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Oregon turns to private-sector coalition for help in expanding employer coverage with CHIP funds

Purchasing group is tapped to administer insurance subsidies

Oregon officials think they have found a way to use Children's Health Insurance Program (CHIP) funds to provide family coverage and still meet the federal government's test that such coverage doesn't redirect any CHIP money away from kids.

If they're right, Oregon will become the only state besides Massachusetts that is successful in covering uninsured parents through employer-sponsored insurance with CHIP money.

The plan centers on using the state's sole health insurance purchasing cooperative and an existing state program, the Family Health Insurance Assistance Program (FHIAP), to administer insurance subsidies.

"Our hope is, if we make it affordable and it is significantly easier to administer, we'll have some businesses sign up," says Oregon Health Council executive director Bob DiPrete. The council has been working with Associated Oregon Industries to craft a CHIP plan amendment recently submitted to Health Care Financing Administration (HCFA) officials.

The heart of the plan is subsidies offered for private insurance at 70%, 80%, or 95% of the employee's share of the premium. Like FHIAP, the subsidy initiative will target families beyond Medicaid eligibility—100% of poverty for most persons, 133% of poverty for children under 6, and pregnant women up to 170% of poverty.

About 8% of Oregon's children in the targeted population, approximately 20,000, are uninsured. The state hopes the latest expansion will cover about 2,000 by April 2001.

"Even though it doesn't promise

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Washington state officials scramble to cover shrinking individual health insurance market

Washington state officials want to re-open the state's high-risk pool to help replace the individual insurance market that's shrunk in the past year to just nine of the state's 39 counties.

"There virtually ain't no individual insurance in this state now," says David Wasser, Washington State Health Care Authority director of communications.

No sooner had Insurance Commissioner Deborah Senn approved new rules to re-open the Washington State Health Insurance Pool than Regence BlueShield and Group Health Cooperative added to her problems.

The companies announced in early September that they, too, were leaving the individual health insurance market, following a similar move by Premera BlueCross last November.

The Premera departure left large areas of rural eastern Washington without individual coverage. With the latest announcement, such coverage is no longer available even in Washington's urban centers.

Ms. Senn's announcement suggests that consumer groups, some insurers, and legislators have reached at least a short-term compromise on how to shore up the state's evaporating

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real large numbers, as a percentage of uninsured children, it's worth doing," says Mr. DiPrete. He notes that, in addition to the relatively low number of uninsured children, Oregon also has the advantage of a higher-than-average percentage of employers who offer insurance to their employees, with about 72% of state residents receiving health insurance through work.

Administrators in the state-only program will be responsible for determining eligibility and processing the premium subsidy. The 6,000-member Associated Oregon Industries will have the same relationship it does with all its member businesses and employees, including brokering plans and facilitating communication with agents.

Significantly, the subsidy will be paid to the employee, not the employer. The employer deducts the cost of the premium from an employee's paycheck, as with any other insured employee, and a carefully timed subsidy to the employee's home essentially replaces the lost income. It's the same technique used in FHIAP since the program's implementation in July 1998.

"We want to maintain the privacy and dignity of people on the program," says Mr. DiPrete. The risks of this approach have proven minimal. The state expects to recoup in full the only premiums paid in error to date—the equivalent of three months' premium paid to someone with Medicaid coverage as well as FHIAP coverage.

HCFA is likely to focus on three issues in its evaluation of Oregon's application, says Mr. DiPrete:

• Cost-effectiveness. As with all CHIP plans, Oregon's program can cover parents only if family coverage costs no more than covering all children individually. Oregon's Medicaid-style CHIP coverage for one child soon will cost about $84 per child per month in federal funds, or about $115 total when the state match is added, says Mr. DiPrete. He predicts that, for families with three or more children, family coverage is likely to cost no more than covering the children individually.

• Cost-sharing. Oregon officials are trying to figure out how to meet HCFA's requirement that, for families over 150% of poverty, cost-sharing is not to exceed 5% of income. For families below that, Medicaid cost-sharing limits apply. The current plan

Harlem program to spread word of availability of emergency contraception among teenagers

Alwyn Cohall wants to spill the beans on "the nation's best-kept secret." That's the term health care providers give emergency contraception, usually a protocol of high-dose oral contraceptives taken within 72 hours of unprotected intercourse.

Mr. Cohall, a physician on the front line as chief of adolescent medicine at St. Luke's-Roosevelt Hospital Center in New York City, is campaigning to expand the profile and use of emergency contraception particularly among teenagers and their doctors.

"In general, the American public is fairly well uninformed about emergency contraception," he says. In Europe, 95% of adolescents and adults know about the practice, Mr. Cohall adds.

The legal status of emergency contraception has changed dramatically in the United States during the past two years. In February 1997, the Food and Drug Administration issued a statement identifying certain oral contraceptive protocols as "safe and effective" in preventing pregnancy after sex. The first pills packaged for use as emergency contraceptives were approved in late 1998, and a progestin-only emergency contraception promising fewer side effects was approved this summer.

With funds from the American Academy of Pediatrics and George Soros' Open Society Institute, Mr. Cohall is starting in the Harlem neighborhood where he works to survey and educate physicians and teenagers about emergency contraception.

"Providers don't have reservations about it, but they don't think about it, and very few providers prescribe it at all," he says.

Mr. Cohall is describing his program to participants of the American Public Health Association meeting in November. One point he plans to raise there: Emergency contraception is rarely used as a routine method of birth control. A survey of 115 of his clinic's emergency patients found two who had used it more than once. But such methods often become a precursor to more conventional forms of contraception and other health care services, he says.

Contact Mr. Cohall at (212) 939-3453. ■

is to buy a supplemental policy to cover all out-of-pocket expenses except for a very modest copay.

• Employer contribution. A letter from HCFA to state health officials in February 1998 said employer subsidies could be used only when the employer contributed 60% of the premium or its "equivalent" to ensure that employers continue to pay a "meaningful share" of the costs of the program.

HCFA and Oregon officials will negotiate the minimum employer contribution that will be required, Mr. DiPrete says.

Contact Mr. DiPrete at (503) 378-2422, ext. 402. ■

HCFA awards Mathematica contract to evaluate CHIP

Mathematica Policy Research Inc., in Plainsboro, NJ, has received a five-year, $4.2 million contract from the Health Care Financing Administration (HCFA) to evaluate the Children's Health Insurance Program (CHIP). The study is designed to help HCFA and Congress understand how different CHIP programs operate, assess how well they perform, and highlight best practices.

In the first phase of the project, Mathematica will synthesize data from several to develop a comprehensive, cross-state picture of CHIP in its early years. An analysis of external studies of CHIP will help to clarify the program's progress. The firm will also track changes in the number of uninsured children by state, before and after CHIP implementation.

The second phase will examine the impact of CHIP on enrollment, expenditures, use of services, access, and quality of care by contrasting state-designed plans with Medicaid plans. Mathematica vice president Margo Rosenbach, PhD, will direct the project. ■

Medication becomes morality: 'Conscience clauses' hit legislatures

Increased availability of emergency contraception is spurring the development of state measures to excuse pharmacists who want nothing to do with it.

In the past legislative session, Indiana, Kansas, Louisiana, Oregon, and Wisconsin have considered proposals that would allow pharmacists to opt out of dispensing drugs they consider morally objectionable, including doses of oral contraceptives taken after unprotected intercourse. Oregon's bill is the most comprehensive, states an analysis in the June issue of Alan Guttmacher Institute's *Family Planning Perspectives*, addressing drugstore owners and operators as well as pharmacists and encompassing all drugs in its scope.

The Washington, DC-based American Pharmaceutical Association has discussed—but never adopted—a position regarding so-called "conscience clauses," says Karen Winckler, the association's group director of policy and advocacy.

"There's some question as to whether it's necessary," she says, noting that licensing statutes and regulations generally respect the role of conscience and personal values in professional pharmaceutical activities.

By the association's reckoning, South Dakota is the only state that has passed explicit legislation to protect a pharmacist's right to demur from dispensing certain prescriptions.

The law excuses pharmacists from dispensing responsibilities when they believe the medication would do any of the following:

• "cause an abortion";

• "destroy an unborn child";

• be used for an assisted suicide, euthanasia, or mercy killing.

An association policy adopted in 1998 recognizes a pharmacist's right to exercise "conscientious refusal" in his or her professional activities. At the same time, the association supported the "establishment of systems to ensure [a] patient's access to legally prescribed therapy."

Referral not always the answer

The association stopped short of recommending referral to another source for a prescription, Ms. Winckler says, suggesting that option is not necessarily "the most efficient system." Instead, she cited mechanisms such as those in place for Washington state's collaborative prescribing arrangements between physicians and pharmacists. (See *State Health Watch*, January 1999, p. 10.)

The profession has explored several alternatives for respecting both the rights of patients and pharmacists, says Ms. Winckler, including providing a toll-free number for information on emergency contraception. For rural areas that may have only one pharmacist, she suggests the pharmacist explore ways to allow the physician to dispense emergency contraception.

Some of the concern over conscience clauses, Ms. Winckler says, may stem from instances in which pharmacists have clashed with the policies of their chain drugstore employers.

In August, the American Center for Law and Justice, an advocate for "pro-liberty, pro-life, and pro-family causes," filed suit in U.S. District Court in Cincinnati on behalf of a pharmacist claiming to have been fired for refusing to dispense Ortho Pharmaceutical's Micronor and similar prescriptions.

Contact Ms. Winckler at (202) 628-4410. ■

Minnesota making progress on 'incredibly hard' task of performance-based contracting for nursing homes

Developing criteria for payment promises to be controversial

Frustrated with buying a pig in a poke, Minnesota is getting serious about performance-based contracting for Medicaid nursing home care.

This month, Minnesota officials are reviewing proposals to help the state develop criteria for the new system of contracting. The target date for implementation is July 1, 2001, moved back a year this spring by legislators and a nursing home industry wary of such a fundamental change in the way nursing home care is paid.

"We got a delay in the implementation in order to spend more time, really, thoughtfully developing a system, given the fact this is an incredibly hard thing to do," says Laurel Illston, manager of special projects for the Minnesota Health & Housing Alliance in St. Paul.

Minnesota already operates a pilot project for contracting involving 246 nursing facilities, more than half of the state's total. The project, approved by legislators in 1995, is intended to develop an alternative to the state's cost-based reimbursement system.

The state's Department of Human Services issues a request for proposals from facilities interested in participating in the demonstration, and chooses among them using a predetermined selection process.

Contracts are renegotiated annually, and state law allows facilities to participate for up to four, one-year terms. The first contract were signed in May 1996, and thus far, all nursing facilities in the demonstration project have chosen to renew their contracts.

Proposals were due to the Department of Human Services Sept. 7 to help officials with four specific areas as they expand the pilot to the rest of the industry:

• Criteria by which the performance-based incentive payments are made. Proposed criteria were discussed in a report to the legislature in January, says Bob Held, division director of the state's Continuing Care for the Elderly. He adds that state officials are "open to hearing what new ideas might emerge."

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>
> Bob Held
> *Division Director, Minnesota's Continuing Care for the Elderly*

• Establishment of a plan to move toward universal adoption of Medicare's resident assessment system so that the financial impact for each facility would be budget neutral. Since 1985, Minnesota Medicaid has reimbursed nursing facilities according to one of 11 payment categories in its own case-mix system.

• Identification of net cost implications for nursing facilities and the Department of Human Services preparing for and implementing performance-based contracting, or any proposed alternative system.

• Identification of facility financial and statistical reporting requirements involved in performance-based contracting.

Public-private work groups will tackle five other issues:

• Interim default payment mechanisms for facilities that don't have a contract. All but eight of the state's 438 nursing home facilities depend upon Medicaid revenue, leaving legislators and industry officials to fret about what would happen to nursing homes unable to snag a contract.

'If you don't have a Medicaid contract, you're out of business," says Ms. Illston. "You can't not take Medicaid."

The concern is valid, particularly in rural areas that may depend upon nursing facilities as an economic base, says Mr. Held, but he maintains that the quality of the care is a separate issue. "If we're going to do business by contract, and you can't get a contract because of your quality or you refuse to apply for a contract, why should we do business with you?"

• Criteria and a system for requesting rate adjustments for low base rates, geographic disparities, or other reasons.

• Development of a dispute resolution mechanism for nursing facilities that are denied a contract, incentive payments, or rate adjustment.

• Development of a property payment system to address capital needs that will be funded with additional appropriations.

• Identification of exemptions from current regulations and statute applicable under performance-based contracting.

Contact Mr. Held at (651) 215-5761 and Ms. Illston at (651) 645-4545. ■

Washington

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market for individual health insurance, but it does not mean that individuals can easily get health insurance in Washington. Adverse selection is threatening to kill the unsubsidized component of Washington State's Basic Health Plan, another state-sponsored option for individual health insurance.

It's "clearly at a point where it likely does not exist in a year unless something drastic changes," says Dennis Martin, director of policy and legislative relations for the Washington State Health Care Authority.

In their last session, Washington legislators rejected measures that advocates say would have at least slowed the decline of the 7,000-member unsubsidized Basic Health Plan. Already at 30% of its initial enrollment three years ago, the Basic Health Plan will lose an additional 3,200 members to service area cutbacks Jan. 1. Virtually all of the 3,200 enrollees are in counties where no other insurance options are available, says Mr. Wasser.

The only way the state could get any insurers at all to bid on the unsubsidized Basic Health Plan was to allow them to freeze enrollment to new applicants. All but one of the six plans operating in 2000—a single-county provider-sponsored plan—accepted the offer and closed enrollment effective Sept. 1.

One size does not fit all

While Washington state's circumstances are unique, its problems with a shrinking market for individual coverage are not, says a health law researcher at Wake Forest University in Winston-Salem, NC.

States can get in trouble when they try to apply reforms that have worked in the small group market, such as restrictions on medical underwriting, to the very different market for individual health insurance, says Mark O. Hall, JD. When such reforms increase the risk of adverse selection, insurers are likely to conclude that the relatively small number of potential customers in the individual market just isn't worth it, he says.

"There's been a large number of insurers who have pulled out, and the market has become very tenuous," he says.

State officials are quick to make the distinction between the unsubsidized Basic Health Plan and the companion program for which the state will subsidize premiums on a sliding scale. The Basic Health Plan targeted to low-income individuals has approximately 130,000 members and is a "very viable program," Mr. Martin says.

The unsubsidized program was an "afterthought" to the subsidized portion Basic Health Plan, says Mr. Wasser. It was designed to provide residents an alternative in the individual group market, even for those who would qualify for Medicaid. There are no income or asset limitations, and no medical underwriting.

Over the years, state officials have purposefully sacrificed the unsubsidized plan to maintain the solvency of the low-income program. For the plan year 1998, the state removed the requirement that the unsubsidized plan rates could exceed those in the low-income plan by no more than 5%.

As expected, cost-shifting evaporated and rates for the low-income program declined. The following year, the state removed the requirement that insurers bid on both products—or none at all—when several companies threatened to leave Basic Health altogether rather than take a chance on the unsubsidized plan.

From the very beginning, the unsubsidized Basic Health Plan disproportionately attracted residents who needed or knew they were going to need health care services, with utilization rates several times that of a comparable population. In 1997, the unsubsidized Basic Health Plan had 66.4 obstetrical admissions per 1,000 enrollees; a similar enrollee group, active state employees, had 8.2 obstetrical admissions per 1,000.

The state's design of both its own product and the regulation of other individual health plans help explain the adverse selection plaguing the Basic Health Plan. For example, the Basic Health Plan had a three-month waiting period before pre-existing conditions had to be covered. Three months is short by industry standards and effectively offered maternity coverage in return for a few months of premiums.

Adverse selection inevitable

At the same time, private insurers were allowed to offer individual health products that excluded high cost—and some say more discretionary—services such as maternity, prescription drugs, and mental health.

"Given that situation, you would have had to have adverse selection somewhere," notes Adele M. Kirk, a senior associate at the Alpha Center who has analyzed Washington state's individual insurance market. She says individual market reforms in other states, Maine and New York, for example, "very carefully" avoided "segmentation of the market" and subsequent death spiral afflicting Washington state.

"It's not that people are gaming the system," says Mr. Martin. "People are coming to us because they've got nowhere else to go. They are doing what makes good economic sense for them."

For the year ending July 2000, the full monthly premium for a single person from 19 to 39 ranged from $145.42 to $244.00. Existing rates reflect back-to-back rate hikes of 50% in the plan's first two

renewal periods.

While state officials are struggling to accommodate enrollees disrupted by the latest changes in the Basic Health Plan, they also wonder what happened to the 17,000 people who have left the program since its inception.

"We can't target where all these people went, but it probably would not be accurate to say the individual insurance market in the state has improved," says Mr. Martin. "If anything, it would be just the opposite."

Contact Ms. Senn's office at (360) 586-4422, Mr. Wasser at (360) 923-2711, Ms. Kirk at (202) 296-1818, and Mr. Hall at (336) 758-4476. ■

Looking on the bright side of the departure of commercial plans from Medicaid market

Reports of the death of Medicaid managed care are greatly exaggerated, say researchers tracking the field. In fact, some of the high-profile departures of commercial plans from the Medicaid market may be "acceptable," says Mathematica researcher Suzanne Felt-Lisk. At the recent annual meeting of the National Academy for State Health Policy in Cincinnati, Ms. Felt-Lisk offered some encouragement to Medicaid officials struggling to maintain the health of commercial plans serving Medicaid enrollees:

- Commercial plans still maintain a role in serving Medicaid. About 60% of Medicaid enrollees are served by commercial plans, according to a Mathematica analysis of Medicaid in 15-states.
- The significance of the departures is diminished by the relatively small size of the Medicaid enrollment they served.
- Some exits may strengthen the role of the plans that remain by increasing their enrollment and allowing the addition of services.
- A smaller number of plans may improve the ability of the state to monitor managed care plans.
- Outcomes analysis is easier with a smaller number of plans.
- A smaller number of plans may simplify enrollment choices for enrollees.
- The departure of commercial plans may reflect state policy favoring nonprofit safety-net plans.

Still, the exodus poses some operational and policy problems. Ms. Felt-Lisk notes that the shrinking of the commercial presence in Medicaid disrupted patient relationships and jeopardized states' ability to offer a "mainstream option" to enrollees.

Just over half of the Medicaid-dominated plans, defined as those that count on Medicaid for at least 75% of their business, are provider-based, according to Mathematica's analysis. Such safety net plans are unlikely to offer growth or even stability to Medicaid managed care markets, researchers say.

"I think we are going to get a second jolt here insofar as states may grow to rely on Medicaid-only or provider-sponsored entities when their staying power is questionable," says Robert Hurley, associate professor of health administration at Virginia Commonwealth University in Richmond, VA.

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Role of Commercial Plans in the Medicaid Market in 15 High-Volume Medicaid Managed Care States, 1994-1998

	1994	1995	1996	1997	1998
Number of Commercial Plans Participating	101	124	153	145	126
Enrollees					
Number of Medicaid Enrollees Served by Commercial Plans (000s)	2,293	3,201	3,982	4,742	4,648
Percentage of Medicaid Enrollees Served by Commercial Plans	62	62	66	64	60

Source: Presented at the National Meeting for State Health Policy. Mathematica Policy Research, Inc. analysis of data from Interstudy (1996-1997), GHAA (1994-1995), HCFA (Medicaid enrollment 1994-1997), and state Medicaid agencies (1998). Cincinnati; August 1999.

Medicaid HMOs

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"The Medicare impacts of the Balanced Budget Act are just now hitting hospitals, and I see many of them jettisoning their [normally] unprofitable HMOs to get back to basics. Thus states may find the organizations they are growing to rely on are, in effect, unreliable," Mr. Hurley said after the meeting.

Even when it has the financial resources to expand, a small, provider-sponsored plan may not find such a move part of its "mission," Ms. Felt-Lisk noted.

Defying the odds is Kentucky, where the state is relying on sole-source partnerships with provider-sponsored organizations to provide Medicaid managed care. (See *State Health Watch*, November1998, p. 3.) Plans are operational in the two markets surrounding Louisville and Lexington, with a single plan for two northeast Kentucky regions expected to be up and running by November.

Sole-sourcing can free up money that otherwise would be used for marketing and similar administrative expenses, notes Rich Heine, director of quality improvement and development for Kentucky's Department of Medicaid Services.

At the same time, he cautions against expecting too much too quickly from provider-sponsored plans anchored by an acute care provider.

"They're not too interested in going really fast" to ratchet down hospital utilization and related costs, Heine says.

Contact Ms. Felt-Lisk at (609) 799-3535, Mr. Hurley at (804) 828-1891, and Mr. Heine at (502) 564-7940. ■

States step up to the plate to cover drug costs for elderly, disabled, poor

Some states are exploring price controls

A modest drug benefit is "something we plainly would provide if we were creating Medicare for the first time today," President Clinton recently told attendees at the National Governors Association annual meeting. But until the federal government accepts that challenge, a growing number of states are taking on the responsibility.

Massachusetts appears ready to ease eligibility and expand benefits of an existing program that pays for seniors' prescription drugs. Maine and Delaware have initiated new programs, and Missouri is turning to tax credits to offset drugs costs among the elderly. (See chart for state-by-state description of drug benefit programs, p. 8.)

The generosity is tempered by the realization that open-ended or overly generous benefits offer no real changes and probably are unsustainable for states in the long run.

"What do we do for a long-term solution?" asks David Martin, chief of staff for Massachusetts state Sen. William Moore (D-Worcester). For that, Massachusetts and Vermont are considering proposals that would use the regulatory and purchasing power of the state to restructure the prescription drug market and, in effect, institute a system of pharmaceutical price controls.

In the meantime, several states are inching toward expanding access to pharmaceuticals:

• The Massachusetts legislature, at press time, appears ready to raise the income eligibility for the state's drug program from 150% of poverty to 200%, and double the benefit cap to $1,500 annually. Expected expenditures for the expansion are between $20 million and $30 million annually. At the same time, legislators were considering a variety of proposals to leverage rebates or discounts into expanded access for low-income residents.

• Delaware hopes to serve about 5,000 persons annually in its Prescription Drug Payment Assistance Program, which takes effect Jan. 1, 2000. The program is open to those who are 65 or older or disabled, and have incomes below 200% of the federal poverty level.

> "What we need to do is find an arrangement to allow suffering people get what they need."
>
> Alan Sager, PhD
> *Researcher, Boston University*

The Delaware law imposes an "enrollment fee" of no more than $20 to defray administrative costs of the program and a copayment of at least $5 up to 25% of the acquisition cost of the prescription. In any given year, benefits are limited to $2,500.

The new program is designed to supplement seniors' drug coverage below 200% of poverty not addressed by Medicaid or Nemours Health Clinic Pharmaceutical Assistance Program, which provides prescription drugs at 20% of cost. The assistance program's family income threshold picks up where Nemours leaves off, at $12,500 for a single person and $17,125 for a married couple. Benefits top out at an annual income

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State Pharmacy Programs

State	Year Begun	Minimum eligible age	Other groups eligible	Enrollment, 1997 (unless indicated otherwise)
Connecticut: ConnPACE	1986	65	Disabled persons under 18 years of age in Social Security Disability Program or Supplemental Security Income Program	37,676
Delaware: The Nemours Foundation	1985	65	None	9,600
Illinois: Circuit Breaker Pharmaceutical Assistance Program	1985	65 (16 if disabled)	Widow or widower who turned 63 before deceased claimant's death	NA
Maine: Elderly Low-Cost Drug Program	1975	62 (55 if disabled)	If more than 40% of annual household income is spent on medications, then a single person with an income of up to $13,250 or a family with an income of up to $16,375 may be eligible. (1997 income thresholds.)	16,179
Maryland: Pharmacy Assistance	1979	No limit	None	11,237 (65 and older), 10,176 (45 to 64)
Massachusetts: The Senior Pharmacy Program	1996	65	None	20,000
Michigan: State Medical Program	NA	No limit	None	20,000
Michigan: Emergency Pharmaceutical Assistance Program for Seniors	1994	65	NA	10,934
Minnesota: Senior Pharmacy Program	1999	65	None	4,500 (1999 projected)
New Jersey: Pharmaceutical Assistance for the Aged and Disabled (PAAD)	1975	65 (21 if disabled)	None	183,000 older adults; 22,300 adults with disabilities
New York: Elderly Pharmaceutical Insurance Coverage (EPIC) Fee Plan	1987	65	None	99,500 (total for both Fee and Deductible plan, described below)
New York: Elderly Pharmaceutical Insurance Coverage (EPIC) Deductible Plan	1987	65	None	See (EPIC) Fee Plan
Pennsylvania: Pharmaceutical Assistance for the Elderly (PACE)	1984	65	None	260,000 (March 1998)
Pennsylvania: PACE Need Enhancement Tier (PACENET)	1996	65	None	12,889
Rhode Island: Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	1985	65	None	27,000
Vermont: Vermont Health Access Program (VHAP)	1996	65	Recipients of disability benefits through Social Security or Medicare	7,149
Vermont: Vscript	1989	65	Recipients of disability benefits through Social Security	2,250
Wyoming: Minimum Medical Program	1988	No limits	None	970

Source: Gross D, Bee S. *State Pharmacy Assistance Programs.* AARP Public Policy Institute. Washington, DC; April 1999.

States step up

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of $16,480 for an individual and $22,120 for married seniors. The allowable income range is broader for disabled residents.

In addition to prescriptions, "cost-effective" over-the-counter drugs prescribed by a physician are covered, as are necessary diabetic supplies not covered by Medicare.

• In Missouri, the governor has signed a bill giving a state income tax credit of up to $200 to residents at least 65 years old for the costs incurred for prescription drugs. Benefits under the program top out for those with incomes of $15,000 or less, and are reduced by $2 for every $100 dollars of income above the threshold.

The credit is considered a tax overpayment, and is refunded even if the amount of the credit exceeds an individual's tax liability.

• Maine's voluntary program,

Drug coverage uneven in Medicare HMOs

Prescription drug coverage varies widely among the 6.2 million elderly enrolled in Medicare HMOs, a recently released report by the Kaiser Family Foundation in Washington, DC, states.

While one in six Medicare HMO enrollees are in a plan with no prescription drug coverage, one in four have unlimited drug benefits. Copays ranged from $0 to $12 for generic drugs and $0 to $20 for brand name drugs. Annual limits ranged from $600 to none. (See table, below.)

The authors concluded that, given the rapid rise in prescription drug costs, the more generous Medicare HMOs may present the "best alternative" to high out-of-pocket payments. However, they note that the "rapid increases in prescription drug costs, coupled with reductions in the growth of Medicare payments to plans, may place increasing financial pressure on Medicare HMOs, potentially jeopardizing the availability of relatively generous, affordable drug coverage under Medicare HMOs in the future."

A copy of the full report is available on the Web at http://www.kff.org/content/1999/1511/HMOAnalysisBarents.pdf.

Source: "Analysis of Benefits Offered by Medicare HMOs, 1999: Complexities and Implications." Washington, DC: Kaiser Family Foundation; August 1999.

County and state	Monthly supplemental premium	Generic drug copay per prescription	Brand name drug copay per prescription	Drug benefit limits
Los Angeles	$0	$0 to $7	$5 to $2	Unlimited or $2,000 to $4,500 for those imposing limit
Dade, FL	$0	$0	$0	$2,400 for one plan, no limits on all other plans
Maricopa, AZ	$0	$3 to $7	$5 to $15	Unlimited or $1,500 to $3,000 for those imposing limit
Cook, IL	$0 to $63	$5 to $10 for all plans except one plan not offering benefit	$10 to $15 for all plans except one not offering benefit	Unlimited or $600 to $1000 for those imposing limit. One plan does not offer
Allegheny, PA	$0 to $13	$5 to $12 for all plans except one plan not offering benefit	$10 to $12 for all plans except one not offering benefit	$1,000-$1,500 for all plans except one plan not offering benefit
King, WA	$0 to $29	Benefit not offered	Benefit not offered	Benefit not offered

passed in the most recent legislative session, relies on enticing manufacturers to provide rebates in return for publicity about the companies' participation in the program. The subsidy must be comparable to that offered to the Medicaid program.

The only eligibility requirement is that someone be a Maine resident and without "significant" drug insurance coverage. Because Maine already has a drug assistance program for the elderly, the new initiative is likely to target working-age residents. Exact numbers are difficult to find, but there are potentially 220,000 Maine residents with inadequate or no insurance coverage for pharmacy, says Bob Carroll, pharmacy program supervisor in the state's Bureau of Medical Services.

The state anticipates distributing $2.5 million in rebates during the first year of operation and $10 million in the second year. One measure of the controversy surrounding the program is that rules for implementation must come back to the legislature for approval during the session that starts in January.

Maine's strategy rests on the assumption that companies participating in the program will increase their market share and reap generous profits from relatively modest boosts in their production costs. Boston University researchers Alan Sager, PhD, and Deborah Socolar, MPH, outlined this approach in a presentation to the U.S. House of Representatives Prescription Drug Task Force in late July. They estimated that a combination of discounts and rebates in a proposal then under consideration in Massachusetts would provide about twice as much in benefits to state residents as it cost manufacturers.

The benefit-to-cost ratio could be as high as 4:1 or 6:1, depending upon whether the state would absorb certain costs in the program and what assumptions are used regarding the price elasticity of prescriptions, Mr. Sager says.

"What we need to do is find an arrangement to allow suffering people get what they need," he says.

One problem with typical state pharmacy assistance programs, says a representative of the Pharmaceutical Research and Manufacturers of America (PhRMA), is that they are not integrated either clinically or financially into the rest of patient's health care. "I—as the payer—shouldn't have an incentive to skimp on your drugs because somebody else pays for your hospital costs if you don't get the drug you need," says PhRMA assistant general counsel Marjorie Powell.

PhRMA does not have a specific position on how pharmacy programs should be developed, but the association's wish list for a Medicare drug benefit is generally applicable, says Ms. Powell.

In addition to advocating the integration of drug and other medical benefits, PhRMA supports drug benefit proposals that maintain competition among health plans, gives the choice of pharmaceutical to the patient and physician, improve access for those in need, and "protect America's system for research and development," she says.

Contact Mr. Carroll at (207) 287-2674, Mr. Martin at (617) 722-1494, Mr. Sager at (617) 638-4664, and Ms. Powell at (202) 835-3400. ■

Correction

A September 1999 *State Health Watch* story misrepresented Jim Verdier's characterization of Iowa's Medicaid program for behavioral health. The passage should have described the program as more venturesome and ambitious than others throughout the country. ■

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

Clip files / Local news from the states

Help available for implementing CHIP from National Academy for State Health Policy

PORTLAND, ME—A collection of the Children's Health Insurance Program (CHIP) case studies and a user's guide have been released by the National Academy for State Health Policy (NASHP) to help state officials with program implementation and evaluation.

The user's guide, *Framework and User's Guide for State Evaluation of the Children's Health Insurance Program*, is intended to help states meet a mandatory March 2000 deadline for evaluation of their CHIP plans. While its use is voluntary, the user's guide was designed by a workgroup of state and federal officials, who have petitioned states to use the framework as a way of standardizing data collection and analysis.

Copies of the report are available through the academy at (207) 875-6354.

—NASHP release, Aug. 13

President Clinton announces initiatives to boost Medicaid and CHIP enrollments

ST. LOUIS—On-site reviews by federal workers are among the initiatives announced by President Clinton recently to gig states into boosting enrollment in Medicaid and the Children's Health Insurance Program (CHIP).

Mr. Clinton also used a speech at the National Governors Association to make a pitch for greater involvement in school-based outreach and increased funding for health insurance from states' tobacco settlements.

While saying CHIP is too new to "rush to judgment" on its success, Mr. Clinton called on states to improve the level of data reporting to the federal government. "We can't improve the program or know what's wrong with it unless we know how many children have signed up for it," he said.

—White House release, Aug. 8

Fort Worth loses provider-sponsored Medicaid HMO, Harris Methodist

FORT WORTH, TX—The second-largest Medicaid HMO in the Fort Worth metropolitan area is leaving the market.

The announcement by the provider-sponsored Harris Methodist Health Plan gives 13,450 plan enrollees 90 days to choose among the four remaining Medicaid plans in the area.

The largest, Americaid Community Care, has 23,300 of the 40,000 Medicaid enrollees in the six-county service area.

The announcement from Harris, which has participated in the Medicaid managed-care program since its rollout three years ago, did not explain why it was dropping the HMO. The overall average monthly per member per month payment in the Tarrant area will be $186.17 for each member in fiscal 2000, up from $174.72 in fiscal 1999.

—*Fort Worth Star-Telegram*, Aug. 26

UNOS halts attempt to exclude Illinois from Midwest referral region

CHICAGO—The United Network for Organ Sharing (UNOS), the Richmond, VA-based agency that oversees the distribution of donated organs, halted in late August an attempt by four Midwest states to establish a referral region that excludes Illinois.

Minnesota, Wisconsin, and the Dakotas have crafted a plan that trims Illinois from the existing five-state referral region. The four states had been negotiating with Illinois for inclusion in the agreement for when the directive came from UNOS. The agency also directed members in the five states to enter into a formal conflict resolution process.

Under the proposed program, livers would be distributed to the sickest patients within the four-state area without regard to state boundaries. States donating the organs would expect reciprocity at some future date.

The plan follows recommendations from the Institute of Medicine, which concluded that catchment areas should contain at least 9 million people to increase the allocation of livers to patients with the most urgent need for transplants. The four states — with a total population of 11 million — are currently part of a transplant region with Illinois, which has a population of nearly 12 million.

—American Hospital Association release, Aug. 30; *St. Paul Pioneer Press*/AP, Aug. 15

New York recruits help of maternity staff to ensure women in labor know HIV status

ALBANY, NY—Hospital maternity staff in New York are required to offer an HIV test to all women in labor who did not get one during prenatal care.

The requirement, which went into effect Aug. 1, is designed to move New York closer to universal prenatal

State Health Watch

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HIV counseling and testing, says a letter from Health Commissioner Antonia Novello, MD, MPH, to the state's health care providers. In 1997-98, about 58% of the women delivering had been tested. State officials estimate that about 200 women deliver each year without learning their HIV status.

The results of the HIV tests are to be returned as soon as possible, no later than 72 hours. If a woman refuses testing, testing will be done on the infants with the results returned in about the same time period.

—Letter from NY Health Commissioner Antonia Novello, June 1999

Washington state insurer agrees to pay fines for denying ER claims; three other targeted companies continue to negotiate

SEATTLE—QualMed Washington will pay a $250,000 fine and the cost of up to 113 denied emergency room claims under an agreement reached with state regulators over the interpretation of the state's "prudent layperson" statute.

Negotiations are ongoing with Aetna U.S. Healthcare, Regency BlueShield and Premera Blue Cross over whether they complied with laws requiring payment for emergency room visits a "prudent layperson" would consider an emergency.

State Insurance Commissioner Deborah Senn is maintaining that more than half of the emergency-room claims denied by the insurers in the first four months of 1998 should have been paid. She said QualMed did not intentionally break the law, but rather denied the claims because of insufficient medical notes from emergency-room doctors.

QualMed, the state's fifth-largest health insurer with more than 132,000 subscribers, will change its policies for processing claims and give doctors more say over what constitutes medical emergencies.

—*Seattle Times*, Aug. 20

Compliance officers meet in Chicago

Health Care Compliance Association: Third Annual Compliance Institute, Oct. 24-27, Chicago Marriott. For more information, call (888) 580-8373 or visit the Web at www.hcca-info.org.