides a federal mechanism to compensate vaccinees who are injured due to negligent manufacture or administration of the smallpox vaccine, the committee said, it does not provide reimbursement to vaccinees for costs associated with participating in the program where there is no negligence.

Those costs could include administrative leave (with possible loss of salary) to avoid accidental infection of vulnerable patients in their workplace; lost income due to time away from work when recuperating from adverse reactions that occur, and unreimbursed medical expenses associated with treating adverse reactions that occur despite non-negligent manufacture and administration of the vaccine.

The committee also cautioned "with concern" that there may be some people, such as patients and family members, who are infected accidentally by contact with a vaccinee, despite efforts to care for the

vaccination site appropriately.

It called for the administration to pursue "bold and creative" solutions to provide compensation for those who are injured.

Unions raise questions

The question of adverse reactions and compensation was uppermost when the Service Employees International Union (SEIU) and the American Federation of State, County, and Municipal Employees (AFSCME), both in Washington, DC, called on the Bush administration to make changes before starting the vaccination program.

"It is wrong for President Bush to ask health care workers to participate in a vaccination program that is not safe," said SEIU president Andrew Stern in a message to his members. "The vaccination program should be delayed until the concerns raised in the IOM report have been properly addressed. If workers or patients get sick as a result of this vaccine, they'll be lucky if they receive a get-well card from Washington."

The union represents doctors, nurses, paramedics, and other health care workers across the country.

And in a letter to President Bush, AFSCME president Gerald McEntee wrote, "We have grave concerns that the smallpox vaccination program is being implemented without a comprehensive program to educate, medically screen, monitor and treat vaccine recipients, and to educate and treat affected family members, co-workers, and patients. Furthermore, the smallpox vaccination program fails to provide compensation to those who will suffer adverse effects from the vaccination exposure to the vaccinia virus. The program also fails to implement the use of safety-designed needles to protect those administering the smallpox vaccine, and provides no safeguards to prevent employers from improperly coercing employees to receive the vaccine.

"The absence of a federally funded, comprehensive approach to the civilian vaccination program is in stark contrast to the more thorough program developed by the Department of Defense for military personnel. Both military and civilian responders are part of the frontline defense against an attack on the United States. Those asked to risk their health, likelihood, and even their lives must be protected from receiving a vaccine where contraindicated and must be compensated for adverse affects resulting from vaccination."

> "The vaccination program should be delayed until concerns raised in the IOM report have been properly addressed. If workers or patients get sick as a result of this vaccine, they'll be lucky if they receive a get-well card from Washington."
>
> Andrew Stern
> President
> Service Employees
> International Union
> *Washington, DC*

Stern also called attention to steps taken with the military vaccination program, saying civilian volunteers should receive the same screening and protections as the military, which has screened out some 30% of its members because of contraindications. The unions say the government should pay for medical tests that could screen out risk factors such as pregnancy, eczema, and weakened immune systems.

Meanwhile, the *Los Angeles Times* reported that as the president's vaccination program was due to get started, its survey of 20 states indicated that the number of frontline health care workers expected to voluntarily be vaccinated had dropped dramatically, and some states reported being months away from starting their programs.

Communication gaps

The newspaper said that several key misunderstandings between state and federal officials exist on issues as basic as when vaccine supplies will be delivered to states.

"All the states have taken enormous steps . . . in an incredibly short period of time," Julie Gerberding, MD, MPH, CDC director, told the *Times*. "Overall we're very pleased and impressed."

Many plans described by state health officials differ markedly, especially in size and timing, from the program laid out by the administration, the *Times* said. State officials cited a variety of reasons including lack of additional liability protection for hospitals, absence of guaranteed compensation for vaccinated health care workers who lose time on the job, a growing sense that a smallpox attack is not imminent, and a deeper understanding of the vaccine's risks.

Several state officials indicated to the *Times* that they would not begin vaccinating emergency response team members until mid-February or later. Others said they did not know when their programs would begin because they were waiting for direction from the CDC and notification of when they would receive vaccine.

But CDC officials said they were waiting to hear from the states and Ms. Gerberding said the agency would ship vaccine to states ready to receive it. "We want states to begin the program as soon as they can

safely do it," she said.

While some state officials indicated a belief that the federal government wanted the first phase completed within 30 days, Ms. Gerberding pointed out that was yet another misunderstanding, because "there is no end date for this program."

State officials expressed concern about the number of health care workers changing their minds about volunteering to be vaccinated.

Because studies in the 1960s indicated that one or two people in every 1 million vaccinated would die and many others will suffer serious complications, health care workers reportedly want to make sure they will be compensated if their reaction to the vaccine causes them to miss work for a time or leaves them with large medical bills.

Vaccinated workers and the hospitals in which they work also are said to want reassurance that they will not be sued if they unintentionally infect vulnerable hospital patients with the smallpox virus.

In her interview with the *Times*, Ms. Gerberding downplayed the reports of people dropping out of the program. "We need to get away from this notion of a number," she said, referring to government estimates of 450,000 frontline healthcare workers to be vaccinated. "We knew full well that we did not need to vaccinate that many people," but overestimated to be sure there would be enough vaccine available.

(Download information from www.smallpox.gov; www.cdc.gov; and www.iom.edu.) ■

Just don't do it: Survey shows Americans support strong sexual abstinence message

The National Campaign to Prevent Teen Pregnancy says that survey results supporting a strong abstinence message should influence policy-makers to understand that many teens and adults believe there's a middle ground between abstinence and contraception.

"The overwhelming majority of Americans hold very practical, common-sense views about how best to prevent too-early pregnancy and parenthood," according to the survey report. "They support a strong emphasis on abstinence as the best option for teens by far, coupled with information about contraception. They continue to reject the notion that it's either abstinence or contraception. Unfortunately, these middle-ground views are often drowned out by the polarizing arguments surrounding the contentious issue of teen pregnancy. . . . In our view, the results of the survey make clear that the public holds very reasonable views about the best means to help our young people delay pregnancy and childbearing until they are adults."

The group has conducted and released survey data since its formation in 1996. The annual, nationally representative surveys have been undertaken specifically to influence the national conversation about teen pregnancy and to compare public attitudes with behavioral data already collected by the federal government.

"Since changes in attitudes can often signal changes in behavior — and given the importance the campaign places on changing social norms on this issue — regularly assessing adult and teen attitudes toward teen sex and pregnancy over time is a key component of understanding the teen pregnancy challenge and taking effective action to reduce it," the report says.

The survey results include:

- Widespread support for a strong abstinence message, but not for an abstinence only message. Most adult and teen respondents said that abstinence is the first and best option for teens, but they also strongly believe that teens should be given information about contraception.
- Respondents believe teens should get more information about both abstinence and birth control rather than just one or the other.
- Americans reject the notion that stressing abstinence while proving information on contraception sends teens a confusing, mixed message.
- Sexually experienced teens wish they had waited.
- Teens generally express cautious attitudes toward early, casual sex.
- Parents continue to underestimate their influence on their teens. While most adults say that teens' friends influence decisions about sex the most, only 8% of teens say that friends are most influential. Younger teens cite parents as the most influential by a wide margin.
- Nearly 70% of teens say it would be much easier for them to postpone sexual activity and avoid teen pregnancy if they could have more open, honest

conversations about these topics with their parents.

- Morals, values, and religious beliefs also are considered influential by many teens.
- Many teens are not getting the message that teen pregnancy is wrong. Some 16% of teens say they don't hear a clear message that teen pregnancy is wrong, and another 25% seem uncertain about the message they are getting.
- Many teens still believe that pregnancy won't affect them. More than half of those surveyed said they had never thought about what their life would be like if they got pregnant or got someone pregnant.
- Many young people are ambivalent about how they would feel about getting pregnant or getting someone pregnant.
- Respondents want the news media to do a better job of depicting the consequences of sex, including teen pregnancy.
- Significant majorities of adults and teens believe that teen pregnancy prevention programs should teach young people to be married before having children.
- 91% of teens say it would be easier for teens to delay having sexual relations if other teens spoke positively about not having sex.
- There are differences in attitudes of teen boys and girls. Although they generally express similar feelings and beliefs about teen pregnancy and related issues, 51% of teen boys say they often receive the message that sex and pregnancy are not a big deal, and teen boys also are more likely than teen girls to say it is embarrassing for teens to admit they are virgins.

(For additional information, go to: www.teenpregnancy.org.) ■

CMS reverses field on ED restrictions

A Centers for Medicare & Medicaid Services (CMS) decision to allow managed care organizations to limit and restrict coverage for emergency services for Medicaid recipients lasted just five weeks and never was implemented by states before the administration reversed field in the face of Congressional pressure and rescinded the provision.

In a Dec. 20, 2002, letter to state Medicaid directors, CMS Medicaid director Dennis Smith said the previous policy for Medicaid recipients had been that states could not limit coverage of emergency services for Medicaid beneficiaries in managed care, even though limits were allowed for those Medicaid recipients in fee-for-service programs. CMS officials say that Alabama, Florida, Idaho, Mississippi, and Wyoming have established limits on emergency services in their fee-for-service program.

The standard for managed care recipients had been that emergency service claims had to be paid if a "prudent layperson" would think that the service was needed. A 1997 law requires that a Medicaid managed care enrollee be allowed to get emergency services immediately at the nearest hospital when the need arises. It also included the prudent layperson provision. Smith's letter said CMS was removing both of the requirements on managed care organizations.

But opposition was voiced by aides to both Republican and Democratic senators who said that legislation would be introduced if necessary to reverse the CMS guidelines. In a letter to leaders of the Senate Finance Committee, CMS administrator Thomas Scully said the Bush administration wanted to defuse the dispute over what he said was a "rather overblown" issue of emergency department (ED) use by Medicaid recipients at a time when "we are trying to get a lot of stuff done." He told the *Washington Post* CMS had not been troubled by the policy, but was concerned about the controversy it had caused. "We want to get off to a friendly, happy, bipartisan start of the year, This clearly wasn't doing it." And he told *The New York Times* that while the policy was "very defensible" in terms of giving states more flexibility, "we have a busy agenda on other health care issues this year, and it was not worth getting into a controversy over coverage of emergency services."

Florida Democratic Sen. Bob Graham, who had sponsored the 1997 legislation, said returning to the original standard "will not only protect coverage for Medicaid patients; it will save lives. People should not be dissuaded from using emergency services when they need them."

While some state officials have said there were disputes over who should pay for emergency care and have expressed a desire to find ways to move patients into primary care settings when they are more appropriate, it appears they had not asked CMS for this change.

National Association of State Medicaid Directors vice chairman Gregory Vadner, Missouri's Medicaid director, said the reversal would have little practical effect because states had not begun to restrict ED use based on Smith's letter. "Really, in the big scheme of things, I don't think it will be something that all the states will be greatly disappointed about," he told the *Post*.

In his letter, Scully said CMS wanted to work with Congress to find other ways of discouraging unnecessary use of EDs. ■

Rising pharmacy copays could lead to health risk

A Johns Hopkins University researcher warns that efforts to control pharmacy costs by increasing patient copays can have an unintended health consequence — people aren't as likely to fill their prescriptions. The ultimate result could be higher health care costs if those patients become sicker and need more intensive care.

Donald Steinwachs, chairman of the Department of Health Policy and Management in the Bloomberg School of Public Health at Johns Hopkins in Baltimore, wrote an editorial in the *Journal of the American Medical Association* responding to a study that showed that employer insurance costs can be reduced substantially by increasing employees' out-of-pocket costs. "The findings consistently show that employer costs decline as the patient's out-of-pocket costs increase with higher copayments, both in single-tier and multitier plans," he says.

The study Mr. Steinwachs responded to was funded by the California HealthCare Foundation and conducted by Geoffrey Joyce, a Rand economist, who analyzed the health coverage of 421,000 workers employed by 25 large private companies from 1997 to 1999.

The study found that increasing copays for prescription drugs led some employees to buy generic drugs instead of branded products, while others switched to over-the-counter treatments.

> "The rapidly escalating costs for drugs makes ensuring adequate prescription drug coverage more critical, especially for drugs essential for the care of chronic health problems."
>
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> Baltimore

The study also found that as copayments become larger, patients fill fewer prescriptions and pay a larger proportion of total drug costs. "As copayments increased, individuals filling any prescription during a year declined modestly (78% to 74.3%), although the average number of prescriptions filled declined substantially by more than 30%," Mr. Joyce writes.

Mr. Steinwachs says the results raise "an important public health concern" that can't be ignored. There is limited research, he says, on the health consequences of not taking prescribed medications because they are not affordable.

Most of the research that is available is from the public sector, and relates to changes in coverage policy. In a Canadian study, for example, when drug copayments and coinsurance were introduced, there were fewer prescriptions filled both with medications classified as essential, such as insulin, and those classified as nonessential. In addition, rates of serious adverse events and emergency department visits associated with reductions in use of essential drugs increased significantly.

"The rapidly escalating costs for drugs make ensuring adequate prescription drug coverage more critical, especially for drugs essential for the care of chronic health problems. Comparisons made between Medicare beneficiaries with and without drug coverage shows those in poor health with no drug coverage fill 36% fewer prescriptions

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than those with coverage, and those with incomes below the poverty line and without coverage fill 48% fewer prescriptions than those with coverage. Other studies have shown the negative effects of reducing drug coverage among poor elderly patients and the consequences of inadequate drug coverage for elderly patients receiving medications that can prevent serious adverse health consequences," Mr. Steinwachs writes.

He also reports that although the driving force behind multitiered pharmacy benefit plans and higher copayments is cost control, there is no evidence that changing to a two-tier or three-tier drug coverage plan or imposing higher copayments or coinsurance levels has any impact on the rate of increase in prescription costs over time.

Families USA executive director Ron Pollack agreed with Mr. Steinwachs that caution is needed, saying, "There is abundant evidence how increased copayments, especially for lower-income employees, can have an adverse impact on the care they need, including prescription drugs."

According to Diane Rowland, executive vice president for the Kaiser Family Foundation, there is concern that people "won't fill prescriptions because of the cost, or they will stretch their medications by breaking pills in half and not taking full doses of liquid drugs. "We certainly need more study into the impact of increased copayments, but it's clear that those who make the least can least afford copays that can be as high a $20 or $30. People still might get an antibiotic if they need one, but they might forgo medication for chronic and ongoing conditions."

[Download the editorial from jama.ama-assn.org/issues/current/ffull/jed20058.html.] ■

Clip files / Local news from the states

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

Arizona governor starts discount drug program

PHOENIX—Arizona Gov. Janet Napolitano has launched a program that could let nearly 600,000 seniors and disabled Arizonans use a discount card to buy prescription drugs at cheaper prices. A network of pharmacies across Arizona would agree to sell drugs at a reduced cost negotiated by the state. Arizonans 65 years or older would pay a $25 annual fee. Ms. Napolitano said about 570,000 seniors would be eligible for the program, which could be running by the end of April. "This is a free-market-based program," said Tim Nelson, Napolitano's adviser on prescription drugs.

Several details still have to be worked out, but it's estimated that seniors could get a 20% discount. Mr. Nelson said seniors should be able to comparison shop for prescription drugs just like they can compare gasoline prices. Ms. Napolitano, a Democrat, kick-started the program with an executive order, bypassing the Republican-controlled legislature.

Last year, a similar idea died in the legislature because lawmakers balked at an estimated $1 million start-up cost. Ms. Napolitano said that her program would cost the state nothing and that the $25 enrollment fee would cover the costs.

—*Arizona Republic*, Jan. 8, 2003

Children's advocacy group gives Nevada poor marks

LAS VEGAS—Nevada ranks among the nation's worst states for the quality of health care, education, and social services provided to its children, according to a new report. The Children's Advocacy Alliance, in its annual report card, gave Fs to Nevada in its suicide and drug-use rates, lack of prenatal care, large numbers of uninsured children, high rates of teen pregnancy, and high school dropouts. "That places Nevada in the company of such states as Louisiana, Mississippi and New Mexico, . . . all states with much higher numbers of children living in poverty," according to the report released by the Henderson-based organization. This isn't the first time Nevada has received poor marks in the annual report card. Alliance officials said the state has shown so little progress for so long that they plan to delay the next report card for Nevada until 2005.

—Associated Press, Jan. 10, 2003