State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

For $48 billion more: Covering the uninsured could save money

An analysis of federal government data released during Cover the Uninsured Week in May indicates that at least 20 million working Americans don't have health insurance coverage. States with the highest uninsurance rate among employed or self-employed adults include Texas (26.9%), Louisiana (23.2%), Mississippi (22.4%), and New Mexico (22.4%). States with the lowest uninsurance rates among those who are working are Minnesota (6.5%), Hawaii (7%), Maryland (8.1%), and Iowa (8.7%).

The data were from the Centers for Disease Control and Prevention's 2002 Behavioral Risk Factor Surveillance System Survey, a national telephone survey of preventive and health risk behaviors. They were analyzed by researchers at the State Health Data Access Assistance Center at the University of Minnesota, and were released by the Robert Wood Johnson Foundation at a media conference kicking off the foundation's Cover the Uninsured Week, a nonpartisan campaign to focus attention on the need to secure health coverage for all

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In This Issue

Rebates on physician-administered drugs go unclaimed; Medicaid losing out on millions

The Department of Health and Human Services' Office of Inspector General (OIG) says that in 2001, Medicaid could have saved millions of additional prescription drug rebate dollars if every state had collected rebates for all single-source physician-administered drugs and 40 multiple-source physician-administered drugs. As of March 2003, the OIG says, 24 states did not collect rebates on any physician-administered drugs.

Fiscal Fitness: How States Cope

"Our study indicates a state's savings in a single year could exceed the one-time cost of implementing system changes needed to collect rebates for these drugs," an April 2004 OIG audit report says. "We recommend that the Centers for Medicare & Medicaid Services [CMS] continue to encourage all states to collect rebates on physician-administered drugs, especially single-source drugs. As part of this effort, CMS should encourage cooperation and sharing of information between states that collect rebates for these

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Uninsured

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Americans. The campaign was co-sponsored by a number of diverse organizations, including the U.S. Chamber of Commerce and the AFL-CIO, supported by nine former surgeons general and secretaries of Health and Human Services appointed by both Democrat and Republican presidents, and co-chaired by former Presidents Gerald Ford and Jimmy Carter.

Among the other findings:

- Uninsured adults are less likely to get the health care they need. Some 19% of uninsured adults report being unable to get needed medical care in the past 12 months, compared to 5% of adults with health coverage.
- Uninsured adults are less likely to have a personal doctor or health care provider. Nationally, 56% of adults without health insurance say they do not have a personal doctor or health care provider, compared with 16% of people with health insurance.
- Individuals who are uninsured are less likely to receive preventive services. Nearly half (46%) of all women who are the appropriate age for mammograms under Centers for Disease Control and Prevention guidelines say they do not have them in the recommended time frame, more than double the rate of insured women. About 70% of uninsured men who are the appropriate age for prostate cancer screenings report not having them in the recommended time frame, compared with 47% of insured men.
- Adults who are uninsured are twice as likely to report being in poor or fair health as adults who are insured. Nationally, more than one in five uninsured adults (21%) say their health is fair or poor, nearly double the rate of adults with health coverage (11%).
- Overall (**see graph, p. 3**), for both the employed and unemployed, the number of uninsured varies from state to state. States with the highest adult uninsurance rates include Texas (31.2%), Louisiana (27%), Mississippi (26.3%), and Nevada (25.6%). States with the lowest adult uninsurance rates include Minnesota (7.8%), Hawaii (10.2%), Delaware (10.3%), and Massachusetts (10.7%).
- Census Bureau data indicate that nearly 44 million Americans lacked health care coverage of any kind for an entire year, including 8.5 million children. In 2002 alone, the number of people without coverage increased by 2 million, the largest one-year increase in a decade.

Special data releases during the campaign looked at the impact of not having health insurance particularly on African Americans and Hispanics. It was reported that 18% of African American adults with jobs are uninsured, compared to 11% of working but uninsured white adults. "African Americans are disproportionately affected by diabetes, cardiovascular disease, kidney disease, and other serious health problems, so regular medical care is especially important for our community," says Randall Maxey, president of the National Medical Association, the largest and oldest national organization representing African American physicians and their patients. "African Americans who don't have insurance are forced to go without care. As a result, small health problems become major ones. That's why we are demanding that everyone in

America must be able to get affordable health insurance."

The report also finds that African Americans without health coverage suffer significant gaps in medical care when compared to African American adults who have health insurance. Uninsured African Americans are less likely to get the care they need, less likely to have a personal doctor or health care provider, less likely to receive preventive services, and more likely to report being in poor or fair health.

Likewise, some 35% of Hispanic adults with jobs are uninsured, compared to the 18% of African Americans and 11% of white working adults. "Across the nation, the number of uninsured Americans is on the rise, but Hispanic Americans are affected more than any other ethnic group by the lack of health insurance," says Risa Lavizzo-Mourey, Robert Wood Johnson Foundation CEO. "These are men and women who work hard to support their families, but either are not offered insurance by their employers or cannot afford the coverage that is offered. We must find a way to solve this problem and make health benefits affordable for all business owners and their employees."

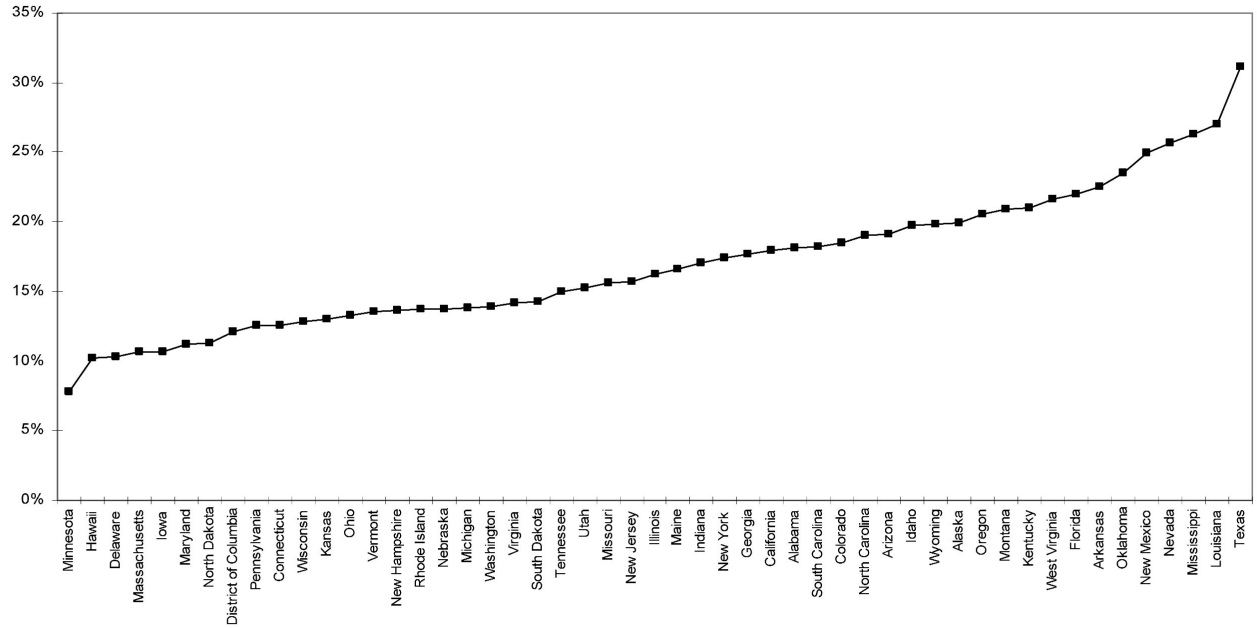
The report also found uninsured Hispanics are forced to go without medical care when it's needed. They are less likely to get the medical care they need, even less likely that uninsured non-Hispanic whites to have a personal doctor or health care provider, less likely to receive preventive services, and more likely to report being in poor or fair health.

Another specialized survey released during the campaign reported on interviews with emergency department (ED) physicians and concluded that the number of uninsured patients being seen in hospital EDs is increasing.

The opinion poll of nearly 2,000 emergency doctors found that 72% said the number of uninsured people they treated in the past year increased, and 79% thought the number was likely to increase again this year. There also was overwhelming agreement among the physicians that the uninsured patients they treat

The number of uninsured varies from state to state.

Figure 1: Uninsurance Rates for Adults, Ages 18-64



Source: 2002, Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.*

- States with the highest adult uninsurance rates include: Texas (31.2%), Louisiana (27.0%), Mississippi (26.3%), and Nevada (25.6%)
- States with the lowest adult uninsurance rates include: Minnesota (7.8%), Hawaii (10.2%), Delaware (10.3%), and Massachusetts (10.7%)

State Health Access Data Assistance Center (SHADAC) , www.shadac.org

are more likely to delay care, suffer from illness, and put their physical and financial health in jeopardy than are patients with health coverage. Some 74% of the doctors said their uninsured patients are more likely to die prematurely. The issue has become so critical that 57% of emergency physicians ranked providing basic health coverage to all Americans as the No. 1 goal in improving the nation's health care system.

"I've been an emergency physician for more than 20 years, and each year I see an increasing number of uninsured patients," says J. Brian Hancock, president of the American College of Emergency Physicians. "While we treat and stabilize them in the emergency department, after they are released, many are faced with the decision of whether to spend their money to fill a prescription, follow a recommendation to see a specialist for follow-up care, or buy groceries that week. That's a choice no one should be forced to make."

The physicians surveyed rated securing specialist referrals, ensuring follow-up care, and filling prescriptions as the three most challenging tasks to coordinate for uninsured patients. Additional survey findings indicated the ED physicians believe that nearly 30% of their patients are without health coverage and nearly 25% of their uninsured patients are children younger than 18. Some 82% of the physicians say their hospital ED functions at or over capacity on a typical week day, and the share increases to 91% for a typical weekend. "Many uninsured patients end up in the emergency department because they did not receive the preventive care they needed earlier," says John Lumpkin, an emergency physician who directs the Robert Wood Johnson Foundation's health care group. "Many uninsured patients don't have a physician they can see regularly for check-ups. Consequently, they arrive in the ED as a last resort and frequently much sicker than they would have been if they had had access to primary and preventive care."

As its contribution to the campaign, the Kaiser Commission on Medicaid and the Uninsured released an issue update, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" The paper contains findings from a new study examining the cost of medical care for the uninsured and how much care the uninsured receive compared to fully insured people.

Total medical care expenditures among all the uninsured in 2004, including those without coverage for all or part of the year, were nearly $125 billion. In the 1998 to 2000 survey years that were used to project current costs for the analysis, more than 60 million people were uninsured for either all or part of a year, with just a little more than half being uninsured for the full year.

About a quarter of the total medical costs are paid directly by the uninsured out of pocket, although people who are uninsured for the full year pay for more than a third of their care (35%), a considerably higher share than paid by either the full-year or part-year insured populations, who paid for just under 20% of their care out of pocket.

In 2004, uncompensated care is estimated to be $40.7 billion, 2.7% of the projected total personal health care spending for 2004 of $1.5 trillion. Most uncompensated care dollars are incurred by hospitals, where services are most costly. In 2001, hospitals accounted for more than 60% of uncompensated care dollars, with office-based physicians and direct-care programs/clinics each accounting for about 20%.

Both parties put forth plans to cover uninsured

As part of Cover the Uninsured Week, Republican and Democratic members of Congress put forth their ideas for reducing the number of uninsured. The U.S. Senate Republican Task Force on Health Care Costs and the Uninsured put out proposals to cover 17 million to 25 million people, relying on tax credits, deductions for premiums paid for health plans sold in conjunction with health savings accounts, efforts to boost Medicaid and SCHIP enrollment, legal reforms to promote information technology, and wider funding of community health centers.

The proposals carry an estimated price tag of $93 billion over five years and reportedly would deliver $110 billion in savings to the federal government over the same time period. They would generate overall health system savings of $137 billion annually, Senate staffers estimate.

Meanwhile, House Democrats offered three proposals they said would cumulatively cover about 21 million uninsured people, targeting three fast-growing vulnerable segments of the uninsured population — low-income families, the near-elderly, and employees who work for small businesses or are self-employed.

The FamilyCare Act of 2004 would give states access to $50 billion in new federal funding to cover parents of children in Medicaid or SCHIP if the family has income below 200% of the federal poverty level. The Medicare Early Access Act would allow individuals between the ages of 55 and 65 who lack access to group or public health insurance to buy into Medicare. And the Small Business Health Insurance Promotion Act would give small businesses and the self-employed a tax credit equal to 50% of the cost of coverage they purchased. ■

The primary funding source for uncompensated care is government dollars. The projected federal, state, and local spending available to pay for the care of the uninsured in 2004 is $34.6 billion, about 85% of the total uncompensated care bill.

The Kaiser report says the uninsured who are without coverage for the full year receive 55% of the medical care per person compared to those who have health coverage for the entire year, even after taking uncompensated care into account.

"Having health insurance increases medical care use," the report says, "and so an important question in the ongoing national debate over whether and how to extend insurance to people who are uninsured is — how much more will it cost, over and above what is currently being spent on the cost of their medical care?"

Extrapolating from the experience and behavior of people who are insured for a full year and have incomes in the low- and middle-income range (less than 400% of the poverty level), if the uninsured had full-year coverage, their per person spending would increase from $2,034 to $2,836, a 39% rise. Total spending for those who would gain coverage under a universal expansion would increase by $48 billion. Added to the current spending level of almost $125 billion, the new dollars would bring the total to $173 billion if coverage were similar to the average low- to middle-income person with health insurance. It reflects the potential increase in overall health spending directly attributable to the uninsured, but does not take into account the additional costs associated with major health care proposals.

Kaiser says that a benefit of a comprehensive approach to covering all of the uninsured, rather than an incremental approach, is that some of the public money already being used to pay for care received by the uninsured could be reallocated toward the cost of insurance. However, the report cautions, providers caring for the uninsured now, primarily hospitals that now receive the largest subsidies for uncompensated care, may be reluctant to relinquish their existing subsidies unless assured that all people will have health insurance.

Added cost relatively modest

To further the debate over how best to cover the uninsured, the Kaiser report says the additional $48 billion a year of medical spending needed to provide universal coverage beyond what is currently being spent can be viewed from several broader perspectives:

1. Relative to current government spending for public health insurance programs and the subsidization of private health insurance in 2004 (Medicare will cost $266.4 billion, Medicaid $280.7 billion, and tax subsidies to private insurance $188.5 billion), the additional spending to cover the uninsured is relatively small.
2. The new dollars would be less than 3% of total personal health care spending in this country.
3. The $48 billion would increase the share of gross domestic product going to health care by 0.4%.

A Duke University health policy researcher says one way to find the money to cover the uninsured would be to significantly reduce the cost of excess health service regulation. Testifying before the U.S. Senate Committee on Health, Education, Labor, and Pensions several months before Cover the Uninsured Week, Christopher Conover said his findings are based on more than two years of research on nearly 50 different kinds of federal and state health service regulations. "These various regulations covered the gamut from mandated health benefits to state certificate of need requirements for hospitals and nursing homes," Mr. Conover said. "We systematically tallied both the benefits and costs associated with such regulations and found that the expected costs of regulation in health care amounted to nearly $335 billion in 2002." The benefits of the health services regulations studied totaled about $207 billion, and he testified that the remaining $128 billion is attributable to excess regulation.

Mr. Conover cited three regulatory areas where savings could be realized: medical liability system, including litigation costs, court expenses, and defensive medicine; Food and Drug Administration (FDA) regulations; and health facility regulations. He said he is not suggesting that FDA be abolished or that nursing home patients be left on their own, but rather scaling back regulations when the cost exceeds the benefits. "Admittedly, our estimates are still preliminary, and we now are engaged in a process of careful review of them. But it seems unlikely that the adjustments yet to come would alter this central conclusion: The net burden of health services regulation likely exceeds the annual cost of covering the 44 million uninsured. So a legitimate policy question is whether the benefits of regulation outweigh the benefits of coverage for all Americans. For example, in the context of the Institute of Medicine finding that 18,000 uninsured die every year due to lack of coverage, is maintaining our current regime of health regulation worth letting that continue?"

(Download research papers, media releases, fact sheets, and other Covering the Uninsured Week materials from www.covertheuninsuredweek.org.) ■

Fiscal Fitness

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drugs and states that do not, to facilitate rebate collection."

The Medicaid drug rebate program was established in 1990 to reduce state and federal Medicaid expenditures for prescription drugs. Under the program, manufacturers are required to provide a rebate on drugs paid for by a state. Drugs that a medical professional administers to a patient in a physician's office — known as physician-administered drugs — are covered under the program.

To collect the rebates, states must identify the drugs by their national drug code and provide units paid data to the company. Unlike self-administered drugs that typically are billed to states with national drug codes, physician-administered drugs are more often billed with procedure codes. States that use procedure codes to bill physician-administered drugs need a crosswalk to national drug codes to collect rebates on the drugs. (A crosswalk is the identification of equivalent national drug codes for drugs represented by procedure codes.)

The national drug code is an 11-digit numeric code, divided into three segments, that identifies the firm that manufactures, distributes, or repacks the drug product; the specific strength, dosage form, and formulation of the product for a particular firm; and the product's package size. The procedure code is a five-digit alphanumeric code that identifies a drug by its generic name, route of administration (oral or injection), and identifies the number of drug units allowed per reimbursement for that code.

The OIG found that in 2001, 17 states collected rebates for physician-administered drugs and 31 states did not. Of the 17 that collected rebates, three — Hawaii, Missouri, and Pennsylvania — collected them on all physician-administered drugs and used national drug codes for billing. The remaining 14 states used procedure codes and crosswalked procedure codes to national drug codes for single-source drugs, collecting rebates only on those drugs.

"If all states had collected rebates for all single-source and 40 multiple-source physician-administered drugs, Medicaid could have added $37 million to its rebate savings for 2001," the OIG report says.

After 2001, seven of 31 states that had not collected rebates on physician-administered drugs began to do so. Of those seven, six collect rebates on single-source, physician-administered drugs, and one collects rebates on all physician-administered drugs billed by a targeted group of providers. The OIG estimated that the 2001 potential savings for those seven states was $14 million on all single-source and 40 multiple-source physician-administered drugs.

Some states don't plan rebates

As of March 2003, 24 states still did not collect rebates on any physician-administered drugs. Those states spent a total of $125 million on physician-administered drugs. Five of the 24 said they have no plans to collect rebates. While 19 of the 24 said they plan to collect rebates, 13 of the 19 did not have specific rebate collection plans, according to the OIG.

The inspector general says rebates for physician-administered drugs help states reduce prescription drug expenditures, which are rising at a time when state budgets are severely stressed. Based on cost estimates provided by states that have implemented changes to collect rebates for physician-administered drugs, savings from rebates in the first year can exceed the one-time cost of implementing system changes.

The report recommends that CMS continue to encourage all states to collect rebates on physician-administered drugs, especially single-source drugs. As part of that effort, the OIG says, CMS should encourage cooperation and the sharing of information between states that collect rebates for the drugs and states that do not, to facilitate rebate collection. "It would be valuable for states that do not collect rebates for physician-administered drugs to know the details of implementing system changes, such as the what, where, when, and why of resources needed, and how the process unfolded for states that have been down this road," the OIG comments. "CMS could also issue a letter to state Medicaid directors informing them about the availability and usefulness of the Medicare crosswalk. States could use this crosswalk, which is on the Internet, to reduce the administrative costs of creating and/or updating their own crosswalk."

CMS follows recommendations

According to the inspector general, CMS agreed with the recommendation and is currently facilitating information sharing. The agency is giving information to states seeking help to collect rebates and providing contact names in states that have experience obtaining rebates. The OIG says CMS disagreed with the $37 million estimate of potential savings. The OIG says it used information provided by states in the calculation of potential savings and acknowledged that savings in future years will depend on rebate amounts and utilization and would likely be different from 2001.

(To read the report, go to www.oig.hhs.gov.) ■

There's light at the end of the states' fiscal tunnel

The most recent analyses by the National Conference of State Legislatures (NCSL) and the National Governors Association (NGA)/National Association of State Budget Officers (NASBO) indicate improvement in states' fiscal situations and cautious optimism that the economic downturn is ending.

In its April report, NCSL said more than half the states are projecting surpluses by the end of the current fiscal year, a sharp contrast to the situation they faced a year ago when they were struggling to close a cumulative $21.5 billion budget gap. Currently, they are working to close a total gap of $720 million, and 32 states were forecasting surpluses for the fiscal year that ended June 30. The projected surpluses were a result of improved collections in major revenue categories and program cutbacks.

Nine states expected surpluses below 1% of their general fund budgets. In Florida, Nevada, Oklahoma, South Dakota, and Wyoming, surpluses were expected to be more than 5%. But officials said this breathing room came after three consecutive years of fiscal crisis, when states had to cut funding in such core areas as education, health care, and corrections. Some states dipped into rainy day funds, increased fees, or raised taxes on items including cigarettes, health insurance, and phone bills to help make ends meet.

Turning red ink into black

"States are turning red ink black," NCSL executive director Bill Pound said. "They should be praised for their diligence and willingness to make tough and often unpopular decisions that were necessary to get through the fiscal crisis. States are also grateful for help from the federal government this past year." (Federal aid in 2002 provided $10 billion in Medicaid relief and $10 billion in discretionary funds.)

Mr. Pound says state budgets still don't look healthy in FY 2005, but are moving in the right direction. Some 33 states were resolving budget gaps as they negotiated their FY 2005 budgets for a July 1, 2004, start of the fiscal year. The aggregate gap reported by NCSL was $36.3 billion, half as high as the $78.4 billion facing states as they opened FY 2004.

"The national economy seems to be improving," Mr. Pound said, "but not all states have felt the full strength of the recovery."

Meanwhile, the NGA/NASBO report says that in FY 2004, state-sourced Medicaid spending was up by 4.6%. Because of the temporary Federal Medical Assistance Percentage increase that was part of the federal fiscal relief package, federal-sourced state Medicaid spending increased by 11.7% in FY 2004. For FY 2005, governors project average state growth rates of 12.1%, while the federal share would grow by 3.9% as the temporary federal aid ends.

Elementary and secondary education has dominated state spending since FY 1993, while Medicaid has been the second largest and fastest growing component of state spending, both from state general funds and from all spending sources.

NGA says Medicaid "continues to exert pressure on state budgets, although for the remainder of FY 2004, the temporarily increased federal share of the program contained in the state fiscal relief provisions of the Jobs and Growth Tax Relief Reconciliation Act of 2003 has alleviated some of the fiscal stress."

Medicaid expenditures account for some 21% of all state spending, with spending on all health care functions taking up approximately 30% of overall spending. Proposed budgets for FY 2005 are looking at Medicaid growth rates of 12.1% in state funds and 3.9% in federal funds, with the significant shifts between state and federal funding attributable to the temporary increase in the federal match from April 2003 through June 2004.

"Even with extensive cost containment and fiscal relief," NGA says, "Medicaid expenditures continue to strain states and to exceed the amount that had been originally budgeted for the program. Twenty-three states experienced Medicaid shortfalls in FY 2003, and 18 states anticipated shortfalls in FY 2004."

The states have maintained a growth rate below private insurance levels due to extensive cost-containment efforts, NGA says. Among steps taken, 50 states reduced or froze provider payments, 50 states implemented policies to control prescription drug costs, 34 states reduced or restricted eligibility, 35 states reduced benefits, and 32 states increased copayments.

In addition to taking cost-containment steps, approximately half the states said they planned to generate additional Medicaid revenue. Most measures that rely on additional resources involve fees or taxes levied on health care providers. Other measures include reallocating tobacco settlement funds and increasing cigarette taxes.

According to the Fiscal Survey of States issued by NGA and NASBO, governors expect FY 2005 expenditures to increase 2.8% from 2004,

well below the 26-year average of 6.2%, but still a considerable improvement over the 0.6% increase in FY 2003, which was the smallest increase in the previous 20 years.

"After three years during which state revenues were exceedingly dismal, the picture is notably — but cautiously — brighter at the end of fiscal 2004," the report says. "As most economic indicators continue to improve, the cyclical instability that plagued state revenues has eased, and revenue collections compared to budgeted estimates contrast markedly with the past several years. Still, the state revenue situation might be characterized both as beginning to recover and ceasing to decline."

NASBO executive director Scott Pattison says the analysis indicates that "despite some improvements in the states' fiscal situations, the picture is far from rosy given the unprecedented strain of the last three years. Spending growth remains weak, and the recovery continues to be uneven. To balance their budgets in fiscal 2004, states also used a combination of layoffs, furloughs, early retirement, reductions to local aid, reorganization of programs, and a variety of other methods."

The worst of years for states

At a media briefing to release the NGA/NASBO report, Mr. Pattison said the last three years have been the worst ever for states. "If states were a patient, we'd say they're out of intensive care but still in the hospital," he said. He said state revenues have been coming in recently as projected, but spending is subdued and rainy day funds are not being replenished.

In visits to 10 state capitols, Mr. Pattison said, budget officers uniformly told him that "Medicaid is eating us alive."

NGA executive director Ray Scheppach told the briefing the basic problem for states is structural, including an obsolete tax system. He also pointed out that states gave to come to grips with the fact that one-third of their budgets (health care expenditures) is growing in double digits. He said enrollment in Medicaid has been increasing, even with cuts in the program.

An independent analysis by the Center on Budget and Policy Priorities finds states continuing to look to spending cuts to close gaps in their FY 2005 budgets. "The decline in expenditures continues to put important government services at risk in many states," the Center's Elizabeth McNichol and Makeda Harris said in an April report. "Publicly funded health insurance for low-income families and children continues to face cutbacks in a number of states this year. Georgia, Florida, California, Missouri, and New York are among the states that have adopted or are considering limiting eligibility for health insurance programs for low-income families in their FY 2005 budgets. For example, the Georgia state legislature has just approved a budget that reduces Medicaid eligibility levels for almost 20,000 pregnant women and infants. The Missouri legislature is considering a budget that would sharply trim Medicaid — ending coverage for about 65,000 low-income people, including 41,000 low-income parents and 21,000 children."

Number of uninsured growing

According to the center, a large number of people are becoming uninsured as a result of the nation's fiscal crisis. Budget cuts enacted since the fiscal crisis began have eliminated Medicaid or SCHIP coverage for more than 1 million people nationwide, and health care services for low-income families continue to face cutbacks this year. In addition to the Georgia and Missouri budgets mentioned above, the Center cites these examples:

- Florida recently enacted legislation to restrict eligibility for low-income children in its SCHIP program. The state stopped enrolling new applicants last year and built up a waiting list of more than 100,000 children. State officials yielded to citizen pressure to cover some 70,000 children from the waiting list but took other actions to restrict future eligibility. Making it harder to keep track of future actions, the state will no longer keep a waiting list.
- In California, Gov. Arnold Schwarzenegger has proposed a number of deep cuts in health programs including freezing enrollment in SCHIP so 114,000 children would not get coverage and reducing provider payment rates by 10%.
- New York is considering scaling back eligibility for low-income children and their parents in Medicaid and Family Health Plus. Also under consideration is restricting eligibility for seniors in Medicaid, reducing the ability of some seniors to obtain long-term care services.
- Several states have initiated plans to redesign Medicaid using waivers. These plans are looking to longer-term savings rather than immediate changes. Details are expected to include reducing the scope of benefits, increasing cost-sharing for low-income beneficiaries, or scaling back eligibility.

(For information from NCSL, go to www.ncsl.org; from NGA/NASBO go to www.nga.org; and from the Center on Budget and Policy Priorities, go to www.cbpp.org.) ■

States not making enough progress meeting women's health needs

The 2004 *Making the Grade on Women's Health: A National and State-by-State Report* issued by the National Women's Law Center and the Oregon Health & Science University says states are making some progress in improving health care for women, but often are taking two steps forward and one step back, so they don't make sufficient progress.

This is the third report issued by the two organizations. It ranks states on 27 health status benchmarks developed largely from goals laid out in the U.S. Department of Health and Human Services' Healthy People initiative. The report ranks the nation as a whole "unsatisfactory" for meeting only two benchmarks — the percentage of women receiving regular mammograms and the number of dental visits.

The best any individual state did was "satisfactory minus," and there were eight states in that category. Minnesota was first overall, followed by Massachusetts, Vermont, Connecticut, New Hampshire, Hawaii, Colorado, Utah, Maine, and Washington. The 10 lowest-ranking states were Mississippi, Louisiana, Arkansas, West Virginia, Oklahoma, Texas, Alabama, the District of Columbia, Kentucky, and Tennessee.

In addition to grading and ranking each state, the report evaluates whether states have adopted 67 key women's health policies. Only Medicaid coverage for breast and cervical cancer was met by all states, up from 40 states in the 2001 report. New York, California, and Rhode Island met a majority of the policy goals (more than 35), while Idaho, South Dakota, and Mississippi met the fewest policy goals. Preventing tobacco sales to minors was the most consistently improved policy, with 18 states now meeting it, compared to only five in the 2001 report.

"State policy-makers' piecemeal approach to our health care crisis has resulted in a complex and ineffective system that fails to meet the health care needs of women," says National Women's Law Center vice president for health Judy Waxman. "Lawmakers need to take a comprehensive, long-term approach to meeting women's health needs and tackle this serious problem that plagues so many families."

Oregon Health & Science University associate professor Michelle Berlin says the outlook for women's health is "grim and nowhere approaching the nation's goals for 2010 set by the Healthy People initiative. There is a great distance to go with the nation meeting only two out of 27 benchmarks graded in this report. Failing to meet these goals undermines not only the health and well-being of women, but the well-being of our country, as well."

The researchers say the nation fails on nine benchmarks, including indicators measuring women's access to health insurance, the prevalence of diseases such as diabetes, and deaths from coronary heart disease. "The two goals met by the nation . . . represent important but hardly adequate progress overall," they say. "The nation's performance needs significant improvement on every other goal. Moreover, nationwide, the disparities women experience in the quality of their health related to race, ethnicity, sexual orientation, disability, and other factors underscore that the problems faced by many women are even greater than those overall numbers suggest."

In addition to a message that much remains to be done, the report says a second message is that the situation in the states is mixed, while overall there has been some serious slippage in the federal government. A number of state governments have improved their policies in some key areas to meet women's health needs, Ms. Waxman and Ms. Berlin say, although a number of states have fallen backward in a few significant policy areas as well.

Twenty states improved at least five of their health policies since the last report card, with 29 states making progress in preventing tobacco sales to minors. Some 16 states improved their Medicaid enrollment process by adopting a mail-in application, and 13 states improved access to health services. "But as a general matter, the specific policy improvements varied considerably among the states," the researchers say.

"Moreover, unfortunately, these gains were offset to some degree by the weakening of other state policies. The majority of states weakened one to three policies, and three states weakened four or more policies. The 2004 findings help identify those priorities for women's health that must be tackled by policy-makers and health care providers, and the serious systemic shortcomings in meeting women's health needs that persist," they explain.

According to the report:

- Women need better access to health insurance to get the health care they need. Nationwide, almost 18% of women ages 18 to 64 are uninsured. No state met the Healthy People goal of access to health insurance. The variation among states was substantial — Minnesota ranked first with 7.9% of women uninsured, while Texas was last at 28.3%.
- Access to specific health care

(Continued on page 11)

Federal policy agenda advocated for women's health

This is the federal policy agenda offered by the National Women's Law Center and the Oregon Health & Science University to significantly improve women's health.

Women's Access to Health Care Services

1. Broaden eligibility requirements for federal publicly funded health insurance programs, including Medicaid, so low-income women without access to private insurance have coverage for the range of services they need.
2. Strengthen and expand federal publicly funded health insurance programs, including Medicare, to ensure it remains available and affordable to older and disabled women, and that they cover the full range of services women need.
3. Invest in outreach, public education, and culturally sensitive materials and remove bureaucratic hurdles to publicly funded health insurance programs.
4. Improve access to employer-based health care coverage for workers and their families and make the coverage affordable.
5. Strengthen public health system infrastructures to improve their ability to address major public health crises.
6. Remove barriers to quality health care faced by women of color and of different ethnic backgrounds.
7. Remove barriers to quality health care faced by lesbians.
8. Remove barriers to quality health care faced by women with disabilities.
9. Require that employers provide adequate, flexible family and medical leave benefits.
10. Require private insurers to cover contraceptives when they provide other prescription coverage.
11. Provide financial assistance to cover the costs of long-term care services.
12. Make available and accessible safety-net health care services for underserved and uninsured women.
13. Require private insurers to cover mental health conditions on the same basis that they cover physical health conditions.

Addressing Wellness and Prevention

1. Expand federal programs and increase funding to provide and/or cover preventive screenings like mammograms, Pap smears, and screening for colorectal cancer, osteoporosis, sexually transmitted diseases, and domestic violence.
2. Increase investment in programs that support physical activity, assist women in getting nutritious food, and educate women about nutrition.
3. Investigate gender-based barriers to girls' and women's participation in physical activities and enforce applicable civil rights laws when violations are found.
4. Expand federal efforts to encourage women not to smoke and allow the Food and Drug Administration to regulate tobacco.
5. Increase support for substance-abuse programs that address women's needs.

Key Conditions, Diseases, and Causes of Death

1. Increase funding for women's health research.
2. Collect, publish, and analyze health data on women in general and on specific populations of women by race, ethnicity, sexual orientation, disability, socioeconomic status, region, and age.
3. Develop and support programs to evaluate and promote effective prevention and health promotion interventions.
4. Increase funding for programs to prevent and treat the diseases, causes of death, and conditions that constitute key health risks for women.
5. Enhance support for the specific programs and policies addressing heart and other cardiovascular diseases, especially the Well-Integrated Screening Education for Women Across the Nation (WISEWOMAN) program and for expanded funding for key screening, counseling, and therapy services for beneficiaries with cardiovascular disease.
6. Expand federal programs including Medicaid to provide HIV/AIDS pharmaceutical therapies and up-to-date treatment to women with HIV and AIDS.
7. Increase investment in mental health services.
8. Expand and invest in federal programs that provide family planning, make infertility treatments more affordable, and increase funding for comprehensive prenatal and postpartum care.
9. Protect and expand access to abortion services.
10. Enact legislation to codify the principles of *Roe v. Wade* to ensure access to abortion.
11. Remove limits imposed on U.S. funding of family planning services throughout the world.
12. Invest in surveillance and research on effective strategies to combat domestic violence and sexual assault, and support programs that address the health, financial, and other needs of victims of these violent crimes.

(For more information on the agenda, go to www.wnlc.org.) ■

providers and services, particularly reproductive health providers and services, is insufficient. The report says women's health suffers when family planning services are not available. Nationally, nearly half of all pregnancies are unintended, missing by a substantial margin the national goal to reduce unintended pregnancies to 30% or less of all pregnancies. Twenty states meet the Report Card policy goal of requiring that private insurers cover contraceptives as they do other prescription drugs; only three states have adequate laws to facilitate women's access to emergency contraception. Some states actively limit women's access to full reproductive health care services through policies such as parental consent and notification requirements, waiting periods, and funding restrictions for abortion procedures.

- Preventive and health promoting measures must be more available. Only a small number of states meet all the nation's goals for screening for key diseases and states made only minimal progress in adopting policies to facilitate essential health screening by providing for insurance coverage for screening tests. "Given the importance of promoting wellness and preventing illness," the report says, "both the nation and the states should adopt policies and programs to help women engage in preventive behavior." Although the 2001 surgeon general's report identifies smoking as a critical women's health issue, only one state meets the national goal for achieving a low percentage of women who smoke. Smoking policies in the states have improved in some aspects but weakened in others since then. Medicaid smoking cessation treatment coverage policies have improved in 13 states, but only seven states have strong enough policies to meet the policy goal, and not one state mandates private insurers to cover smoking cessation. Although effective and comprehensive smoking prevention and cessation programs have been identified, only four states have allocated funds from their tobacco settlements to them, and that's down from six states in 2001.
- Disparities and gaps in economic security continue to compromise women's health because lower income women have more difficulty getting their health care needs met. Nationwide, 12% of women live in poverty, ranging from 7.4% in New Hampshire to 20.3% in Mississippi. Also, the gap between wages of men and women reflects the economic hurdles facing women, including those not living in poverty. Nationwide, women earn 72.7% of what men earn, and the states vary widely, from 89.2% in the District of Columbia to 64.4% in Wyoming.

The report puts a particular emphasis on the role the federal government can play in the health of women throughout the country. Through national programs and assistance to states, it can establish laws addressing private and public health care policies, fund health and ancillary services to individuals, and fund and conduct public education campaigns. But the report complains that the federal health policy agenda articulated in the 2001 Report Card has not advanced as it should, but rather

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

has moved in the wrong direction in some critically important ways.

"According to the most recently available figures, almost 16.5 million women do not have any health insurance at all, representing an alarming increase in the number of uninsured women in the nation," the report adds. "Moreover, many women who are insured are particularly vulnerable. Millions of women, even more than men, rely on public programs for their health insurance. Both Medicare and Medicaid are two of the public programs that provide crucial health care services for women, yet proposals have been passed or are being forcefully pressed that would significantly weaken both programs and reduce critically important health care services to women most in need."

The report puts forth a new federal policy agenda for women's health (**see box, p. 10**) with 31 recommended federal policies it says would promote women's health and well-being and allow the country to move forward.

[To see the report and additional information, go to www.nwlc.org. Contact Ms. Waxman at (202) 588-5180 and Ms. Berlin at (503) 494-5942.] ■

CALENDAR

9th Annual Summit on the Medicaid Drug Rebate Program & Other Public Sector Reimbursement Programs, Sept. 20-22, 2004, Denver. Web: www.medicaiddrugrebates.com. Telephone: Shari Gelfand, (888) 670-8200.

National Association of State Medicaid Directors, Nov. 17-20, 2004, Washington, DC. Web: www.nasmd.org. Telephone: Sharon Thompson Henson, (202) 682-0100.

Clip files / Local news from the states

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

Warner raising the bar on FAMIS enrollment

RICHMOND, VA—Virginia officials and child health advocates over the next few months will try to sign up more than 6,000 additional children to state-supported child health insurance programs. Currently, 93,000 children are enrolled. The goal is to reach 100,000 additional children enrolled in the Family Access to Medical Insurance Security plan, called FAMIS, and the state Medicaid program, over the course of Gov. Mark R. Warner's administration that began in 2002. The more enrollment grows, the more children living in low-income and working families can get regular health care instead of relying on emergency departments or delaying treatment as their conditions worsen. By the time school starts in September, Warner said he wants to see an increase in the number of children enrolled during his tenure. "That means that over the summer, during a time that we traditionally see a slowdown in enrollment, we'll all need to step up our efforts to reach and enroll these uninsured children," he said.

—*Richmond Times-Dispatch,* May 11

State to lift cap on health insurance plan for poor children

FORT COLLINS, CO—The cap on a Colorado health program intended to help thousands of poor children was to be lifted July 1. The legislature capped enrollment in Child Health Plan Plus at 53,000 last year to help offset a state budget shortfall of nearly $1 billion. The Colorado Health Care Policy and Financing Department, which oversees the program, stopped accepting applications Nov. 1. Department spokeswoman Rhonda Bentz said the cap would be lifted because lawmakers restored some $6 million for the program. "It was very difficult for the department to have to make the decision last fall," she said. "We're very, very pleased to have the ability to lift the cap." The plan helps children whose families earn too much to qualify for Medicaid, but cannot afford private insurance. Enrollment dropped from 52,370 to 43,643 from Nov. 1 to March 30, according to the most recent data available. Officials at the Colorado Community Health Network estimate at least 3,243 children and probably many more were denied coverage because of the freeze.

—*Denver Rocky Mountain News/AP,* May 17