State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

Families USA: Study illustrates the depth of problems of uninsured

Families USA has a different view of the uninsured than the federal government. The group says that while the Census Bureau's Current Population Survey estimated there were 43.6 million uninsured people in the United States in 2002, 14.6% more than in 2001, the reality is that 81.8 million people — or one out of three Americans younger than 65 — were without health insurance for all or part of 2002 or 2003.

Of that 81.8 million, two-thirds were uninsured for six months or more, Families USA says, and the 81.8 million figure does not double count people who were uninsured in both 2002 and 2003.

The difference between the Census Bureau statistics and those from Families USA comes because many people are uninsured for a portion of a year, but not for the entire year.

Families USA says such people are not reflected in the widely quoted Census Bureau numbers, but they may be profoundly affected by their uninsured status, in terms of both their physical and economic well-being.

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In This Issue

Pharmaceutical assistance programs walk a high wire while looking for ways to save money

Fiscal Fitness: How States Cope

Even using generic substitution and discounted prices, state pharmaceutical assistance program (SPAP) drug expenditures have escalated, according to a report funded by New York City-based The Commonwealth Fund and carried out by the Rutgers Center for State Health Policy.

Study authors Kimberly Fox, Thomas Trail, Susan Reinhard, and Stephen Crystal say further study is needed to assess the effects of other strategies such as prior authorization on pharmaceutical use and outcomes for poor and near-poor consumers. They also caution that problems related to coordination of benefits are likely to become even more challenging to states with the enactment of the Medicare drug benefit.

"Many states will seek to continue to provide pharmacy coverage that is less limited than the federally defined plan," the researchers write. "Prior difficulties in coordinating SPAP benefits with other coverage suggest that a great deal of work will

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Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@thomson.com.
Editorial Group Head: Lee Landenberger, (404) 262-5483, lee.landenberger@thomson.com.
Managing Editor: Alison Allen, (404) 262-5431, alison.allen@thomson.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Ann Duncan.

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Uninsured

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"To fully understand the scope of the problem — to know how many Americans are directly affected by a lack of health insurance — we need to broaden our sights and include those who are uninsured for a portion of the year, as well," Families USA says in its report. **(For six reasons why health insurance matters, see box, p. 4.)**

Enormous epidemic

"One out of three nonelderly Americans without health insurance constitutes an enormous epidemic that requires immediate attention," says Families USA executive director Ron Pollack. "It is high time that this problem rises to the top of our national agenda. The growing number of Americans without health insurance is now a phenomenon that significantly affects middle-class and working families. As a result, this problem is no longer simply an altruistic issue affecting the poor, but a matter of self-interest for almost everyone."

For 14 states, including the four most populous states, more than one-third of the people younger than 65 went without health insurance for all or part of 2002-03. Those states, with the percentage of the population younger than 65 that was uninsured, were:

- Texas (43.4%);
- New Mexico (42.4%);
- California (37.1%);
- Nevada (36.8%);
- Louisiana (36.2%);
- Arizona (35.7%);
- Mississippi (35.1%);
- Oklahoma (35%);
- Alaska (35%);
- Florida (34.6%);
- Arkansas (34.4%);
- Idaho (33.8%);
- North Carolina (33.7%);
- New York (33.4%).

The 10 states with the largest numbers of uninsured people were California (11.9 million), Texas (8.5 million), New York (5.6 million), Florida (4.8 million), Illinois (3.5 million), Pennsylvania (2.8 million), Ohio (2.8 million), Michigan (2.5 million), Georgia (2.5 million), and North Carolina (2.4 million).

Families USA estimates that just over half the 81.8 million uninsured (50.6%) were without health coverage for nine or more months. They contend that 11.8% were uninsured for nine to 12 months, 22.1% for 13 to 23 months, and 16.7% for more than 24 months. Only 7.1% were uninsured for two months or less, and 27.6% for three to five months.

Many factors cause variations

The wide variation in state experience is due to variations in a number of factors, Families USA says, including the categories of people covered by, income eligibility levels for, and enrollment rules of a state's Medicaid and SCHIP programs; the prevalence of jobs that offer health coverage; state economies and the incomes of state residents; the existence of state COBRA-like health continuation laws for workers in small firms who lose their employer-based coverage; and the presence of other state health insurance programs.

As has been noted in many other studies, more than four in five individuals (84.5%) who went without health insurance in 2002-03 were connected to the work force in December 2003, with 78.7% employed and 5.7% actively seeking employment. Only 15.5% of the uninsured adults and parents of uninsured children were not in the

labor force, either because they were disabled, chronically ill, family caregivers, or not looking for employment for other reasons.

Families USA says there are four principal reasons why employed people went without health insurance coverage (or their children went without coverage) for all or part of the previous two years. First, not all jobs offer health insurance benefits. The likelihood that an employer offers benefits to its workers varies considerably according to the characteristics of the employer. Thus, small employers, low-wage employers, and employers with older workers are all less likely to offer health coverage to their employees than their counterparts.

The second factor is that some employees who are offered coverage by their employers, especially low-wage workers, can't afford to pay their share of the premium cost. As income rises, the risk of being uninsured declines.

Third, contrary to popular belief, Medicaid doesn't provide coverage to most workers in low-wage jobs. Medicaid eligibility levels are set by each state. A parent in a family of three working full-time all year at the federal minimum wage of $5.15 per hour would earn too much to qualify for Medicaid in half the states, even though the family's annual income only would be about $10,700, well below the poverty level.

The fourth important reason why people employed in December 2003 experienced gaps in health insurance coverage in the past two years was temporary job loss due to layoffs, job elimination, termination, or worker choice. Families USA suggests that as the work force becomes increasingly mobile, it is likely that more workers will experience periods of joblessness and thus temporary loss of insurance.

"Any attempt to provide coverage to a significant number of uninsured individuals must address the problem of lower wage workers who are not offered or cannot afford employer-based health insurance," Families USA says. "Further, solutions to the uninsured that build on the employer-based health insurance system also must address the gaps in health insurance coverage that occur with gaps in employment."

Nearly two-thirds (60.9%) of individuals in families with incomes at or below 100% of the federal poverty level ($18,660 a year for a family of four in 2003) were uninsured. And more than half (53.5%) of individuals in families with incomes between 100% and 200% of poverty were uninsured. While the likelihood of being uninsured decreases considerably as income increases, there still were 25.2% of working individuals and their families with incomes between 300% and 400% of the federal poverty level (from $55,980 to $74,040 a year for a family of four in 2003) who were uninsured. For people with incomes even at four or more times the poverty level, the rate of uninsurance still was 13.7%.

Cutting the data by race, Families USA found that Hispanics and African Americans were much more likely to be uninsured compared to white, non-Hispanics (59.5% Hispanics, 42.9% African Americans, and 23.5% non-Hispanic whites). However, white, non-Hispanics made up the largest category (48.1%) of people younger than 65 without health insurance for all or part of the two-year period.

Minorities uninsured longer

Not only are Hispanics and African Americans more likely to be uninsured, they also experience longer spells of uninsurance compared to white non-Hispanics. Of the total number of uninsured Hispanics, 50.2% were uninsured for 13 months or more. And of the total number of uninsured African Americans, 34.1% were uninsured for 13 months or more. By contrast, of the total number of white, non-Hispanic people who were uninsured, only 24.2% were uninsured for 13 months or more.

Families USA says that while employer-based health insurance coverage is the most common source of insurance for people younger than 65 in the United States, data show many uninsured people are in families with at least one member who is working. Hispanics and African Americans are disproportionately represented in low-wage jobs and jobs in sectors that are less likely to have health insurance benefits. As a result, Hispanics and African Americans are more likely to work and not have health insurance benefits than are white, non-Hispanic people.

Also, uninsured Hispanics and African Americans are poorer than uninsured white, non-Hispanic people. Among uninsured Hispanics and African Americans, 82.9% and 80% respectively have family incomes below 300% of the poverty level ($55,980 for a family of four in 2003), while for white, non-Hispanic people 64.4% have incomes below 300% of the poverty level. Families USA says any solution to the uninsured must effectively target people with incomes below 300% of the poverty level if it is to reach the majority of uninsured Hispanics and African Americans.

Looking at the data in terms of age, 54.8 million of the 81.8 million uninsured people were adults between 18 and 64. The likelihood of being uninsured declined among adults as age increased. The percentage who were uninsured was highest among 18- to 24-year-olds (50.3%)

and 25- to 44-year-olds (32.9%). The percentage that was uninsured declined for 45- to 54-year-olds to 20.7%, and for 55- to 64-year-olds to 17.3%.

Since two-thirds of insured people get health insurance coverage through an employer (either their own or that of a family member), the decline in the likelihood of being uninsured is probably explained by the tendency of adults to move to better compensated employment with health insurance benefits as they move up the job ladder over time.

Although older adults are less likely to be uninsured, they may have more difficulty obtaining coverage. People who do not have employer-based coverage and must therefore rely on the individual market are less able to secure health insurance coverage as they age. Insurers often will not offer coverage to older people; and if they do, they may charge much higher premiums. Thus, according to Families USA, any solution that helps provide health insurance coverage to uninsured Americans must reach and work for middle-aged populations. Solutions that rely on the

Families USA's Six Reasons Why Health Insurance Matters

Here are six reasons from Families USA in Washington, DC, why health insurance matters:

1. **The uninsured are less likely to have a usual source of care outside the emergency department.** They are up to four times less likely to have a regular source of care than the insured. Uninsured children are nearly eight times as likely to not have a regular source of care as insured children. Two-thirds of all care delivered to uninsured Americans is delivered by hospitals.
2. **The uninsured often go without screenings and preventive care.** Uninsured adults are more than 30% less likely than insured adults to have had a checkup in the past year. They also are more likely to go without diabetes management. Long-term uninsured adults are three to four times more likely than insured adults to go without preventive services such as breast cancer or hypertension screening. Uninsured adults are likely to be diagnosed with a disease at a later stage and once diagnosed, the uninsured tend to receive less therapeutic care (drugs or surgical interventions) than the insured.
3. **The uninsured often delay or forgo needed medical care.** Uninsured adults are more likely than insured adults to put off or delay seeking medical care (39% to 10%). Nearly 70% of uninsured adults in poor health and nearly 50% of uninsured adults in fair health said they were unable to see a doctor in the past year when they needed to because of high cost of care. Uninsured people with chronic health conditions receive less care than their insured counterparts.
4. **The uninsured are often subject to avoidable hospital stays.** The rate of unnecessary hospital stays for uninsured adults more than doubled from 1980 to 1998. For uninsured people in 1998, an estimated 11.6% of hospital stays could have been avoided if people had received treatment earlier. The average cost of an unnecessary hospitalization for an uninsured adult was $3,300 in 2002.
5. **Uninsured Americans are sicker and die earlier than those who have insurance.** Families USA says every year, the deaths of 18,000 people between 25 and 64 can be attributed to a lack of insurance coverage, making uninsurance the sixth leading cause of death, ahead of HIV/AIDS and diabetes. The Institute of Medicine has concluded that uninsured adults are 25% more likely to die prematurely than adults with private health coverage. Uninsured patients are three times more likely to die in the hospital than insured patients. When admitted, uninsured patients are more likely to receive fewer services and to experience second-rate care than insured patients. And when hospitalized, uninsured patients are likely to be in worse condition than insured patients. Uninsured adults have a greater chance of experiencing a major health decline than insured adults.
6. **Medical care is more costly for the uninsured, and costs are higher for the American health system.** Uninsured Americans received approximately $35 billion in uncompensated care in 2001. The uninsured often are charged more for health services than people with insurance. Major insurers, including Medicare and Medicaid, negotiate big discounts with hospitals and other providers, who compensate by raising prices for the uninsured. While 51% of uninsured adults say health insurance is a high priority in their personal budgets, 40% of all uninsured people say they would have to cut back on necessities such as food, rent, and utility bills to be able to buy health insurance. Nearly 40% of uninsured adults reported problems paying medical bills. When the uninsured can no longer avoid obtaining care from professional health care providers, they borrow money to pay costs up front, work more than one job, charge credit cards for large health care bills that will take years to repay, or eventually file for bankruptcy. Families USA asserts that when the uninsured rely on emergency instead of preventive care, access is limited for all Americans, productivity is reduced, and costs are added to the health care system. ■

individual, private health insurance market without protections against health status and age underwriting will do little to ameliorate the uninsurance problem.

Families USA says one of the most disturbing findings in its analysis was the rate of uninsurance among children. Some 27 million of the 81.8 million uninsured were children, 36.7% of all children in the United States. By comparison, the March 2003 Current Population Study report using 2002 data showed that only 8.5 million, 11.6%, of the total number of children in the United States were uninsured. The significant difference, Families USA says, is because the population report purports to estimate the number of uninsured children for a full year, while Families USA is making an estimate of the number of children uninsured for a full year as well as children uninsured for shorter periods of time. Uninsured children tend to experience shorter periods of uninsurance than adults for several reasons, according to the Families USA analysis.

First, more than 16 million uninsured children are in families with incomes below 200% of the federal poverty level and thus should be eligible for their states' Medicaid or SCHIP programs.

One explanation for the high rate of uninsurance among these children is movement on and off and back on Medicaid and SCHIP, which leaves a significant number uninsured for short periods of time. This pattern of enrollment and disenrollment, sometimes referred to as churning, occurs for several reasons. For instance, some states have periodic eligibility review processes that a parent may not follow in a timely manner. Other states require families to pay monthly premiums to receive health services and the inability of an unemployed or low-wage parent to pay these premiums can result in loss of SCHIP eligibility until the premium is paid.

Also, access of low-income children to health insurance coverage was affected by state actions during 2002-03 in response to fiscal problems and the pressure to reduce Medicaid budgets. Not only did many states increase barriers to enrollment and eligibility review, but six states — Alabama, Colorado, Florida, Maryland, Montana, and Utah — stopped enrolling children in their SCHIP programs.

Call to action

At a news conference releasing the report, a number of governors and members of the U.S. House of Representatives talked about the impact of so many uninsured people. "As Families USA's prescient study states, there are considerably larger numbers of people who are without health insurance at different times than popularly believed," commented Iowa Gov. Tom Vilsack.

"This means an even greater number of people are without guaranteed health care security. This is a reflection of an economy that is still not on solid ground. And it is a call to action to ensure that government programs that provide health care remain solvent and viable," he noted.

Maine governor John Balducci said health reform is a necessity in his state. "We brought all the stakeholders together and created Dirigo Health [Maine's attempt to achieve universal health coverage], our solution to fix a broken system," he said. "Our goal is universal access to affordable and quality coverage within five years."

(The report is available on-line at www.familiesusa.org.) ■

Fiscal Fitness

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be required to achieve effective coordination between SPAPs and the new private pharmacy plans."

The researchers base their findings on results of a survey of all direct-benefit programs in place during the year 2000. The findings were collected through qualitative case studies of programs in Maine, Massachusetts, Minnesota, Nevada, New Jersey, Pennsylvania, South Carolina, and Vermont, and through reviews of the literature and program documents.

In the last few years, the report says, SPAPs have faced the same double-digit increases in pharmaceutical expenditures as many Medicaid and private prescription drug insurance programs. Direct-benefit SPAPs pay directly for some or all prescription drug costs for eligible low-income elderly and disabled persons. There is considerable variation among states in terms of who is eligible, what drugs are covered, and consumer cost-sharing, but costs have grown steadily in all states. In response, SPAPs have implemented initiatives to control use of prescription drugs and lower prices negotiated with manufacturers and pharmacies.

For programs in place as of December 2000, total prescription claim costs rose by some 17.7% between 1999 and 2000, lower than increases in Medicaid prescription drug costs and overall retail prescription drug spending. While all states experienced increases in prescription costs from 1999 to 2000, Maine, Minnesota, and Vermont all expanded some element of their programs during the period and, as a result, experienced the greatest increases. In states that did not expand benefits, increases in total prescription claim

costs were driven mainly by higher costs per claim and per enrollee. The average cost per enrollee and per claim in SPAPs increased at a much greater rate (16.5% and 11.1% respectively, in reporting states) than total enrollment (5.4%) or average claims per enrollee (4.7%). And in Maryland, Michigan, New Jersey, and Pennsylvania, enrollment actually declined during the period. The researchers say this suggests that the price per claim and the type and cost of specific drugs purchased were contributing significantly to program costs.

Wide variation in claims costs

SPAPs paid on average $41 per drug claim and $1,345 per enrollee per year during 2000. State costs per claim varied considerably across states, influenced by the generosity of the benefits offered and program enrollee health characteristics. The number of claims per enrollee also varied considerably by state, ranging from approximately nine scripts filled per enrollee in Delaware and Rhode Island to 40 in Pennsylvania. The researchers say some of the differences can be attributed to benefit design features, but others are more difficult to interpret and may be related to variations in supply limits set by state programs.

State pharmacy programs have confronted a difficult balancing challenge in continuing to cover vulnerable elderly and disabled citizens while limiting state financial exposure. They have considered a variety of strategies for controlling program utilization and costs. Options available to states fall into four categories — benefit limitations, barriers to deter purchase of expensive drugs or to change purchasing or prescribing behavior, price negotiations for higher rebates or lower prices at the pharmacy level, and cost-recovery systems to maximize program revenues and recoup costs from third-party payers.

States often combine strategies and use them to varying degrees, the survey found, especially since there often is political pressure not to implement some of them because of negative impacts on consumers, pharmacies, or manufacturers:

- Utilization controls reduce costs by influencing which drugs are purchased and in what quantities. In the eight case study states, control strategies included mandatory generic substitution, prior authorization, formularies, tiered copays, and supply limits. One advantage of utilization controls — in contrast to changes in benefit design — is that they often can be implemented as administrative actions and don't require statutory amendments.
- Price negotiation strategies are accomplished through manufacturer rebates and price discounts with pharmacies, recognizing that the cost of a prescription reflects the manufacturer's price and any rebates, wholesaler markups, and pharmacy markups and dispensing fees.
- Pooled purchasing and federal waivers are innovative approaches being pursued by some states. The researchers say the few pooled purchasing initiatives under discussion during the study period primarily involved Medicaid programs and some state employee benefits programs. State pharmacy programs have not generally been included. But Maine, Vermont, and New Hampshire agreed to join efforts in the bulk purchase of drugs for their Medicaid and state pharmacy programs through a single pharmacy benefit manager. Another option to limit state expenditures was to seek federal matching funds by expanding Medicaid eligibility to low-income aged and disabled for a drug-only benefit. As of February 2003, five states have received waiver approval to extend a drug-only benefit to some portion of their population — Florida, Illinois, Maryland, South Carolina, and Wisconsin. Ten other states had filed applications with the Department of Health and Human Services and still others had passed laws or were engaged in discussions about establishing such a program.
- Recovery of third-party payments from other insurers and Medicare is another tool less frequently used by SPAPs to lower program costs. Of 16 states surveyed, only four reported recoveries from third-party payers for their state pharmacy program.

With state officials recognizing they will have difficulty maintaining growth rates of 17% to 20% in SPAPs, they are implementing stricter cost-control strategies. Of the measures used by states, generic substitution and manufacturer rebates are estimated to result in the greatest impact on per-prescription expenditures. Although states don't specifically track cost savings from generic substitution, some program officials said that strategy yielded the most savings of the various cost-control initiatives, as generic drugs account for neatly half of the claims paid in many programs and the average cost of a generic is approximately half that of a multisource brand name drug.

Manufacturer rebates are an average of 15% of state pharmacy costs and as much as 36% in one state. In addition to the rebate formula used by the program, the return rate is influenced by factors such as the mix of brand-name drugs used by participants, use of generic drugs, the pharmacy reimbursement rate, and the

amount of cost sharing required by the program. States also save a significant amount through pharmacy discounts, even though pharmacy-level prices and dispensing fees generally are higher than those negotiated in the private sector.

The researchers say that given the budget pressures in many states, it is likely that SPAP cost-containment efforts will become more stringent over time. Further study is needed, they say, to assess the impact of cost-containment interventions such as prior authorization for expensive drugs on consumer health outcomes.

What seems clear is that strong political pressure by state-level interest groups limits states' ability to impose stringent cost-containment policies. Many measures proposed by state officials to reduce program costs have met with strong resistance from consumers, pharmacists, or manufacturers and have generally been rejected or significantly scaled back.

Efforts to increase cost sharing through differential copayments for brand name and generic drugs have been controversial because of beneficiaries' low incomes. Pharmacists generally favor measures that increase use of generic drugs because generics often provide larger margins at the pharmacy level. But state efforts to reduce pharmacy discounts further, such as basic generic discounts on maximum allowable cost pricing rather than a percentage of average wholesale price, are strongly contested by pharmacists, as are efforts to shift program administration to pharmacy benefit managers. Manufacturers oppose anything that looks to them like price controls, including efforts to further improve rebates through supplemental rebate strategies.

[For information, contact The Commonwealth Fund at (888) 777-2744. Web: www.cmwf.org.] ■

Is Medicaid too big to fail?

If you could change one thing about Medicaid, what would it be?

It's an interesting question that often seems to produce as many answers as there are people answering it. The conventional wisdom always has been that if you've seen one state Medicaid program you've seen only one state Medicaid program because there is such variety among the states in the ways they handle Medicaid. The same often is true of Medicaid experts and the approaches they bring to resolving Medicaid's problems.

The question about the single most important change to recommend for Medicaid was one of several posed by moderator Diane Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured, to a panel of experts convened for a symposium on the future of Medicaid at the University of the Sciences in Philadelphia.

National Conference of State Legislatures health policy director Joy Wilson said the thing she would change is the way people view Medicaid because not enough people see it as a mainstream program and as a quality program.

"If we were able to do with Medicaid what we have done with SCHIP, that would be a major step in the right direction," she said, "because we need that support for the program."

A former Michigan governor, John Engler, called for much greater use of electronic medical records to make it easier to move information around. He also talked in terms of making more information available to consumers so they can make better health care decisions in terms of their own care as well as allocation of resources within communities.

Ms. Rowland pointed out Mr. Engler's reforms apply to the whole health care system and he said Medicaid can't be separated from the rest of the system but needs to be a leader, with the government using Medicaid, Medicare, and the Veterans Administration programs to drive overall health care reform.

Heritage Foundation Center for Health Policy Studies senior health policy analyst Nina Owcharenko suggested that improved communication between the states and the federal government would be the single most important reform that could be accomplished now.

"There's a lack of interest of those in Washington to address the Medicaid problem head on," she declared. "I think the debate over Medicare lost any kind of steam to look at the Medicaid program, which is actually more costly than the Medicare program is today. The Bush administration put out a reform proposal that looked at separating long-term care from acute care and maybe funding them separately so you could get at the crux of what the program is about. Unfortunately, that just kind of fizzled out, but it's a debate that's important to have come back up in the coming months to years."

Challenging assumptions

But it was left to the Urban Institute's director of the Assessing the New Federalism Project, Alan Weil, to object to the assumptions behind the question and move the discussion in a new direction.

"The variety of answers already given suggest, first of all, that it's very hard to talk about the things that need to be done in the Medicaid program without talking

about the things that need to be done in the health care system as a whole," Mr. Weil said. "At one level, we want Medicaid to be a leader; and in many respects, it has been a leader despite its negative reputation in some areas. But in other ways, it has been a follower because there have been tremendous changes in the health care system since the program was created."

Mr. Weil said he also would begin by separating out and thinking very differently about long-term care and chronic care and what it means for our country to try to finance and meet the service needs of people with chronic conditions.

He praised Medicaid as an innovative program in meeting the evolving needs of people with chronic conditions.

"As those conditions have changed with time, as our treatment patterns have changed with time, as the role of pharmaceuticals has changed, there's really no other payer out there with as much experience and understanding about the complex needs of populations with long-term and chronic conditions as the Medicaid program," Mr. Weil said. "That's not to say that Medicaid's gotten it all right. But I would worry, for example, about the federal government just taking over the running as well as the financing, because one of the benefits we've had of state variety and leadership in this area is that we have learned a great deal. But we've lost the sense of how complex a problem this is, that Medicaid is filling in roles for Medicare and also is filling in and making it possible for much of the private employer system to function as well."

Zero-based Medicaid

Mr. Weil said that over time, many of the high-cost items have been pulled out of the Medicare program and the employer system and put in Medicaid.

"If I could do just one thing, I would say let's take a look at these [costs] across the populations and try to figure out how much we really need and who should really do these things. If we fixed that, Medicaid would be in a much better position to meet the acute care needs of the moms and kids who form the bulk of the program, and it would be a much more manageable program. But I also think we would have a more honest discussion about the changing demographics of this country and the increasing demands on the health care system due to the burden of chronic conditions," he said.

Stakeholder buy-in needed

Ms. Rowland also asked the panelists how to achieve stakeholder buy-in to any massive overhaul of Medicaid.

Ms. Wilson said the most important factor is to develop more trust between states and the federal government. "Right now, we're always looking over our shoulder at each other, and you can't really proceed with that kind of a relationship," she said. "Part of that is a fiscal issue, where there's a shell game. We're moving too little money around — you've got it, I've got it — and somehow we've got to get past that and really try to have a conversation about what we can really do, whether it's incremental or we're talking about revolutionizing, and what we can do in a position of trust moving together."

To Mr. Engler, it's important that organizations representing legislators and governors come together to see if they can fashion a united proposal.

"If you have different proposals, you're dead," he said. "That's Washington."

Mr. Weil again objected to the question because he saw a faulty premise. He said that when Medicare and Medicaid were created, they were fashioned on the Blue Cross claims payment model, and Medicare still is overwhelmingly a fee-for-service system.

"Only in 2006 are we going to start seeing prescription drug coverage," Mr. Weil said. "It does nothing for long-term and chronic care. It has really changed very little with the times and the practice of medicine and the organization of medicine, whereas Medicaid has covered prescription drugs for years, has developed systems to meet very chronic needs of populations, stepped in to address the HIV/AIDS epidemic, is working with systems to respond to people with traumatic brain injuries that would have been fatal when this program began. And you know, Medicaid muddles through. It's not pretty, and there's certainly a lot more good to be done with this program. But in fact, Medicaid is a very responsive program to changes in the health care system, especially relative to the other big payers in the system.

"I think the harder question is, 'How do we get the broader health care system to engage in these kinds of discussions as opposed to thinking that these are Medicaid problems and Medicaid issues?' Because imperfect as it is, and with all the ideas for improvement we've discussed today and many more we haven't had time to get into, this is a program that has evolved and will continue to do so; and we shouldn't let the problems today, as real as they may be, let us think that this is a program that can never respond to challenge.

"As Gov. Engler said, Medicaid is a program too big to fail. The challenge is how to provide all these

services. While we may differ on strategies for putting a program out into the future, we know that this nation requires something that is a Medicaid, even if we rename it. The future of Medicaid is the future of how we care for all of the ills in our society that fall through the cracks."

Closing the session, Ms. Owcharenko said the best first step in looking to the future of Medicaid might be to look at how to provide better care for current beneficiaries, by realigning the focus, realigning the incentives, and really looking at how to make Medicaid more patient-centered, rather than system-centered.

For his closing comment, Mr. Weil drew on his past experience as a state Medicaid administrator to remind the audience that while conversations such as this one often are on budgets, allocation of responsibility, and benefit levels, "at the end of the day, this is an incredibly important program for approximately 50 million Americans, which is a phenomenal number of people, with a tremendously heterogeneous set of needs ranging from very low-income people to people with very substantial medical, physical, and mental needs that we simply aren't set up as a society to meet any other way. So this is a program that we need to pay attention to, but we need to move with a lot of care and caution because it is the safety net. And it's the safety net for a lot of people who would have nowhere to turn without it. So we need to remember it's not just a line in the budget, but it's also a very important set of supports for some of our most vulnerable and disadvantaged neighbors."

(To view a webcast of the symposium or read a transcript, go to www.kaisernetwork.org.) ■

Rhode Island models Medicaid concerns

Many Medicaid reports from national organizations discuss concerns with the program by using national averages. But an FY 2005 Medicaid report from the Rhode Island Public Expenditure Council (RIPEC) shows the impact the program has in the state that ranks second in the nation in per-capita spending on Medicaid and gives recommendations for increased efficiencies that may be of assistance to other states.

RIPEC describes itself as an "independent, nonprofit and nonpartisan public policy research and education organization dedicated to the advancement of effective, efficient, and equitable government in Rhode Island."

Almost 20% of all Rhode Islanders receive Medicaid benefits, and since FY 2000, there has been a 30.2% increase in the caseload, from 146,439 in 2000 to a projected 190,709 in FY 2005. Three-quarters of the caseload are children and families, but they account for only one-third of total Medicaid expenditures.

Adults with disabilities represent 14.3% of the caseload and 34.4% of Medicaid expenditures, while the elderly are 10.8% of the caseload but consume more than 25% of Medicaid expenditures.

Between FY 2000 and FY 2005, Medicaid spending in Rhode Island increased by 49.1% from $1.2 billion to a projected $1.7 billion in FY 2005. That compares to a 34.4% increase in total state spending in the same time period. However, Rhode Island's average annual Medicaid growth rate of 8.3% between FY 2000 and FY 2005 was lower than the national average annual growth rate of 9.4%.

The caseload in Rhode Island's Medicaid managed care program, RIte Care, increased from 95,687 people in FY 2000 to a projected 133,940 people in FY 2005, an increase of 38,253 people or 40%. The caseload includes some 5,400 children in foster care and with special health care needs. About two-thirds of RIte Care recipients are children.

RIPEC says that given the uncertainties about the future level of federal support for Medicaid and demographic factors that will continue to influence Medicaid costs in the future, it has recommended several steps to control costs while enhancing the delivery of necessary medical services to needy Rhode Islanders.

The organization has called for enhanced coordination of health and human services in state government through creation of a Human Services Secretariat that would bring together the five cabinet-level departments that now share the human services function — Department of Human Services; Department of Children, Youth, and Families; Department of Mental Health and Retardation; Department of Elderly Affairs; and Department of Health.

"Creation of a Human Services Secretariat could strengthen coordination between related state functions, improve focus on strategic initiatives, and provide for greater accountability for department operations," RIPEC says.

Secretariat sought

Based on recommendations from the state's Fiscal Fitness Team, the governor earlier this year created the Office of Health and Human Services as the first step toward a cabinet-level Health and Human Services Secretariat.

RIPEC suggests the new organization might help foster interdepartmental coordination of Medicaid policies and programs, leading to an enhanced system of service delivery. For example, it says, both the Department of Human Services and the Department of Children, Youth, and Families provide services for children's behavioral health. Improved coordination of these services could lead to a more effective and efficient service delivery system for the children, parents, caseworkers, and providers.

RIPEC's second recommendation is for unified Medicaid expenditure reporting. It says the Secretariat for Health and Human Services should be responsible for developing and maintaining a unified Medicaid expenditure reporting system, so there is greater accountability of department operations.

Currently, it says, only the Department of Human Services reports its Medicaid expenditures and caseloads for population subgroups — the elderly, disabled, and children and families.

The other departments that spend Medicaid money are not required to break it out the same way. RIPEC also suggests the secretariat publish statewide Medicaid expenditure data and analysis as part of the budget process, including trend data. To monitor and evaluate use of Medicaid resources, it says, the secretariat should collect and disseminate data to help evaluate utilization of Medicaid dollars. If the state ends up not establishing a secretariat, RIPEC says responsibility for unified Medicaid expenditure reporting should be assigned to an existing agency.

The group's third recommendation is to monitor the impact of the new Medicare prescription drug benefit on the Rhode Island Medicaid program.

Although Medicaid and Medicare were created to serve distinct populations, certain Medicare beneficiaries with low incomes and limited resources also may receive assistance through Medicaid.

In 2002, these so-called dual-eligibles accounted for 16% of all Rhode Island Medicaid enrollees. Some 82% of all dual-eligibles are eligible for full Medicaid benefits, and for them Medicaid pays for services such as prescription drug coverage and long-term care that, although not available through Medicare, are offered as part of the state's Medicaid benefits package.

Beyond those fully eligible individuals, federal law mandates partial Medicaid coverage for certain other groups of qualified beneficiaries.

In Rhode Island, total expenditures on dual-eligibles accounted for about 52% of total Medicaid spending in 2002 and for 16% of all Medicaid enrollees. The largest category of expenditure was for long-term care, which represented some

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

68% of total dual-eligible spending.

Under provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as of Jan. 1, 2006, dual-eligibles will receive prescription drug coverage under the new Medicare Part D. As a result, states will no longer need to cover them with their own outlays.

If dual-eligibles do not enroll in Part D, or if they need more coverage than is available under their Part D plan, states can provide it using their own funds, but they will no longer receive a Medicaid match for those expenditures.

Coverage could hurt budgets

But, RIPEC says that other provisions of the new law could significantly lower the savings that states actually achieve. Chief among those provisions is the so-called clawback that requires states to continue financing some of the cost of providing the prescription drug benefit to dual-eligibles.

The Congressional Budget Office has estimated that in the initial years, the new law will cost some states more Medicaid spending as a result of clawback payments in 2006 that will, possibly, remain larger than the amount of fiscal savings that certain states will secure as a result of no longer providing prescription drug coverage to dual-eligibles.

Also, the new law places significant new responsibilities on states to administer Medicare's low-income subsidy program. As a result of these new requirements, states may incur substantial administrative costs that will offset savings resulting from elimination of state-funded dual-eligible drug coverage.

(To see the full report, go to www.ripec.com.) ■

Case made for Medicaid, health care reform

National Governors Association executive director Raymond Scheppach said that while both education and Medicaid take significant portions of state budgets, Medicaid creates more problems because much of its spending is not discretionary — while all education spending is discretionary.

In a commentary written for the on-line service Stateline, Mr. Scheppach pointed out that "regardless of the length and bullishness of the economic recovery, states will continue to confront very difficult long-run budget choices.

"More than 50% of a state's budget goes to education and Medicaid. Medicaid is a mandatory federal entitlement whose growth rate is driven by rapidly changing demographics and rising costs, while education is primarily discretionary. Medicaid's growth is biasing state budget decisions and is winning the contest for state dollars. This will limit the ability of states to adequately fund education over the next decade," he added.

States have limited ability to control Medicaid costs, according to Mr. Scheppach, because much of the program involves mandates for specific benefits given to specific populations.

State spending for Medicaid increased 8.4% per year over the last 10 years, but has accelerated to 11.3% over the last three years in spite of the fact that virtually every state cut reimbursement rates as well as optional populations and benefits and restricted drug purchases through use of formularies.

Education spending affected

State spending on education has increased 6.6% per year over the last 10 years, Mr. Scheppach said, but over the last three years when Medicaid growth exploded, secondary education growth fell to 2.7% and higher education fell to 1.5%.

"Unfortunately, the next decade looks like a continuation of recent growth rates of 8% to 10% for Medicaid and 2% to 4% for education," he predicted.

"The existence of a federal entitlement health care program that states administer and partially fund, but have limited ability to control costs, creates a serious bias in state budget priorities. These are not the growth rates preferred by most governors or their citizens. Most would prefer more equal growth rates for both, or even moderately higher growth rates for education as opposed to Medicaid," Mr. Scheppach continued.

"Now that the United States is operating in a true global marketplace, it is critical that the United States develop a highly educated and skilled labor force. Furthermore, it must be a creative labor force whose education will stimulate continuous innovations that can be converted into products sold in the global marketplace and utilized to continue high rates of productivity change. This is not the time to reduce our commitment to education," he explained.

Medicare and dual-eligibles

Mr. Scheppach said one aspect of Medicaid reform should be for the federal government to assume the cost of low-income individuals older than 65 who are eligible for both Medicare and Medicaid (the so-called dual-eligibles).

He pointed out that this population is growing rapidly, is very

costly, and from a programmatic standpoint, should be part of Medicare rather than Medicaid.

Cost-effective health care

In addition to such a realignment of Medicare and Medicaid, Mr. Scheppach added it also is critical to develop a cost-effective, high-quality health care system for the 21st century.

Failure to do so will limit the nation's ability to maintain its commitment to education, which will, in turn, make it very difficult to maintain our country's position in the new global marketplace, he stressed.

[Contact Mr. Scheppach at (202) 624-5300. More information is available at www.nga.org.] ■

Clip files / Local news from the states

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

Seniors saving big on state's drug plan

PHOENIX—More than 45,000 seniors and disabled Arizonans have saved $3.2 million on prescription drugs in the year since Gov. Janet Napolitano launched her program to deal with expensive but necessary medication. The state program added 30,000 seniors since eliminating its enrollment fee in January. But the number of participants remains smaller than what the governor expected when the program began last June. Continued growth is expected to be tested by lack of advertising and confusion surrounding a new federal Medicare drug program. The concept is simple. Participants use discount cards at more than 500 pharmacies to get reduced rates on generic and brand-name prescription drugs. Critics say the plan does not help most seniors in the lowest income levels and scant advertising has kept a large chunk of eligible seniors from hearing about the program.

—*Arizona Republic,* June 8

Oregon Health Plan to drop some copays

PORTLAND, OR—Five homeless people and their pro bono lawyer have successfully sued Oregon over a policy of charging a copayment of $2 for prescription drugs and $5 for doctors visits for some Medicaid patients. The lead plaintiff in the lawsuit that affects 50,700 people in the so-called standard population of the Oregon Health Plan was Elizabeth Spry, a resident of the Dignity Village homeless camp in Portland. The four other plaintiffs also live at the camp. According to the ruling, the state was required to eliminate a $250 copay for hospital visits for the standard population, mostly single adults and childless couples earning less than the federal poverty level. "These are incredibly impoverished people," said Ellen Pinney, director of the Oregon Health Action Campaign, a health care reform group. "The level of copays on this population was excessive." The copays and a monthly premium that still will be charged had become a battleground between the state and advocates for low-income people, who said even the small payments showed a misunderstanding of poverty and were bad social policy that cost the public sector far more than it saved.

—*AP/Salem Statesman-Journal,* June 9

Medicaid premiums for children delayed

SEATTLE—Washington Gov. Gary Locke has postponed a long-pending move to charge monthly premiums for children enrolled in Medicaid, extending free health coverage for 60,000 low-income Washington kids for at least one more year. But premium increases for an additional 10,000 higher-income children enrolled in a related insurance program were to take effect as planned in July. The reprieve for children on Medicaid came after dozens of hospitals and children's advocacy groups lobbied the governor for months, contending that even modest premiums would leave more children uninsured and in worse health. At the same time, stricter eligibility rules adopted by the state last year and increased paperwork for recipients have driven thousands of children off Medicaid's rolls, saving the state much more money than it stood to collect in new premiums.

—*Seattle Times,* June 9