State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

States with reformed litigation systems have lower premiums

In This Issue

With no consensus on the causes of malpractice insurance problems or their cure, many patients covered by state health programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) may have a tough time obtaining needed health care. States that have not reformed their litigation systems, according to the federal government, are those with the highest average malpractice insurance premiums.

Physicians complain about the high premiums they pay and demand reductions or threaten to leave the practice of medicine or perhaps move their practice to a state that has lower premiums, as the Washington, DC-based American College of Obstetricians and Gynecologists in (ACOG), recently told a U.S. House of Representatives subcommittee.

"Across the country, the meteoric rise in medical liability premiums is threatening women's access to health care. Faced with the unaffordability and unavailability of insurance coverage, OB/GYNs are forced to stop delivering babies, reduce the number of deliveries, scale back their

*See **Malpractice** on page 2*

Want the job done right and cheaply? Here's how states can help moms and taxpayers save

State agencies often are involved in programs so large and complex that it can be difficult to see the benefits for residents. But occasionally they are able to work with something simple and straightforward that has an obvious positive impact on people's lives and also should benefit the state budget in the long-term. One such program is the partnership between the New Mexico Department of Health's Women, Infants, and Children (WIC) program and Fresh Baby, a start-up company founded to teach women to make their own baby food.

Fiscal Fitness: How States Cope

Fresh Baby co-founder Joan Ahlers, a New Mexico resident and former WIC recipient, tells *State Health Watch* she and her sister started the company when they realized there wasn't any single source of information and guidance available to help mothers learn to make their own baby food when their children were ready to start on solid foods.

"With my first child," she says, "I brought home canned foods from

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State Health Watch
The Newsletter on State Health Care Reform

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Malpractice

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practices by eliminating high-risk procedures, or close their doors entirely."

Group members made it clear that the crisis is centered in a culture that looks to lawsuits to solve problems. "The high rate of suits does not equate to malpractice," ACOG told Congress. "Rather, it demonstrates a lawsuit culture where doctors are held responsible for less than perfect outcomes. And in obstetrics and gynecology, there is no guarantee of a perfect outcome, no matter how perfect the prenatal care and delivery."

ACOG says OB/GYNs win most of the claims filed against them. A 1999 survey of its members found that 54% of claims were dropped by plaintiffs' attorneys, dismissed, or settled without payment. Of cases that proceeded, doctors won more than 65% of those resolved by court verdict, arbitration, or mediation, meaning that only 10% of all cases filed against OB/GYNs were found in favor of the patient.

"Enormous resources are spent to deal with these claims, only 10% of which are found to have merit," ACOG declared in its testimony. "The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients."

Support for the notion that the litigation system is responsible for the malpractice problem can be found in an official U.S. Department of Health and Human Services (HHS) report issued in March 2003 that flatly declares that "the crisis that we face, as consumers, taxpayers, or health care professionals, is caused by our expensive litigation system, which often finds liability on a random basis and increasingly imposes very large judgments for noneconomic damages."

HHS says that expenses on claims settled in 2001 averaged $39,819. And between 1999 and 2001, the number of payments made for malpractice claims against physicians reported to the National Practitioner Data Bank increased 21.6% from 13,711 to 16,676. During that same period, the median payment more than doubled, from $63,750 to $135,941, while the maximum payment report went from $5.3 million to $20.7 million.

'Mega-awards' going up

"Of particular concern," says the HHS report, "is the rise in mega-awards and settlements. The number of payments of $1 million or more . . . exploded in the past seven years. . . . Between 1991 and 2002, the number of payments of $1 million or more . . . increased from 298 to 806; payments of $1 million or more increased from 2.2% to 5.4% of total payments reported."

HHS says that mega awards for noneconomic damages have occurred in states that do not have limitations on the amounts of noneconomic damages that can be recovered. Awarded on top of compensation for an injured patient's actual economic loss, noneconomic damages are meant to be compensation for intangible, nonmonetary losses such as pain and suffering, loss of consortium, hedonic damages (loss of the enjoyment of life), and various other theories that are developed. The report complains that the theories on which noneconomic awards are made are entirely subjective, with juries told to apply their "enlightened conscience" in determining an amount that is fair.

The report says that at the same time the litigation system is expensive, it also is slow and provides little

benefits to patients who are injured by medical error.

"The friction generated by operating the system consumes most of the money," according to HHS. "When doctors and hospitals buy insurance (sometimes, they are required to buy coverage that provides more protection than the total amount of their assets), it is intended to compensate victims of malpractice for their loss. However, only 28% of what they pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs. Our current system forces injured patients to sue their doctors to obtain compensation, and forces both patients and doctors to go through what is a traumatic process for all. Patients must wait years for recovery (if they ever win any). Doctors are subject to minute scrutiny of actions they took, often years before, and their actions are judged on the basis of hindsight and perhaps even on the basis of changed medical standards. The process consumes the time and energy of the doctor that could better be spent in patient care."

State caps needed

The conclusion HHS draws is that the states with the highest average malpractice insurance premiums are those states that have not reformed their litigation systems. "Over the last two years, states with limits of $250,000 or $350,000 on noneconomic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on noneconomic damages have seen increases of 45%." **(See chart, p. 4.)**

It praises the action California took with the Medical Injury Compensation Reform Act of 1975 which (1) placed a $250,000 limit on noneconomic damages while continuing unlimited compensation for economic damages; (2) shortened the time in which lawsuits could be brought to three years; and (3) provided for periodic payment of damages to ensure the money is available to the patient in the future.

HHS says the California reform has been a success: "Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%."

According to the HHS document, President Bush supports federal reforms in medical liability law that would:

- improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their economic losses, including loss of the ability to provide valuable unpaid services such as care for children or a parent;
- ensure that recoveries for noneconomic damages not exceed a reasonable amount ($250,000);
- reserve punitive damages for cases that justify them such as where there is clear and convincing proof that a defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to a patient;
- provide for payment of a judgment over time rather than in one lump sum to ensure that the money is there for an injured patient when needed;
- ensure that old cases cannot be brought years after an event when medical standards may have changed or witnesses' memories have faded, by providing that a case may not be brought more than three years following the date of injury or one year after a claimant discovered or, with reasonable diligence, should have discovered the injury;
- inform the jury if a plaintiff also has another source of payment for the injury such as health insurance;
- provide that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.

The administration also calls for legislation to protect efforts by hospitals, doctors, and other experts to improve quality by encouraging reporting of needed information and collaborative use of it.

Another federal government report, this one issued by the General Accounting Office (GAO) in July 2003, says that multiple factors, including falling investment income and rising reinsurance rates, have contributed to recent increases in malpractice insurance premiums. But GAO says that losses on malpractice claims, which make up the largest part of insurers' costs, appear to be the primary driver of rate increases in the long run. Although losses for the entire industry have shown a persistent upward trend, GAO says that insurers' loss experiences have varied dramatically across the sample of states it studied, resulting in wide variations in premium rates.

The GAO report declined to make any specific recommendations, saying only that to further understanding of conditions in current and future medical malpractice markets, Congress may want to consider encouraging the National Association of Insurance Commissioners and state insurance regulators to identify and collect additional mutually beneficial data necessary for evaluating the medical malpractice insurance market.

(Continued on page 6)

States with Realistic Limits on Noneconomic Damages Faring Better

The insurance crisis is acute in states that have not reformed their litigation systems. Over the last two years, states with limits of $250,000 or $350,000 on non-economic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on non-economic damages (in states representing almost half of the entire United States population) have seen average increases of 45%, as shown in Table 6.

TABLE 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Highest Premium Increase)

States with Caps ≤ $250,000				States without Caps			
	2001	2002	Avg.		2001	2002	Avg.
California	20%	20%		Arkansas	18%	104%	
Indiana	16%	55%		Connecticut	50%	28%	
Montana	21%	35%		Florida+	47%	59%	
Utah	5%	35%		Georgia	32%	37%	
AVERAGE	16%	36%		Illinois	52%	72%	
AVERAGE over 2 years			26%	Mississippi	0%	66%	
States with Caps < $350,000				Nevada	35%	50%	
	2001	2002		New Jersey	24%	13%	
California	20%	20%		North Carolina	0%	50%	
Hawaii	0%	5%		Ohio+	60%	60%	
Indiana	16%	55%		Oregon	56%	80%	
Michigan	39%	13%		Pennsylvania	77%	62%	
Montana	21%	35%		Rhode Island	60%	9%	
New Mexico	12%	42%		Tennessee	17%	49%	
North Dakota	0%	15%		Texas+	32%	45%	
South Dakota	0%	20%		Virginia	37%	74%	
Utah	5%	35%		Washington	55%	6%	
Wisconsin	5%	5%		West Virginia	44%	46%	
AVERAGE	13%	24%		AVERAGE	39%	51%	
AVERAGE over 2 years			18%	AVERAGE over 2 years			45%

SOURCE: Medical Liability Monitor, October 2001 and October 2002. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2002. Average highest premium increase is derived from the highest potential premium increase among internal medicine, general surgery or obstetrics/gynecology specialists in that state during 2002. These combined averages are not weighted.
+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; the statute had applied to all negligence actions but was ruled unconstitutional in 1990.

Does malpractice liability pressure lead to reduced care?

As the debate over the malpractice insurance crisis continues with little sign of agreement on causes or cures, there is little definitive that can be said about the impact of malpractice insurance pressures on access to and utilization of care.

Utah Division of Health Care Financing director Michael Deily tells *State Health Watch* that malpractice rate increases are pressuring Medicaid programs to increase rates and also may be driving access problems. "The issue seems to be most acute in the nursing home industry and with OB/GYNs. Because of the low nursing home patient census in many states, the increasing cost in malpractice is primarily a rate issue. There appears to be several interacting factors that may eventually lead to problems with access.

"Medicaid in many, if not all, states pays for a significant percentage of deliveries. Therefore, the Medicaid rate is an important revenue source for OB/GYNs," he adds. "Being a public program, Medicaid provides a forum for the industry to negotiate rates and surface issues like the increasing cost of malpractice. Commercial plans reputedly are not as open to the type of dialogue we engage in with Medicaid. And Medicaid rates are often lower than commercial plans."

Mr. Deily says that given these dynamics, there will be pressures to increase Medicaid rates as costs go up in any area of practice. There also are other changes going on that may increase the challenges for Medicaid programs. For instance, he says he's hearing that many OB/GYNs are tiring of the long hours of work and other lifestyle issues related to the type of practice, and could look to those issues, plus the cost of malpractice insurance premiums, as reason to leave the specialty. Such issues also could mean fewer medical students deciding to enter the specialty, ultimately leading to problems for pregnant women in accessing care.

American Association of Health Plans spokeswoman Susan Pisano tells *State Health Watch* that litigation and the threat of litigation have an impact on all parts of the health care system, through direct costs such as malpractice insurance premiums and defensive medicine and through problems with access to certain providers and services as units are closed and physicians retire or move to states with more favorable environments.

One area that has been studied more than others is prenatal care provided by OB/GYNs, a specialty with some of the most severe malpractice insurance premium problems.

In 2001, the *Journal of Health Economics* carried a paper by the Urban Institute's Lisa Dubay and colleagues that analyzed the widely held belief that malpractice liability pressure results in a reduction in access to and utilization of prenatal care. Ms. Dubay says the results are "broadly consistent" with the hypothesis, although the effect is relatively small: an increase of $10,000 in malpractice premiums increases the incidence of late prenatal care by between 3% and 5.9% for black women and between 2.2% and 4.7% for white women.

"Our results are important," Ms. Dubay says, "because they show that the malpractice liability system has the potential to affect health care utilization in ways other than that associated with positive defensive medicine and overutilization. In this case, we show that the quantity of prenatal care is lower when malpractice premiums are higher, which is consistent with what we have referred to as negative defensive medicine."

A second finding of the study was that the effect of malpractice premiums on prenatal care utilization tends to differ by demographic characteristics that are strongly correlated with socioeconomic and insurance status. Estimates indicated that unmarried women, who are of lower socioeconomic status, are affected more by negative defensive medicine practices than are married women, who are of higher socioeconomic status. And the finding was more pronounced for white women than for black women. Ms. Dubay says the finding is consistent with anecdotal evidence that physicians use insurance coverage and socioeconomic status as an indicator of the risk of a malpractice claim being filed. Another possible explanation is that less generous Medicaid fees interact with malpractice liability pressure to cause physicians to practice negative defensive medicine disproportionately among low-income women, who are predominantly covered by Medicaid. She says that if this is the cause, one policy option could be to increase Medicaid fee levels, but such a more thorough analysis is needed before any such recommendation could be made.

Although the researchers found evidence of negative defensive medicine, they did not find evidence that reduced utilization of prenatal case associated with negative defensive practices adversely affected infant health as measured by birth weight and Apgar scores. Ms. Dubay says that finding suggests that some prenatal care may have marginal value in determining infant health outcomes and that policies that reduce malpractice liability pressure may increase prenatal care that is socially wasteful.

[Contact Mr. Deily at (801) 538-6406; Ms. Pisano at (202) 778-3245; and Ms. Dubay at (202) 833-7200.] ■

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The GAO report was praised by the Physician Insurers Association of America for its emphasis on higher claims costs as the primary driver of malpractice premium increases, and by the American Association of Health Plans for refuting trial lawyers and some politicians who have said that higher insurance premiums are not connected to a similar rise in lawsuits and jury awards.

But not everyone agrees that claims are the primary culprit. While HHS has offered a strong defense for the position staked out by physicians and come down on trial lawyers, a July 2002 paper written by Mimi Marchev, senior analyst at the National Academy for State Health Policy (NASHP), says that the malpractice insurance companies may be equally to blame due to their pricing policies of the 1990s, and warns that the "move toward restrictive tort reform does not address the complexity of the problem."

Striking a note of caution on the increasing call for limits on the right to sue, she says that reforms that followed earlier malpractice crises of the 1970s and 1980s "have not succeeded in preventing periodic and dramatic rises in insurance premiums. And tort reform does not address the important and related issues of patient safety and medical errors."

Ms. Marchev previously said the data are inconclusive as to the causes of rapidly rising medical malpractice insurance premiums. While there

Pennsylvania reform lauded by NASHP

Pennsylvania's 2002 comprehensive malpractice reform legislation is a model for states to consider, according to a 2002 paper by National Academy for State Health Policy (NASHP) senior analyst Mimi Marchev.

What she didn't know at the time was that in the spring of 2003, many Pennsylvania physicians closed their offices for five days to protest what they found was the still-unacceptable malpractice insurance situation in the state and a continuing need for caps on noneconomic damages. Ms. Marchev said the Pennsylvania legislation included reforms aimed at the legal system, the insurance industry, and patient safety.

"This inclusive approach provoked intense lobbying," she said, "and each side in the dynamic debate had to compromise cherished positions."

The law gave tort reform proponents a cap on punitive damages, a change in the collateral source rule so that patients are prohibited from collecting damages on medical expenses already paid by health insurance companies, and the possibility of periodic payment of future medical expenses exceeding $100,000.

It also allows a judge to consider the effect a large verdict would have on the availability or access to a physician or health care in the community when a request is made to lower a verdict. Strict qualifications for expert witnesses were established. A cap on noneconomic damages was dropped from the final bill. A controversial provision abolishing joint and several liability was initially included but then dropped from the final bill. Six months later, the state's General Assembly passed a separate bill that abolished joint and several liability.

The new law lowered the amount of mandatory professional liability coverage from $1.2 million to $1 million and limited an insurer's liability to the coverage limits of the policy. An ability to cancel policies was reinstated. A joint underwriting association was established to offer coverage to physicians and health care workers who are unable to obtain private coverage.

Provisions in the law designed to limit litigation and reduce or stabilize insurance rates are counterbalanced with wide-ranging patient safety requirements. Physicians, other health care workers, and medical facilities in Pennsylvania are required by the new law to report serious events and incidents to a newly established Patient Safety Authority, which is to contract with an outside agency to analyze the reports and make recommendations to improve patient safety.

Patients affected by a serious event in a medical facility are to be given a written notice of the event. Physicians and licensed health care workers are to inform their licensing boards of any complaints or disciplinary or legal action against them, and the state medical board has enforcement authority to conduct independent investigations. But within a year of passage of this comprehensive reform, a study funded by the Pew Charitable Trust said that medical malpractice was back in the headlines in Pennsylvania, with physician and hospitals complaining of a "crisis of availability and affordability" of malpractice insurance.

The study noted that in the late 1990s, four major carriers serving Pennsylvania failed, including the state's largest. Other private insurers partly filled in, but more hospitals and physicians had to turn to risk-retention groups and other alternative mechanisms as well as the Joint Underwriting Association, a costly insurer of last resort.

(To see the NASHP report, go to: www. nashp.org.) ■

are reported increases in frequency and severity of medical malpractice claims, the underpricing of malpractice premiums throughout the 1990s in an effort to expand market share and a downturn in the stock market exacerbated by Sept. 11 are also to blame, she maintains. Because of the reluctance to report errors, the data also are inconclusive as to whether any increase in malpractice claims corresponds to an increase in incidents of medical malpractice and medical errors.

The NASHP report says that state interests straddle the divide because states want quality medical care and hospital services to be accessible throughout the jurisdictions and are concerned that medical liability insurance be available and affordable for all providers. And states also want to see medical errors reduced or eliminated, while making sure that patients who are injured, either by error or malfeasance, can be fairly compensated.

"The challenge facing the states — to determine the cause and find a solution to this pressing and complicated problem — is made that much more difficult by the crossfire of accusations and dearth of empirical research," Ms. Marchev explains.

Comprehensive solution

Citing the experience of Pennsylvania with a comprehensive reform package (**see related story, p. 6**), Ms. Marchev says that a comprehensive approach to the medical malpractice insurance crisis that addresses tort and insurance reform in conjunction with reporting requirements and other strategies aimed at reducing medical errors may be the most effective course of action for states.

"Although evidence suggests that tort reform is not the definitive solution to the malpractice insurance crisis," she says, "some reform may be beneficial if it serves to diffuse the defensiveness and antagonism of the malpractice debate and provides the opportunity to build patient safety initiatives. In a less hostile environment, states may be able to work collaboratively with stakeholders and develop creative strategies that meet the goals of affording victims of medical negligence fair compensation, ensuring available and affordable liability insurance to all medical practitioners, and reducing or eliminating medical error."

William Sage, a physician and Columbia University Law School professor, says the key message for all parties is that the malpractice insurance crisis reflects changes in the health care system and there is a need for reforms that improve the health care system, rather than being distracted by broader ideological battles. Mr. Sage spoke at a Kaiser Family Foundation briefing on malpractice. There are six problems that malpractice reformers should address, according to Mr. Sage: liability coverage is expensive and sometimes unavailable; liability crises potentially impair access to medical services because the health care system is less resilient now than in the past; compensation for injured plaintiffs is inadequate; too many avoidable medical errors occur; the process of resolving disputes through tort law is too slow, too costly, too uncertain, and too unpleasant; and the liability climate threatens the economic success of the health care industry by discouraging providers and reducing incentives to innovate.

"No reform can solve all of these problems, but the desirability of any proposal must be measured by its likely effect on each of them."

He points out that most reform proposals touch on only one or two of the problems and could worsen the rest. One notable exception, he says, is an Institute of Medicine (IOM) proposal that "draws on established though largely untested reform ideas [and] integrates liability policy with other key areas of health system performance: primary care, chronic care, information technology, and access to health insurance."

The IOM recommended replacing much of current malpractice law with an administrative system of strict liability for clearly avoidable injuries. It offers two options — provider-based early payment and statewide administrative resolution. Mr. Sage says that both options are intended to be "no-trial" rather than "no-fault" systems, capping noneconomic damages in accordance with a predetermined schedule based on severity and duration of injury, but preserving financial incentives for safety at the provider level.

If Congress enacts a California-style cap on damages, no national tragedy will follow, he says. But there also will not be any lasting benefit to health care. And the same will be true if Congress fails to do anything after prolonged political debate, as was the case with the right to sue managed care plans. Government will simply have missed a significant opportunity for truly productive change.

"The real malpractice debate," according to Mr. Sage, "is between those who view medical liability as an external drag on the health care system and those who see a properly functioning liability system as integral to its future success. Politics favor the former camp, but history is on the side of the latter."

[To contact ACOG, go to: www.acog.org. For the HHS report, go to: www.hhs.gov. To download the GAO report, go to: www.gao.gov. To learn more about the Kaiser briefing, go to: www.kff.org. Contact Ms. Marchev at (207) 874-6524.] ■

Fiscal Fitness

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the grocery store and didn't like the way they looked or tasted. I decided I couldn't give my child food that tasted like that, so my mother helped me learn to make my own. I taught my sister when she had her first child, and we decided to put everything together in a kit and market it to help other mothers get started."

Ms. Ahlers says that while there are some cookbooks available for homemade baby food, there hasn't been anything that puts all the answers in one box and includes hard-to-find supplies that are needed, such as covered ice cube trays that have compartments for 1-ounce servings.

"We have an instructional video; hints on how to pick good fruits and vegetables and then store them properly to preserve their nutritional value; charts on the nutrients in each food item; [and] reference cards on when to introduce different foods as well as on baby ailments and health problems — everything a mother needs to make 24 servings in 30 minutes," Ms. Ahlers says.

While Fresh Baby initially marketed its kits through stores and Internet/direct mail, Ms. Ahlers realized the information and techniques in them could be very useful to mothers receiving assistance through the WIC program.

The U.S. Department of Agriculture formed WIC in 1974 to assist low-income pregnant, postpartum, and breast-feeding women, and infants and children up to age 5 who are at nutrition risk. Operating through state agencies, WIC provides nutritious foods, nutrition counseling, and referrals to health and other social services free to participants. Nearly 47% of all babies born in the United States participate in WIC. In New Mexico, 51% of newborns are WIC participants.

New Mexico Department of Health WIC Nutrition Coordinator Deanna Torres tells *State Health Watch* that Ms. Ahlers initially asked the agency for help in reviewing the Fresh Baby kit, and the staff realized it would be beneficial for their clients. They purchased kits for each of the WIC centers across the state and will use them as the centerpiece of an educational program to teach mothers how to prepare their own baby food. The mothers also will have an opportunity to purchase a stripped-down version of the kit at a reduced price.

Helps rest of family, too

Ms. Ahlers and Ms. Torres say the key benefits of making your own baby food are that the infants receive a high level of nutritional value, while the parents spend less money than they would for processed foods. In addition, they say, the parental involvement in preparing and serving foods for those between 6 months and 12 months of age actually helps the entire family eat a more healthy diet.

WIC also promotes the Farmers' Market Nutrition Program that provides coupons families can use to purchase fresh fruits and vegetables at participating farmers' markets. The program provides fresh, unprepared, locally grown fruits and vegetables to WIC participants and also expands consumers' awareness and use of farmers' markets.

Fresh Baby now is approaching other states and ultimately plans to offer the nutritional education and kits through every WIC agency nationally, Ms. Ahlers says.

[For more information, go to: www.freshbaby.com. Contact Ms. Ahlers at (505) 661-0216 and Ms. Torres at (505) 476-8805.] ■

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

Medicaid block grants could hurt mentally ill

What impact on the mentally ill would there be if the federal government carries out its Medicaid reform strategy by making the program a block grant?

The Bazelon Center for Mental Health Law says the results could include making more people with mental illness homeless; denying early mental health treatment for children; and increasing the number of adults and juveniles with serious mental illnesses who are in jails, juvenile detention centers, and prisons because of lack of access to community mental health care.

The report was written by Bazelon's Chris Koyanagi to analyze proposals to change Medicaid from the perspective of adults and children with mental illnesses. The issue is important, she says, because low-income children and adults must rely heavily on Medicaid, having nowhere else to turn for mental health care. In addition, many of those with mental illnesses also have significant overall health care needs and depend on Medicaid for medical and surgical care.

Proposals that have been floated for Medicaid reform include plans to reduce the array of services that states must provide and reduce the number of beneficiaries entitled to services by (1) replacing the current entitlement program with one or more block grants to states; (2) giving states greater flexibility to reduce the benefit package for some or all eligible individuals; and (3) permitting states to create separate programs within Medicaid, with a lower level of coverage, higher copayments, and fewer protections for individuals who fall within optional eligibility populations.

Ms. Koyanagi says that other suggested reforms would:

1. give states a greater role in defining specific services in the benefit package;
2. expand the program to pay for covering low-income uninsured individuals who are not eligible now;
3. change the financing arrangement of Medicaid to provide fiscal relief to states.

"Drastic changes that curtail access to mental health care could have the unintended consequences of increasing overall state, local, and federal spending while leading to poorer outcomes, wasted lives, and even death," Ms. Koyanagi warns.

She says that drastic and fundamental change to Medicaid could unravel the safety net for low-income individuals with mental illness, and it is important to maintain what works while modernizing and improving other aspects.

"Recent proposals to substantially restructure Medicaid would undermine that goal," she says.

Ms. Koyanagi cautions that going to a block grant would dismantle the uniform federal standards and safeguards that ensure quality and accountability in Medicaid. She says it would eliminate federal requirements, such as the requirement that recipients receive sufficient services to treat their condition effectively and that all residents of a state have the same coverage, regardless of where they live. Instead, it would allow for services to be covered in one part of a state but not others, or for services to have arbitrary limits on mental health care such as 20 visits per year.

A block grant also eliminates the federal match for state spending, replacing the current flexible funding with a capped amount of resources that cannot increase if people need more services or if the state wants to expand its program. On average, according to Ms. Koyanagi, states receive 57 cents from the federal government for every 43 cents they spend on a Medicaid service to a covered person.

"Over time," she says, "if health costs increase but federal matching funds do not because the federal contribution has been capped through a block grant, states would be forced either to pay 100% of the costs or to deny services even to those currently eligible."

A third issue raised by the report is that a block grant would undermine one of Medicaid's most important features — its ability to compensate automatically in times of need. Ms. Koyanagi points out that Medicaid is countercyclical, meaning that when unemployment rises and more individuals have low incomes or are uninsured, coverage becomes available to them. Under a block grant, states could not claim the necessary federal match for such fluctuations, but would be given the flexibility to deny coverage during the economic downturns, compounding the adverse impact of such events.

The report also looks at the State Children's Health Insurance Program (SCHIP), noting that every state that covers any level of mental health disorders through a separate SCHIP plan applies limitations and exclusions that would not be permissible in Medicaid. Many of the services needed by children with special health care needs are those that are omitted or subject to limits under SCHIP, according to Ms. Koyanagi, including case management, rehabilitation therapies, and behavioral health services.

She says that a shift to SCHIP or a private insurance model of benefits also would have the effect of eliminating access to many rehabilitative and other optional Medicaid services needed by adults and children with more serious disorders. People with disabilities, including psychiatric disabilities, rely heavily on the Medicaid optional services.

Significant home- and community-based mental health services are widely available under Medicaid, in part, because they are optional services and do not require a special federal waiver. Included are things such as social and independent living skills training and assertive community treatment for adults, as well as behavioral aides and therapeutic foster care for children.

Proposals not cost-effective

Ms. Koyanagi says that the rationale for Health Insurance Flexibility and Accountability (HIFA) waivers and proposals to block grant Medicaid is that by reducing benefits and increasing cost sharing for those currently eligible, savings can be redirected to provide some level of coverage for some people who are uninsured. However, significant numbers of children and adults with serious disorders who need mental health services currently are on Medicaid, and the package of benefits in the program is critical to maintaining them in the community. Covering more of the uninsured by reducing their benefits is neither cost-effective nor humane, she says.

"A study of the fiscal impact of reducing coverage by amending current eligibility and benefit rules in the manner recently proposed by the Bush administration shows that an estimated 3.8 million children and 1.2 million people with disabilities could lose coverage they would otherwise have," the report says. "If the policy question at hand is expanding access to health insurance coverage, a combination of Medicaid expansions for very low income people and access to other health policies for others would address the issue directly, without detriment to the most needy, who depend on the comprehensive array of services Medicaid provides them."

Ms. Koyanagi also makes the point that states already are moving to cut back their Medicaid programs using the flexibility that already exists in federal law. And these cost-savings measures will have a dramatic impact on the fragile mental health safety net, she says, unless they can be reversed. With the severity of state budget shortfalls, she sees a need for federal intervention.

"In times of economic downturn, it is critically important to protect both the population in need of Medicaid mental health services and the states' mental health systems," the report says. "Individuals with serious mental illnesses will use some form of services — whether early and effective community services or high-cost institutional placements. Medicaid provides a strong mechanism for states to secure federal support for their community mental health systems. Once these funds are capped or cut (or eligibility and benefits are reduced), cost shifting occurs. These cost shifts are almost entirely into state- and local-funded systems such as state psychiatric hospitals, jails, and prisons. While such reductions save the federal government money, they save the states resources only in theory. Medicaid expenditures may fall, but other costs rise at even higher rates. A better mechanism is needed to aid both states and low-income individuals."

Rather than what has been proposed, Ms. Koyanagi calls for changes to Medicaid such as giving states greater flexibility in service definitions; covering the uninsured with the lowest incomes directly, without reducing benefits to Medicaid recipients; and providing fiscal relief for states. Federal rules, she says, should allow states to:

1. create a single community mental health services category to incorporate clinic, rehabilitation, and targeted case management services;
2. cover home- and community-based services without a waiver;
3. expand consumer-directed services to include initiatives focused on people with mental disorders;
4. ensure that very young children, whose problems are not yet diagnosable using standard instruments, receive services when they show significant developmental, social, and behavioral delay.

Speaking out in support of the concerns raised in the Bazelon paper, National Alliance for the Mentally Ill president Michael Faenza says that rather than propose a rescue plan for the millions of people with mental illness who are dependent on public services, the administration and Congress are considering budget plans that would cut mental health funding.

"Not only are state and local mental health systems in crisis," Faenza says, "but states across the country are wrestling with severe, record budget shortfalls, currently estimated to total $85 billion. Forced to balance their budgets, states are cutting mental health and other services. Congress needs to provide relief to the states and meet other pressing national needs, including making mental health a national priority."

[To see the Bazelon report, go to: www.bazelon.org. Contact Ms. Koyanagi at (202) 467-5730; and Mr. Faenza at (703) 524-7600.] ■

What can be done about a mental health system in disarray?

The nation's mental health system is in a shambles and needs a major overhaul rather than incremental improvements.

That's the assessment of the New Freedom Commission on Mental Health appointed by President Bush to "study the mental health delivery system and make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities."

While the commission doesn't assign specific responsibility for its recommendations and doesn't consider funding, it is clear that state governments, many of which already are facing severe financial problems, especially in their health care programs, would be expected to step up to the plate and assume significant responsibility for rebuilding a broken mental health system.

The commission based its assessment and recommendations on a year of study and a review of research and testimony, and has concluded that for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected, and often inadequate, frustrating the opportunity for recovery. And it is that opportunity for recovery that the commission said should be the centerpiece of a coherent system. But too often, according to the commission, the system simply manages symptoms and accepts long-term disability.

What it said it found is a "patchwork relic — the result of disjointed reforms and priorities. Instead of ready access to quality care, the system presents barriers that all too often add to the burden on mental illnesses for individuals, their families, and our communities. The time has long passed for another piecemeal approach to mental health reform. Instead, the commission recommends a fundamental transformation of the nation's approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges."

The commission estimates that in any give year, some 5% to 7% of adults and 5% to 9% of children suffer from mental illness or severe emotional disturbance. These figures translate into millions of people disabled by mental illness each year. Despite significant investments of resources that have enormously increased the scientific knowledge base and led to developing many effective treatments, many Americans don't benefit from what has been learned.

"Far too often," the commission declared, "treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity." The commission envisions a system that ensures that when a serious mental illness or emotional disturbance is first diagnosed, a health care provider, in full partnership with consumers and families, will develop an individualized plan of care for managing the illness. It said that such a partnership of personalized care means "basically choosing who, what, and how appropriate health care will be provided: choosing which mental health professionals are on the team, sharing in decision making, and having the option to agree or disagree with the treatment plan."

The commission voiced the expectation that since all treatment plans would be oriented toward recovery, the stigma surrounding mental illnesses would be reduced, reinforcing the hope of recovery for every individual with a mental illness. Successfully transforming the mental health service delivery system rests on two principles, it said. First, services and treatments must be consumer- and family-centered, geared to giving consumers real and meaningful choices about treatment options and providers, rather than being oriented to the requirements of bureaucracies. And second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.The commission identified six goals as the foundation for transforming the mental health system, and recommendations for meeting each of the goals, noting that the goals are intertwined and no single step can achieve the fundamental restructuring that is needed.

Generally positive reaction

By and large, the mental health community and advocacy organizations strongly supported the commission's work and recommendations. "Mental health advocates today call on the nation's leaders to capitalize on this historic opportunity to address the growing crisis in public mental health systems," said Robert Bernstein, executive director of Bazelon Center for Mental Health Law. "Policy-makers have a choice — they can put this report on a shelf and continue the past policies of hopelessness, or they can act on its recommendations and make recovery-focused services a priority for millions of Americans with unmet mental health needs."

National Alliance for the Mentally Ill executive director Robert Birkel said the nation "cannot wait another

day, another year, or another decade for real progress. . . . Let today be the turning point. Let today begin the transformation of a broken system of care to one that provides recovery-oriented, community-based treatment and services that we know will work."

From the provider community, the American Psychiatric Association called on the president and Congress to provide real solutions to fix the current fragmented mental health delivery system, pass mental health parity legislation, and provide adequate funding in the public health system. The association called the commission report a "major step on the road to recovery of the nation's mental health system."

Federation of Families for Children's Mental Health executive director Barbara Huff said her group looks to the Bush administration "for a commitment to take action and support changes with necessary increased funding in order to change the way this nation serves children with mental health needs and their families."

While most organizations praised the commission's work, cautioning that its recommendations cannot be allowed to pass without implementation, at least one advocacy organization said the commission missed the mark and ignored people with the most severe mental illnesses.

The Treatment Advocacy Center in Arlington, VA, a nonprofit organization working to eliminate barriers to timely and humane treatment of those with mental illness, said that in a desire to be politically correct the commission report "left out the people who needed them most, ignored powerful tools proven to save time and money, and reinforced harmful stereotypes about recovery and stigma. Many mental health advocates are praising the report for its assessment of the system, but we find it sad that because there is such a low bar for success with such reports, none wants to mention the important things that were omitted."

Treatment Advocacy Center president E. Fuller Torrey said the commissioners glossed over tools such as police training, mental health courts, and commitment laws, especially assisted-outpatient treatment.

"Adopting and utilizing assisted outpatient treatment is a proven way to meet the commission's goal to disseminate and apply proven treatments to mental health care delivery," Mr. Torrey said. "The commission's hesitancy to address this treatment mechanism is especially astonishing given the results from instituting such measures. For instance, in New York, of those placed in six months of assisted outpatient treatment, 77% fewer were hospitalized, 85% fewer experienced homelessness, 83% fewer were arrested, and 85% fewer were incarcerated."

He also challenged the commission's lack of recommendation for eliminating the Medicaid IMD exclusion under which the federal government does not reimburse states for Medicaid-eligible people with severe mental illnesses who are in state psychiatric hospitals, although it will pay for medical and psychiatric treatment in other settings. He said the commission didn't acknowledge that a major reason for the stigma associated with mental health patients is crimes committed by those not receiving treatment, and said the best way to reduce stigma is not through a public education campaign but rather to help people before they become a headline.

Finally, Mr. Torrey said the commission erred in promoting the notion that all of those who have a serious mental illness can recover. "The implication that failure to fully recover is because a person who is sick failed to have a strong-enough faith in recovery is akin to suggesting that happy thoughts can cure a broken leg. This perspective implies that the person with the brain disease is somehow at fault. Although the commission's focus on full recovery is understandable and recovery for all is a laudable long-term vision, it is important to remember that recovery is not currently possible for every person who has a severe psychiatric illness."

[To see the commission report, go to: www.mentalhealthcommission.gov/reports/reports.htm. Contact Bazelon Center at (202) 467-5730; NAMI at (703) 524-7600; American Psychiatric Association at (703) 907-7300; American Psychological Association at (202) 336-5500; the Federation of Families for Children's Mental Health at (703) 684-7710; and the Treatment Advocacy Center at (703) 294-6001.] ■