State Health Watch
The Newsletter on State Health Care Reform
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THOMSON
AMERICAN HEALTH CONSULTANTS

New plan for health insurance for all could mean savings for states

A proposal by health policy experts Karen Davis, president, and Cathy Schoen, vice president, for health policy, research, and evaluation for the Commonwealth Fund in New York City, suggests a framework through which automatic, affordable health insurance could be provided to nearly all Americans.

With this plan, state and local governments would save money, the authors say, as costs would be reduced in charity care in public hospitals and also for public employee health benefits.

Ms. Davis and Ms. Schoen say that major disagreements standing in the way of expanded coverage include the role of private insurance in covering the uninsured, whether public programs should be expanded to additional groups, and the commitment of adequate budgetary resources required to assist those who are unable to afford the full cost of health coverage. There also are the questions, they say, of whether to focus simply on expanding coverage or to reform the delivery of health care services

Special Report: Solution for the Uninsured?

*See **Cover story** on page 2*

In the wake of the Supreme Court decision on Maine's drug program, states look for direction

Given the complex set of opinions handed down by the U.S. Supreme Court in its 6-3 vote allowing work on Maine's prescription drug program to continue, states have been forced to try to determine what impact the decision will have on their efforts to control pharmacy costs and to make cost-effective drugs available to those who need them.

Fiscal Fitness: How States Cope

While the high court voted to lift an injunction against the Maine Rx program put in place by a federal district court, it did not greenlight the program to begin operations. Instead, it sent the case back to the district court.

Justice John Paul Stevens, who wrote the basic majority opinion, said it was not possible to predict "at this preliminary stage, the ultimate fate of the Maine Rx program." Under the plan, which the state approved in 2000, the state government would negotiate with drug companies for rebates on prescription drugs equal to or larger than those set by federal law for Medicaid. The state intended to pass the rebates on to pharmacies that would use them to fund a discount

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Cover story

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at the same time, and whether to focus expansion efforts on the uninsured or to replace existing coverage with a new system of insurance for all.

The proposal would expand the State Children's Health Insurance Program (SCHIP) to include all families and single people with incomes below 150% of poverty. The program would be renamed FHIP, the Family Health Insurance Plan. It would have the same benefits as SCHIP has, and states would administer it as they now administer SCHIP. States would have the option of buying eligible families into employer coverage or potentially into the Congressional Health Plan (CHP). States also would have the option of extending coverage above 150% of poverty through use of federal matching funds and premiums charged on a sliding scale. FHIP would be the default coverage for all uninsured people filing tax returns with incomes below 150% of poverty.

Ms. Davis and Ms. Schoen put together their consensus framework based on general principles, including retention of current coverage choices, affordability, automatic coverage, and protection from adverse risk selection.

At the heart of their proposal is creation of what they call the CHP, which would make available a choice of any insurance plan participating in the Federal Employees Health Benefits Program (FEHBP). Although plans in FEHBP would be required to also participate in CHP, they would remain distinct and separate entities. The proposal assumes that members of Congress would switch their own coverage to the CHP to symbolize their commitment to ensuring high-quality coverage and choices. Benefit packages would be the same in the CHP and FEHBP market and subject to FEHBP approval.

Enrollment in CHP would be open to all self-employed individuals and small businesses with fewer than 50 employees, without regard for the individual's or group's health risks.

"Expecting that initially this community rate would attract those with higher than average health risks," the proposal says, "federal funds would finance these risks through reinsurance or other risk-pooling arrangements. The resulting 'average' premium rates would likely be particularly attractive to those now insured in the individual or small group market that have higher than average health risks. Furthermore, because the federal government would compensate participating plans for adverse risk selection, the community-rated premiums would be less than that now available to many small businesses and individuals purchasing coverage in the individual market."

Ms. Davis and Ms. Schoen project that based on the FEHBP Blue Cross Blue Shield Standard Plan, the 2002 CHP premium would have been $2,880 for an individual, $5,772 for a couple, $8,328 for a two-parent family, and $4,716 for a single-parent family.

Another of the framework's important new approaches is a mechanism to assess health insurance coverage annually, automatically enroll uninsured people in coverage, and provide tax credits for premiums in excess of a certain percentage of income. All individual tax filers would have to show evidence of health insurance when they file their personal income taxes.

Individuals or families without coverage would receive tax credits for premiums in excess of 5% of adjusted gross income for those with lower incomes and in the lower tax brackets and 10% of adjusted gross income for those with higher incomes.

To further reduce adverse risk selection in the CHP and promote insurance continuity and integrity within families, a new Part E would be added to Medicare to offer coverage to three groups: dependents of current Medicare beneficiaries, adults age 60 and older who don't have access to group coverage, and the disabled in the two-year waiting period for Medicare coverage.

The article states that the CHP options are unlikely to work well for families and adults with very low incomes who cannot afford out-of-pocket costs for excluded benefits, cost sharing, or premiums. To help these people, Ms. Davis and Ms. Schoen propose to expand eligibility under public programs to include Americans living below 150% of poverty. Any low-income person or family preferring to obtain coverage through the CHP and meeting its eligibility requirements still could do so, and there is an assumption that some would prefer the CHP's greater choice of private plans and providers.

The authors say they recognize that keeping employer coverage as a mainstay of the current health insurance system in a transition to more universal coverage is essential to minimize disruptions in coverage and the incremental budgetary cost of covering the uninsured. They suggest a number of reforms to strengthen the stability of employer benefits for working families by modestly expanding employer health coverage and helping workers and their families retain insurance.

Ms. Davis and Ms. Schoen acknowledge the "fundamental inequity between employers that help finance coverage for their workers and those that do not." They say that a contribution from all firms would be needed to help generate the revenue to finance coverage, to create a disincentive for firms to drop coverage, and to reduce inequities across firms and in labor markets. They suggest that companies not offering coverage to employees contribute 5% of payroll, up to $1 per hour worked, through the payroll tax option. These funds would be pooled to provide coverage in the CHP. Those offering coverage would be exempt from this "play or pay" provision, so long as they meet general prevailing minimum standards on coverage and achieve 80% participation.

According to Ms. David and Ms. Schoen, their plan's elements could be combined and linked through the tax system to identify and enroll the uninsured automatically. The expansion could either require everyone to participate (individual mandate) or allow opting out.

The numbers of uninsured people would drop under either alternative, the authors say. Among the 41 million people who are now uninsured, an estimated 33 million would be insured under the opt-out version and 39 million under the

Federal government has a new estimate of the number of uninsured

The Congressional Budget Office (CBO) has refined the often-quoted estimate that about 40 million Americans lack health insurance.

CBO said the estimate "overstates the number of people who are uninsured all year." The agency estimated instead that between 21 million and 31 million people were uninsured for all of 1998, the last year for which reliable comparative data are available. **(See graph, p. 4.)** Since 1998, analysts said, the number who are uninsured all year probably has not changed substantially. Also, the uninsured population is fluid, with many people gaining and losing coverage.

According to a CBO issue summary, education level and family income are tied closely to the likelihood of being uninsured. In contrast, the likelihood of being uninsured did not vary greatly by self-reported health status in 1998.

The uninsured population is constantly changing, and the duration of uninsured spells varies with demographic characteristics such as education, race/ethnicity, and income. About 30% of nonelderly Americans who become uninsured in a given year remain so for more than 12 months, while nearly half regain coverage within four months.

The congressional analysts said policies aimed at increasing insurance coverage most likely are to be effective if they consider the distinction between the short-term and long-term uninsured.

"For people with short uninsured spells, policies might have the goal of filling a temporary gap in coverage of preventing a gap from occurring," the report said. "For people with longer periods without insurance, policies might seek to provide or facilitate an ongoing source of coverage." ■

individual mandate. The authors say the individual mandate would be particularly effective in lowering uninsurance rates among those at higher income levels who might not participate under a purely voluntary scheme.

The uninsured would be covered by a balance of private and public coverage; about 59% of the population would be covered in private plans in the individual mandate version. Public programs would enroll slightly less than a third of the population under either version. The mix of private and public coverage for people who are now uninsured would vary by income.

Ms. Davis and Ms. Schoen project that expansion in coverage would increase use of health care services by an estimated $50 billion, a 3% increase in the $1.5 trillion national health spending expected in the absence of change. Improved coverage would help correct the underuse of preventive and chronic disease services by the under- and uninsured. Out-of-pocket costs for the under- and uninsured would fall by $20 billion, reducing the financial burdens and risk of medical bankruptcy that we have today.

They also project a number of efficiency gains from their proposal, the most important of which is substitution of the economies of group coverage for those of individual coverage.

The authors say their consensus framework lends itself to being phased in over time and to having elements modified based on experience. Ideally, they say, the CHP program would be established first, perhaps opening coverage to small businesses and uninsured people voluntarily. Insurance verification through the income tax system would require time to be put in place and should be implemented early in any transition. They suggest the program could start with automatic enrollment with opt-out, perhaps followed by the individual mandate in later phases. Medicaid/FHIP expansion could occur in steps, as could be Medicare coverage expansion for the disabled and older adults.

The plan was designed on balance to impose no net additional cost on employers or state and local governments. Employers that now offer health coverage would save an estimated $22 billion, while employers that do not would incur additional costs of $20 billion. This amount would be split about equally between firms purchasing coverage through CHP and those contributing to a pool to fund coverage for uninsured workers. According to the authors, the enhanced match for current Medicaid nonlong-term-care services plus the expansion groups would offset new costs for public programs. State and local governments would see modest net savings as a result of reduced costs of charity care in public hospitals and reduced costs of charity care in public hospitals and reduced cost of public employee health benefits.

There are five major sources of federal budget costs, according to Ms. Davis and Ms. Schoen: CHP reinsurance costs, tax credits for CHP premium assistance, tax credits for Medicare buy-in premiums and COBRA (the Consolidated Omnibus Budget Reconciliation Act) coverage, coverage of disabled and older adults under Medicare Part E, and expansion of Medicaid/SCHIP/FHIP. Offsets to these costs could include contributions from employers not offering coverage and from reduction of $30 billion

Estimated Number of Nonelderly People without Health Insurance in 1998

Source: Congressional Budget Office, Washington, DC.

in current federal subsidies for uncompensated care.

The two say that concerns that would need to be addressed in implementing their framework include that fact that maintaining the current system of health insurance coverage while adding features to provide affordable choices to the under- and uninsured is more complex than eliminating the current system and replacing it with something new that applies to everyone. One of the greatest potential weaknesses, they say, is that healthier and sicker people will choose different forms of coverage and this risk selection could prove destabilizing.

Financing is the most controversial issue. Employers are likely to resist taking on additional costs, whether covering workers who are now uninsured or paying the additional cost of COBRA coverage. Diverting funds that now go for uncompensated care of the uninsured will also meet with resistance from safety-net providers.

Substantial new federal revenues would be required, forcing societal trade-offs of tax relief vs. improved insurance coverage. But, Ms. Davis and Ms. Schoen say, "universal coverage is unlikely to be feasible unless all parties — the uninsured, the insured, employers, and government — are willing to share in the cost."

The framework was published in an on-line *Health Affairs* article and presented it at a joint Alliance for Health Reform/Commonwealth Fund presentation that included reaction from congressional staff members.

[Contact Ms. Davis and Ms. Schoen at (212) 606-3800. For the consensus framework article, go to: www.healthaffairs.org/1130_abstract_c.php?ID=http://www.healthaffairs.org/Library/v22n3/s6.pdf.] ■

No lack of solutions for problem of uninsured

"The barriers to solving the problem of the uninsured do not include a lack of viable solutions. There are a number of reform strategies that would solve the problem, but deciding on a particular one is difficult because all viable solutions require making difficult trade-offs.

"However, the fact that there are no easy solutions to the problem of the uninsured should not deter us from making a commitment to find a lasting solution." That's the assessment of the Economic and Social Research Institute (ESRI) in Washington, DC. In less than two years, ESRI has published 13 different potential solutions to the problem of the uninsured in the United States.

The institute went to expert health analysts and researchers with a request that they rethink the present approach to providing health insurance and provide new, fresh ideas. "Although political feasibility is obviously important," ESRI says, "we wanted authors to consider approaches that involve fundamental reform and perhaps even a complete overhaul of many current structures. We asked authors to acknowledge the political difficulties and barriers that would need to be overcome to implement their proposals, but we said that they should not assume that current views cannot be changed."

In publishing its commissioned solutions, it hopes that policy makers will be able to draw upon the proposals to formulate a set of comprehensive reforms, ESRI says. Here is a brief summary of each proposal and information on how to obtain much more material from ESRI.

1. Reforming the tax treatment of health care to achieve universal coverage, Stuart Butler, Heritage Foundation. The cornerstone of Mr. Butler's proposal is a fully refundable tax credit for working Americans that would be based on household income and medical costs, including premiums and out-of-pocket expenses. A major source of funding would be the repeal of the federal income tax provision that makes employer contributions to employees' health insurance a nontaxable form of income. Tax credits would be funded from general tax revenues and states would receive grants to supplement credits for low-income families for whom the credits might be insufficient to make coverage affordable. Mr. Butler says his plan is politically attractive because it works through the private market rather than creating a new federal entitlement program. It also preserves the link between health care and employment that many people take for granted.

2. Assessing the combination of public programs and tax credits, Judith Feder, Larry Levitt, Eileen O'Brien, and Diane Rowland, Georgetown University and the Kaiser Family Foundation. These four argue that in the absence of comprehensive reform, it is most appropriate to target expansions to the population least able to afford coverage, and to avoid disrupting either the public insurance system that works quite well for low income people or the employer-sponsored system that provides coverage for many Americans. They focus on ensuring that the low-income population has access to publicly subsidized insurance, and then explore the use of a tax credit to

encourage higher-income people to obtain private insurance. They say different policy strategies will be more or less effective in reaching different segments of the uninsured population and suggest Medicaid/SCHIP (State Children's Health Insurance Program)expansion for those with incomes below 200% of the poverty level and tax credits targeted to people above that level.

3. A private/public partnership for national health insurance, Jonathan Gruber, National Bureau of Economic Research. Mr. Gruber finds fault with the employer-sponsored system because it leaves people who are unemployed, self-employed, or in small businesses without an efficient pooling mechanism through which to buy affordable coverage. And he sees major holes in the public program safety net. To address these problems, Mr. Gruber, a professor at the Massachusetts Institute of Technology, proposes to build on the voluntary, private system while "rationalizing" public safety-net programs to ensure broader coverage. He proposes a significant redistribution of federal health outlays, seeks to level the playing field on which individuals purchase insurance, and tries to harness the powers of competition to address rising health care premiums for nearly all Americans. The foundation of his plan is voluntary state-based purchasing pools that would offer a menu of health plan choices to all individuals and employers.

4. Medicare Plus: Increasing health insurance coverage by expanding Medicare, Jacob Hacker, Harvard University Society of Fellows. Mr. Hacker would replace the current scattered patchwork of voluntary private coverage and residual public programs with an employer mandate and enrollment of much of the population in an expanded Medicare program he calls Medicare Plus. Mr. Hacker's proposal is a variation on the "play or pay" employer mandate model with this twist — for many employers, the pay option would be far less costly than the play option, so most firms would pay the payroll tax and automatically enroll their employees in Medicare Plus. In addition to the standard Medicare package, Medicare Plus would cover outpatient prescription drugs, preventive services, mental health services, and maternal and child health services. It would have a single deductible and coinsurance rate and an out-of-pocket spending cap.

5. Expanding health insurance coverage: A new federal/state approach, John F. Holahan, Len M. Nichols, and Linda J. Blumberg, the Urban Institute. The Urban Institute researchers propose a model that, like SCHIP, gives states increased federal funding and considerable flexibility to extend coverage to families with incomes below 250% of poverty and with high health risks at any income level. Foundation of this model is a purchasing pool organized by combining current Medicaid and SCHIP recipients, those newly eligible for subsidies, and others. To receive subsidies, people would have to purchase coverage through the state purchasing pool, but the pool would be open to all. Participants would be assured of paying no more than the statewide community rate. The federal government would establish a minimum set of required benefits and cost-sharing provisions, but states would have flexibility to design their own standard benefit packages. A new higher federal match would go to participating states to help fund coverage for everyone below 250% of poverty, including previous Medicaid enrollees. The authors contend that a purely federal expansion of coverage is politically impossible, but that a federal-state partnership is more acceptable.

6. A state-based proposal for achieving universal coverage, Richard Kronick and Thomas Rice, University of California at San Diego and University of California at Los Angeles. Mr. Kronick and Mr. Rice propose that the country adopt a health care financing system that provides comprehensive health insurance to all nonelderly legal residents and replace most major components of the current system except for Medicare and Medicaid-financed long-term care. While employers and employees would continue to contribute to the health system, employers no longer would be involved with providing insurance. Instead, the federal government would oversee the new system, and states would administer it. All health insurance choices offered by states would have to include services specified in a federally defined benefits package that states could choose to augment. Eligible residents would have at least one health insurance option that does not require premiums. The primary

revenue source would be a payroll tax levied on employers and employees, supplemented by general federal revenues, state revenues, and, possibly, individual contributions for certain plans or benefits beyond those included in the standard benefit package. States would receive an annual fixed-dollar contribution from the federal government to urge them to contain costs.

7. An adaptive credit plan for covering the uninsured, Mark V. Pauley, University of Pennsylvania. Mr. Pauley proposes a tax credit/coupon approach to expanding health coverage that emphasizes the advantage of beginning reform with a relatively straightforward, financially feasible, and easily modified intervention. His two-phase plan initially would provide refundable tax credits or vouchers to lower middle income families and individuals between 125% and 300% of poverty to be used to buy health insurance. Minimal restrictions would be placed on the type and comprehensiveness of insurance that could be bought. Very low-income households would be eligible for publicly provided or contracted comprehensive insurance with no premium share required. Households with income above 300% would not be eligible for the new program initially but could retain the tax credit for health insurance. For the second phase, if private markets have worked well and coverage rates have increased, very low-income households would be permitted to use tax credit coupons to purchase private insurance equal in value to the cost of public coverage. Also, households with income above 300% of poverty would be required to buy coverage.

8. Near-universal coverage through health plan competition: An insurance exchange approach, Sara J. Singer, Alan M. Garber, and Alain C. Enthoven, Stanford University. Tax credits and creation of new mechanisms for purchasing private health insurance are key features in this plan. The authors say that viable reform must include incentives for health plans to control medical costs and to offer "high-value" coverage to all who seek it, regardless of income or medical history. One of the key elements in this proposal is creation of insurance exchanges designed to help individuals buy reasonably priced coverage. Offering choice among multiple plans, with incentives for individuals to select high-value plans, the exchanges would have a role comparable to that of the Federal Employees Health Benefits Program or CalPERS. For exchanges to succeed, they have to cover a very large share of the market so they can negotiate effectively with plans. The authors say the major drawing point for the exchanges would be that a new tax credit subsidy could only be used for coverage purchased through a qualified exchange. A risk-adjustment mechanism would be established among exchanges to financially protect those that might attract a disproportionate share of high-risk enrollees.

9. The medical security system: A proposal to ensure health insurance coverage for all Americans, Alan R. Weil, Urban Institute. His plan combines three elements: making access to a standard free health plan a right; requiring employers to play or pay; and allowing everyone not covered by an employer plan to buy coverage through large purchasing pools called insurance exchanges. Mr. Weil sees the insurance exchange, which he compares with a stock exchange, as the key to organizing insurance markets to insure that affordable coverage is available to all and to promote competition among health plans.

10. A plan for achieving universal health coverage: Combining the new with the best of the past, Elliot K. Wicks, Jack A. Meyer, and Sharon Silow-Carroll, ESRI. The researchers say their plan would achieve universal coverage while reducing the fragmentation and inequities of the present financial system, simplifying administration of health coverage, and maintaining the role of market-based decision making and employer-sponsored private health insurance. Their keys to ensuring universal coverage are generous tax credit subsidies so everyone has the means to buy coverage, a federal requirement that everyone purchase coverage, and a fallback coverage system to guarantee temporary coverage for anyone who would otherwise fall through the cracks.

11. A performance-based approach to universal health care, David B. Kendall, Jeff Lemieux, and S. Robert Levine, Progressive Policy Institute. The authors rely heavily on the basic structure of the current system, but propose to use new federally financed tax credits to make coverage affordable. They also assign state governments major responsibilities for ensuring that people actually get coverage. The federal government would finance tax credits to help low- to middle-income people buy coverage,

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Is Congress ready for universal health care coverage?

Congressional staffers and health policy experts who participated in an Alliance for Health Reform presentation on the Commonwealth Fund's proposal for a consensus framework to provide coverage for the uninsured see value in discussing the issue but are far from united about the proposal.

David Nexon, health policy director for the Democrats on the Senate Labor and Human Resources Committee, said it is "positive that this issue of universal coverage is back on the national agenda. The fact that we're having this [program] at all is indicative of a change. I don't know that we would have had it a year or two years ago."

Special Report: Solution for the Uninsured?

Mr. Nexon said there has been a problem with covering the uninsured since President Theodore Roosevelt proposed universal health insurance at the beginning of the 20th century and expressed the hope that the time is coming when something will be done about it. He urged that those who are working on the problem keep three things in mind: 1) any expansion of coverage is going to be expensive in terms of the public expenditure and while it is not an insurmountable amount, the problem won't be solved without a substantial increase in federal resources; 2) there is a special role for employers because the U.S. system has been built on employment-based coverage; and 3) for a program to be credible and to meet the needs of the American people, it has to have an element of reducing costs or reducing the rate of inflation in health care.

"There are major opportunities to reduce cost by improving quality of care and by moving health care really into the 20th, not just the 21st, century, in terms of information technology," he said. "We have immense administrative costs in health care, estimated at as much as 40 cents of every health care dollar. And a large part of those could be reduced or eliminated by moving to a more advanced information technology system in health care. But it's not going to happen without a substantial public investment."

Mr. Nexon outlined a proposal made by his boss, Sen. Edward M. Kennedy (D-MA). Mr. Kennedy would provide universal coverage by requiring all employers to offer quality coverage to their employees and contribute to the cost of that coverage. Mr. Nexon said the time is overdue to insist that every good job should come with health insurance coverage and declared that it's appropriate that every employer fulfill social responsibility that the vast majority of employers already provide. The second element in Mr. Kennedy's proposal provides for special assistance to vulnerable small businesses, recognizing that they have special problems in providing health insurance coverage to their employees. Mr. Kennedy also has a concept similar to the Congressional Health Plan outlined in the Commonwealth Fund framework.

Mr. Nexon also referred to an approach put forth by Sen. John Breaux (D-LA) based on an individual mandate with tax credits. He said the two senators have been having talks about whether they could come together with a proposal that would unite the two approaches.

From the majority Republican side of the Senate, Finance Committee majority health policy advisor and counsel Colin Roskey said his boss, Sen. Chuck Grassley (R-IA), "subscribes to the view that incrementalism is not dead, although some have come to him and said that it was. I think consensus is obviously the key word in a Senate that is as divided as it is over here and certainly Senator Grassley's view is that to get anything done around this place you need to get not just 50, not just 60, probably something like 70 or 80 [votes in the Senate] or a real breadth of support for a proposal that's even as small as $50 billion. Unfortunately, I don't think the Commonwealth Fund proposal cuts and does consensus very well." Mr. Roskey said last year's experience in approving a bipartisan Trade Promotion Authority bill is instructive in the approach that needs to be taken for health coverage. He said Republicans have concerns about the lack of a nongroup market option in the Commonwealth Fund plan and are concerned that access to unrestricted individual insurance is severely limited. He also questioned the wisdom of expanding Medicare and Medicaid.

Another senator, Ron Wyden (D-OR), has a plan explained at the presentation by his senior health policy advisor, Stephanie Kennan. She described key elements in Mr. Wyden's bill, Health Care That Works for All Americans Act, a bipartisan effort accomplished with Sen. Orrin Hatch (R-UT). She said the central point in the bill is "public input and political accountability. Essentially, our bill is a process to develop a road map so that we can get to an endgame. It doesn't support one solution over another, but rather is about getting input and then holding Congress accountable to do something." Ms. Kennan said the bill would establish a 26-member citizens' work group that report to the American people on what it

means to have 41 million people uninsured. The group would hold community hearings around the country to help people understand issues and trade-offs involved in potential solutions. The work group would send to Congress, in narrative form or legislative language, the preferences of the American people. The bill would specify that if the work-group recommendations don't come out of committee within six months, any member of Congress could go to the House or Senate and eventually call up a bill that it based on the work-group recommendations and force consideration through what is known as a discharge vote.

Neil Trautwein, director of employment policy for the National Association of Manufacturers, said he sees encouraging signs, although his association does not back the Commonwealth Fund plan. He added that employers care about the uninsured and about the impact of cost shifting and uncompensated care. "But we do not care enough to embrace the wrong kinds of health care proposals." Mr. Trautwein said employer-based coverage has worked because it has been voluntary and has evolved over time. "Today's economy is too fragile, and we simply cannot afford a 5% of payroll mandate and simply can't afford to be locked into coverage. The consumer-driven market is getting a lot of attention. There's a surprising degree of interest in individual mandates and the idea that every American should have coverage. I don't see any softening whatsoever in the traditional opposition to employer mandates or mandated participation. . . . we really prefer an incremental approach building off the employer system." ■

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with larger amounts available to those who do not have employer-sponsored coverage. Employers would not be required to contribute toward the cost of health insurance, but would have responsibilities for making sure their employees could readily choose from a variety of health plans. States would receive federal grants to provide a menu of reasonably priced health plan choices to everyone who lacks employer-sponsored coverage. The authors foresee a two-step process starting with making coverage affordable and assessing success of those efforts. The second phase would be to move toward making purchase of health coverage mandatory for all individuals.

12. Improving access to health care without comprehensive health insurance coverage: Competition, choice, and priorities, Tom Miller, Cato Institute. Mr. Miller says he puts more emphasis on the end of achieving access to services and improved health status than on the means of covering everyone with insurance. He would leave in place existing subsidy programs such as Medicaid, SCHIP, and Medicare, and favors more funding for tax credits that would be used to purchase high-deductible health coverage, improvements in the safety net to cover people without insurance, and high-risk pools that substitute coverage for the uninsurable. He also would change incentives for consumers, insurers, and state insurance regulators to encourage competition, economy, and efficiency.

13. Medicare for all, James A. Morone, Brown University. Mr. Morone would guarantee that all Americans would be automatically covered under an augmented Medicare program funded solely by a new value-added tax. This single payer system would emphasize delivery of primary care in community-based health centers. States would have some flexibility to develop alternative approaches and employers would have the option of providing coverage that supplements the benefits package available through Medicare. Morone says the time has come to abandon the employment-based system of financing health care, given that few workers stay in a full-time job for long and that the new economy requires that employers be able to quickly adjust the size of their work forces, with consequent disruption of insurance coverage. He argues that a new dedicated tax is needed to finance his system (Medicare payroll taxes would be eliminated) because of the large amount of revenue that would have to be raised. To make the tax less regressive, Morone would exempt food, medicine, and shelter, and would provide relief by expanding the earned-income tax credit to families with income as high as $45,000 a year.

ESRI notes the problem of the uninsured has grown worse in recent years and nothing on the economic horizon suggests that market forces alone will cause more people to get coverage in the near future. "The need for imaginative, far-reaching proposals to reform the way we make health insurance available and affordable for all Americans remains as strong as ever," the group says.

(For more information, go to: www.esresearch.org.) ■

Grants fund ways to improve health system access and navigation

The Center for Health Care Strategies (CHCS) in Lawrenceville, NJ, has given 10 grants of up to $50,000 each to consumer organizations representing people with chronic illnesses and disabilities for projects that will increase access to services and enhance consumer capacity to navigate the Medicaid managed care delivery system.

CHCS officials say that managed care can offer consumers with disabilities and chronic illnesses opportunities to participate in designing, monitoring, and evaluating health care programs and, in so doing, opportunities to contribute to the improvement of their own health care and quality of life.

The Council on Mental Retardation in Louisville, KY, received a grant under which Access Ability — an organization in Louisville that promotes self-advocacy and self-determination among the mentally retarded — will train 40 primary and secondary consumers with mental retardation to increase their ability to access managed care services and navigate the Medicaid system.

Of the 40 trained people, 10 primary consumers will work with a personal mentor to ensure meaningful participation in positions on decision-making boards; 10 primary consumers will train other primary consumers; and 10 secondary consumers will mentor other parents as volunteers in the Parent Outreach program.

Seth Klukoff, CHCS vice president for operations, tells *State Health Watch* that Kentucky has ranked at the bottom of the 50 states in spending for service to people with mental retardation. "This history of low spending, the demographics of aging parents, and the economic downturn make this a critical time for consumer voices to be heard in Kentucky. The momentum established to enable consumers to access and navigate the Medicaid system needs to continue."

Beth Richardson, the director of the Council on Mental Retardation Leadership Institute in Louisville, tells *State Health Watch* that in a long career in working with the mentally retarded, she has seen that decisions often are made without consulting the people who are expected to benefit from the decisions.

The Robert Wood Johnson Foundation in Princeton, NJ, which funded the CHCS grants, has been pushing for a participant-driven system, she says. "We can talk about it, but people still are not at the table where decisions are made, or at best, there is just a token effort. We need to mentor people so they are able to participate."

Ms. Richardson says she anticipates the grant will fund 15-hour training programs. She says they will identify people who'd like to be on boards or committees and then recruit mentors to assist these participants. "I don't think there can be meaningful participation without coaching and encouragement."

Ms. Richardson says the program also will address transportation and other issues that can be barriers to effective participant involvement in meaningful decision making.

Does this sort of program lead to inequity among board members? She doesn't think so. "We have to change how we look at that question. We have to realize that it's not unusual to provide support to people. On any board, some members are better than others. Even if there are lots of disabled people on a board, there may be only one or two who make a real contribution. And that's OK. If we can neutralize the self-importance that professionals give themselves, it can be very helpful." Ms. Richardson contends that there has to be a place in the system for people who are affected by what agencies are doing to and for them; there can be more efficient, effective service delivery if agencies listen to what people say they need or want.

She says evaluation of the program will concentrate on how many people are prepared to make a contribution on boards and committees and how many families are available to mentor other families. "There's nothing earth-shattering here for Medicaid services. We're testing the waters to see what can help."

In Santa Cruz, CA, the Mental Health Client Action Network, a community drop-in center for adults with psychiatric disabilities, received a grant to enable 300 more adults with serious mental illness than the previous year to access physical health care from primary care physicians. Mr. Klukoff tells *State Health Watch* that the project will use consumers of mental health services working out of the drop-in center to encourage their peers to make appointments with primary care physicians, provide transportation, and encourage others to be proactive in their physical health issues.

He points out that Santa Cruz County data have shown that adults with major psychiatric disabilities have a significantly shorter life expectancy and have a higher rate of undetected and untreated general medical problems than the general population. Focus groups, Mr. Klukoff says, indicated consumers did not have routine medical examinations and used hospital emergency departments when they felt sick. Consumers indicated they were ashamed to see a primary doctor due to fear and embarrassment about

discussing side effects of psychiatric medications, such as obesity and sexual dysfunction.

Project representative Bonnie Schell tells *State Health Watch* the project will have unique outreach efforts, including posters in bathrooms in supportive housing units about tests people should get. Those who work with their peers will help by providing transportation to the doctor, going with patients, helping organize questions to ask doctors, and surveying doctors to determine who doesn't want Medicaid patients who are mental health patients. Ms. Schell says there is a culture disparity between mental health patients and doctors. "Clients think they are not being believed when they describe their problems, and the doctors may think the patients talk too much."

With its grant, the Mental Health Association of Southeastern Pennsylvania plans to:

1. expand Health CHECK nursing services for people with serious mental illnesses at 10 drop-in centers;
2. administer more than 2,000 health care checkups;
3. provide medical and/or psychiatric referrals for more than 600 consumers;
4. conduct more than 400 health education workshops for more than 5,000 consumers.

Mr. Klukoff says some expected outcomes are an increased ability by consumers to navigate behavioral and physical health care systems, reduced consumer fear and resistance to managed care services, increased consumer knowledge and commitment to self-care, and increased consumer referrals to behavioral and physical health services.

Others receiving grants include:

- Maine Parent Federation, Augusta, to establish seven regional peer-to-peer mentoring programs for Maine youth with special health care needs.
- Health Care for All, Boston, to strengthen the role of Haitian consumers enrolled in the Boston Health Net plan and improve the quality of care provided to the Boston Haitian community, focusing on consumers with diabetes and cardiovascular disease.
- The Tohono O'odham Nation Department of Human Services, Sells, AZ, to build knowledge and skills of Tohono O'odham consumers with disabilities and chronic illnesses to help them obtain managed care services.
- Oregon Health Access Project, Salem, to conduct focus groups to explore enrollee understanding of how to navigate the health care system and train nearly 100 enrollees with chronic illnesses and disabilities on how to use the system to improve access to health care.
- Massachusetts Family Voices at the Federation for Children with Special Health Care Needs, Boston, to support partnerships between parents of children with special needs and managed care plans to improve access to and navigation of health care services.
- HEALTH Project-Community Services Planning Council, Sacramento, CA, to assist 650 homeless and low-income consumers to navigate the public health care system by training 18 formerly homeless adults to serve as peer counselors.
- Colorado Cross-Disability Coalition, Denver, to help consumers obtain a primary care physician and participate in the design of integrated long-term care, acute care, and related support services.

[Contact Mr. Klukoff at (609) 895-810; Ms. Richardson at (502) 587-5500; and Ms. Schell at (831) 429-6713.] ■

Fiscal Fitness

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to state residents without prescription drug coverage, regardless of income. If a drug company would not grant a discount on a particular drug, Maine would require doctors to obtain prior authorization before prescribing that drug to Medicaid beneficiaries.

Soon after the plan was announced, it was challenged in federal court by Pharmaceutical Research and Manufacturers of America (PhRMA), a drug industry trade association. PhRMA said the scheme violated Medicaid law and interstate commerce laws. Its position was upheld by a district court in Maine but overturned by the U.S. Court of Appeals in Boston. The case went to the Supreme Court on appeal. Six of the Supreme Court's nine justices (Stephen Breyer, Ruth Bader Ginsburg, Antonin Scalia, David Souter, John Paul Stevens, and Clarence Thomas) said the district court should not have issued an injunction blocking the state program. But they reached their decision through differing views. For instance, Mr. Stevens said, "The severity of any impediment that Maine's program may impose on a Medicaid patient's access to the drug of her choice is a matter of conjecture." Mr. Souter and Ms. Ginsburg seemed to endorse his view, and Mr. Breyer did so partially. Mr. Stevens concluded that at this stage in the litigation, PhRMA had not carried its burden of showing a probability of success on the merits of its suit.

In another majority opinion, Mr. Thomas wrote he saw "no circumstances under which the Medicaid statute would preempt Maine Rx," and also said that the industry's legal complaints were "without merit."

Mr. Scalia said PhRMA should have taken its concerns to the

Department of Health and Human Services (HHS), rather than pursuing a judicial remedy, while Mr. Breyer said the agency "is better able than a court to assemble relevant facts [for example, regarding harm caused to present Medicaid patients] and to make relevant predictions [for example, regarding furtherance of Medicaid-related goals]."

Mr. Stevens agreed that the case should have gone through HHS, and said, "The issue we confront is, of course, quite different from the question that would be presented if the secretary [of HHS], after a hearing, had held that the Maine Rx program was an impermissible amendment of its Medicaid plan. In such event, the secretary's ruling would be presumptively valid."

For the minority, Justice Sandra Day O'Connor said the district court had correctly blocked implementation of Maine Rx because its pre-authorization requirement (triggered if a company refuses to provide a discount on a specific drug) would impose a burden on Medicaid beneficiaries. She was joined by Chief Justice William Rehnquist and Justice Anthony Kennedy. But Mr. Stevens countered that the state's desire to safeguard the health of its uninsured residents "provides a plainly permissible justification for a prior authorization requirement that is assumed to have only a minimal impact on Medicaid recipients' access to prescription drugs."

Maine Gov. John Baldacci characterized the ruling as "welcome news for Maine. Although more work remains before the benefits of Maine Rx can be realized, this is a very encouraging development." He added the ruling underscores that states can lead the way in health care reform and innovation. He said he would convene the original group that developed the program, and ask its members to work with others to examine the ruling and determine what steps should be taken next. Next steps would be taken under auspices of the Governor's Office on Health Policy and Finance, he said.

For the drug companies, PhRMA counsel Marjorie Powell stressed that the case was going back to the court that originally ruled the program did not benefit Medicaid patients, and also quoted Mr. Stevens to the effect that the decision does not determine the validity of the Maine Rx program. Ms. Powell said there are key factual issues that still must be decided by the district court. And she pointed to sections in Justice O'Connor's dissent that said that the district court already had concrete evidence of the burdens that the prior authorization requirement would impose on Medicaid beneficiaries.

"It is important to be clear about the core issue in this case," Ms. Powell said in a statement after the ruling. "Under Maine's program, government officials, rather than doctors and patients, would effectively decide which medicines will be available for Medicaid and non-Medicaid patients. And government officials will explicitly make this decision based on cost, not what is best for each individual patient.

"There are better answers than the one Maine offers — that is, effectively denying patients the specific medicine they need based on cost — to assuring patients' access to needed prescription medicines. Real solutions that help rather than hurt patients begin with passing a Medicare prescription drug benefit for seniors and disabled persons this year." She also pointed out that more than 1,400 brand name medicines are available free to needy patients without prescription drug coverage through drug company patient assistance programs.

(Additional information is available on-line from www.hhs.gov, www.ncsl.org, and www.phrma.org. The complete text of the 26-page Supreme Court decision is available at http://laws.findlaw.com/us/000/01-188.html.) ■

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