State Health Watch

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THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

Two new plans for covering the uninsured take divergent routes

Editor's note: There is no shortage of proposals from experts on ways to expand coverage to the uninsured.

Some say the problem is a shortage of political will and/or moral imperative. Others say the stall is related to a failure to gain a legislative consensus for any one plan.

Two proposals that are attracting considerable attention — and it is hoped, one or both will gain political support — share some techniques but also move in very different directions.

This month, State Health Watch *profiles the Plan for a Healthy America and A New Deal for Health.*

Plan for a Healthy America

The Plan for a Healthy America was developed by Jeanne Lambrew, senior fellow at the Center for American Progress and an assistant professor at George Washington University School of Public Health; John Podesta, Center for American Progress president and CEO; and Teresa Shaw, Center associate director of domestic policy.

The three said their plan would insure all Americans while improving the value and cost-effectiveness

See ***Two plans*** *on page 2*

New York insurer develops plan to improve outcomes and save money on at-risk births

Willie Sutton reportedly once said he robbed banks because "that's where the money is." Take a leap to health care and you'll find that a good part of the money — re: Medicaid dollars — is in pregnancy. In a report in the March 2005 edition of the *American Journal of Managed Care,* pregnancy is listed as one of the primary events leading to eligibility for Medicaid, and deliveries account for almost 50% of Medicaid inpatient discharges.

Fiscal Fitness: How States Cope

For Rochester, NY, Monroe Plan for Medical Care, one area of concern was high-risk pregnancies among Medicaid clients that led to high-cost neonatal intensive care unit (NICU) stays. Women from lower socioeconomic groups experience poorer birth outcomes than those from higher socioeconomic groups, and thus delivery claims and high-cost NICU expenses consume a large portion of Medicaid managed care medical expenses, says Monroe chief medical officer Joseph Stankaitis.

See ***Fiscal Fitness*** *on page 6*

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Two plans

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of health care by pulling together employer-sponsored insurance and Medicaid; promoting prevention, research, and information technology; and financing its needed investments through a new dedicated national value-added tax.

As laid out in a *Health Affairs* web exclusive, the Plan for a Healthy America has three major parts: affordable coverage for all, improving the value of coverage, and financing the investment.

Affordable coverage for all

Instead of creating a new health care system as some have proposed, this plan builds on two major existing sources of coverage — employer-based coverage and Medicaid, which together cover about 75% of Americans.

Ms. Lambrew and her colleagues would supplement the employer coverage with a system modeled on the Federal Employees Health Benefits Program (FEHBP) for those who lack private group insurance options. Medicaid, they said, would be simplified and strengthened to fulfill its role as a safety net for low-income people.

All those who lack job-based insurance would have access to the same private health plans offered to more than 8 million federal employees through FEHBP.

"The Plan for a Healthy America would build on this system," the researchers wrote. "Private insurers offering coverage through the FEHBP would also offer group coverage through a new Healthy America national insurance pool. The pool would be open to anyone who lacks access to job-based insurance, a problem for about 80% of all uninsured people. The plan would also help the 6% of nonelderly Americans who purchase coverage in the individual market today."

Employers also could have access to the Healthy America insurance pool, but none would be required to join it. Access to the pool is expected to be attractive to those employers, especially small businesses that want to streamline their efforts to provide a choice of health plans.

Employers could participate only if they enrolled all their workers, and not just the sicker ones. Individuals offered coverage through an employer would be free to decline the coverage and enroll in a pool plan instead. Reinsurance would be used to prevent unexpectedly high premiums resulting from enrollment of high-cost individuals.

To keep coverage affordable, the plan would ensure that no one pays more than a certain percentage of income (perhaps 5% to 7.5%) on health insurance premiums.

This protection would function as a refundable tax credit and would apply to employer-based insurance as well as private coverage obtained through the pool. Employer contributions would continue to be excluded from employees' taxable income, whether employers retain their existing benefit plans or opted to join the pool. As a result, the authors said, employers' voluntary contributions toward the cost of health benefits likely would not change substantially.

The plan would simplify and extend Medicaid to cover all below a certain income level and would increase the share of program costs paid for by the federal government so the state share would not increase.

"It is not enough to expand access to the current system," Ms. Lambrew and her co-authors said.

"Americans must also secure better value for their health care dollar through improvements in health care quality, outcomes, and efficiency." The Plan for a Healthy America includes three key value improvements that the authors said would produce large returns on investment:

1. Creating a national focus on disease prevention and health promotion. Coverage for preventive services would be carved out of private health insurance and financed through a new nationwide preventive benefit. Covered core preventive services would be based on recommendations from the U.S. Preventive Services Task Force and other evidence-based guidelines. Physicians and other providers would continue to deliver preventive and other medical services as they do today, but they would be reimbursed for preventive services through the new benefit. The reimbursement would be based in part on their success at improving community-based health promotion and disease prevention measures. There also would be an aggressive community-based system to complement existing services through consolidated health promotion and prevention activities.
2. Developing better information on what is high-quality, high-value care. There would be increased funding for research on comparative effectiveness with strong conflict-of-interest protections to ensure the research's credibility is beyond reproach.
3. Improving health care productivity through information technology. The authors said the U.S. health system is in the information "dark ages" and cutting-edge information technology, structured to safeguard patient privacy, has the potential to dramatically improve health care quality.

Financing the investment

Based on estimates for comparable plans, the authors said the Plan for a Healthy America would cost $100 billion to $160 billion per year.

Even though they anticipate long-run savings from reduced uncompensated care, better health, and improved efficiency, they have quantified those savings to present a fiscally conservative picture.

They say the level of funding needed cannot be achieved through health system efficiencies alone and also cannot be accomplished by redirecting existing public revenue toward health care.

"Because the plan's health investment benefits all, we think it should be funded by all through a new, dedicated source," the authors said.

"We proposed a small value-added tax [VAT] — a tax on the value of a good or service added in its various stages of production — effectively the difference between what a business sells and what it buys from other businesses. . . . A broad-based VAT in the range of 3%to 4% with targeted exemptions [for example, exempting small businesses, food, education, religion, or health care] would be sufficient to support the plan's investment," they continued.

The authors noted that the United States and Australia are the only major economies without a VAT. Revenue from this VAT would go to a trust fund and be restricted to exclusively financing the plan.

Making the plan a reality

The three researchers, who described themselves as veterans of previous policy battles, said they don't underestimate the political challenge involved in making the U.S. health system accessible to all. Nor do they disagree that moral conviction has been lacking in past health policy debates.

"However," they said, "we reject the claims that health reform is doomed by political paralysis and an incapacity for Americans to sacrifice for the greater good. At opportune points in U.S. history, pragmatic ideas have overcome seemingly impossible political odds and become policy. We also believe that the perceived disconnect between values and health reform reflects not a lack of conviction, but a failure to express that conviction in a policy environment."

Ms. Lambrew said the three disagree with critics that the lack of health insurance is inevitable or a conundrum that defies solution.

They noted the problem has been eradicated in virtually all of the world's leading countries, including many with considerably less wealth than the United States. This country already provides universal coverage to older Americans through Medicare. And public opinion research indicates that Americans want the same right to health care for their children and themselves, and they will make sacrifices to secure it.

"The challenge," the authors said, "is to prove to policy-makers that the goal is both urgent and achievable — not an abstract ideal but a real and imminent possibility if anchored in vision, values, and a practical plan."

The authors wrote that the part of the plan that is unavoidably controversial is its call for greater government involvement and investment in the nation's health and health insurance system.

They said such involvement and investment is necessary because the risk and cost of health care must be

spread across the population instead of being borne by individuals, small employers, and providers in the form of uncompensated care, as is the case today.

A New Deal for Health

A New Deal for Health is the plan proposed by Leif Wellington Haase through the Century Foundation. It proposes a new national health insurance system that is government-sponsored, but not government-run. Thus, the government would negotiate with private insurers, set minimum benefit packages for several levels of care, and make an annual contribution for each American toward purchase of a premium for a health care plan.

"This system would offer a basic and decent health care plan — a 'floor' — to all Americans while encouraging those who want more comprehensive coverage to join higher-end insurance plans," Mr. Haase tells *State Health Watch*.

"The proposal tries to bring better-off Americans and the uninsured into the same insurance pools while retaining a strong element of consumer choice among health insurance plans. The expectation is that this approach will use the savings generated from lower administrative costs, higher participation levels, competition among health plans, and selective coverage of new technology to cover more services for more people, especially those previously without insurance," he adds.

Under Mr. Haase's proposal:

1. American families would be required to purchase their own health insurance, and government subsidies would be offered to make coverage affordable for everyone.
2. The existing federal tax subsidy for employer-based insurance would be phased out and the new revenues obtained from eliminating the subsidy would pay for a portion of the financing for the plan.
3. For every American household, the government would make a contribution to the purchase of a premium for a basic health insurance plan, with the level of support set to allow each household to enroll in a basic plan at a modest premium. Older Americans, the disabled, those with low incomes, and veterans would receive a larger subsidy to allow them to buy a midlevel plan.
4. Individuals would be required to purchase at least the basic level of coverage.
5. Medicaid would be phased out, along with all other government insurance plans based on categorical eligibility. Medicare would continue to function for current beneficiaries, but also would be phased out. Current Medicare beneficiaries would have the option of joining the new national health program.
6. Subject to federal approval, insurers would be allowed to offer different plan designs, such as restricted physician networks and copayments. At any level of coverage, insurers could offer a benefit package exceeding the federally mandated minimum.
7. An independent government board would be created to evaluate the cost-effectiveness of medical therapies and procedures, with a focus on assessing new technologies.
8. A large new investment in the public health system would be made to encourage Americans to practice healthier lifestyles. Each insurance program would have to offer generous coverage of preventive care, including vision and dental coverage.
9. Financing the plan would be done through a payroll tax, a dedicated corporate tax, general revenues, and the revenues from eliminating the employer-based tax subsidy.

Rationale for the approach

Mr. Haase says he has tried to appeal to all political segments. Thus, "liberals ought to like this plan's universal coverage, insurance risk pooling, government sponsorship, and emphasis on public health.

"Conservatives ought to applaud the greater visibility of health care costs to consumers and the emphasis on choice and competition under this plan. Liberals will want much more equalized coverage, while conservatives will dislike this level of government involvement. But the true test is not whether this plan satisfies either ideological criteria or utopian dreams, but whether it would be superior to the existing system, workable in practice, better than the alternatives, and politically feasible," he continues.

According to Mr. Haase, the flaws of the current U.S. health care system flow from its basis in employer-sponsored health insurance, which is unique among developed nations.

After tracing the history that led to our employer-based system, he finds that statistics suggest that it is collapsing in slow motion. He notes that 65% of companies with fewer than 200 employees offered health coverage at all in 2002, down from 68% the previous year. Less than half of firms with fewer than 20 employees offer any coverage at all.

While almost all large firms continue to offer health insurance coverage, increasing numbers of employees are unwilling or unable to participate in the plans because

of rising premiums, increased cost-sharing, and eligibility restrictions.

In 2001, he says, almost 10 million uninsured Americans, more than 25% of the nation's total uninsured, either worked for large companies or were dependents of those who did. Firms also are rapidly phasing out coverage for their retirees, putting an increasing strain on public programs.

Mr. Haase says that even if the job-based system could be salvaged, there are many structural reasons why it would be unwise to follow that course. First, the system discriminates against groups that are more likely to be unemployed or have tenuous connections to the labor market, such as young people and minorities.

Also, employer-based care distorts labor market decisions, forcing people to choose or stay with jobs because of the coverage. And since well-insured employees bear relatively little of the cost of their care directly, employer-based coverage contributes greatly to the overuse of medical care, as well as to the misunderstanding of the nature of insurance.

Flaws in the system could be forgiven, Mr. Haase says, if employers wanted to be in the health benefits business. But despite some perfunctory comments to the contrary, they do not.

"Employer coverage is not set in stone, though it may seem that way after having been in place for decades in the United States," Mr. Haase writes. "Other than history and experience, there is no reason why the employer should be the basic sponsor of health coverage. But experience is overrated, and the arrangements on which the system has been constructed [the employer deduction and employee tax break] should not be sacrosanct."

To keep medical costs under control, so that insurance premiums remain affordable, Mr. Haase proposes establishing an office to review the cost-effectiveness of medical procedures, therapies, and drugs. That agency would fix the basis for coverage decisions for different plan benefit levels, making the most promising treatments available to the largest number of Americans and distinguishing them from treatments that deserve lesser subsidies.

"Objections can and will be raised that basing coverage levels on determinations of cost-effectiveness amounts to rationing care and that this is unacceptable," he says.

"What this overlooks is that the current system is based squarely on haphazard rationing. Leaving some 45 million Americans without insurance coverage is only the most obvious example, but rationing takes place in a thousand ways at the hands of doctors, hospital administrators, and insurers. The U.S. health care system resembles a lottery. Under the current regime, some will get care — mostly those who are sympathetic victims or who share an illness with a celebrity who has publicized it — but many will get substandard treatment or none at all."

He says that with a basic universal plan in place, charging some Americans higher premiums for access to the most expensive and unproven procedures can be justified, much as we accept private education because the public school system exists. Requiring the purchase of at least a minimal level of insurance expresses the social contract element of the proposal — recognition that basic health care is a right for all and in everyone's social interest, Mr. Haase explains.

He says the government premium contribution essentially could be financed through redirecting the payment streams currently paying for U.S. health care. He goes through some possible scenarios, while acknowledging that it is difficult to come up with firm figures at this stage in the planning process.

In arguing in favor of his approach, Mr. Haase points out why other recent proposals are unlikely either to result in a system that is as efficient or equitable as he believes his would be or to achieve political support:

- A plan based on employer mandates is unlikely to succeed because employers want to get out of the health benefits business.
- A single-payer plan would require restructuring the nation's insurance industry, a prospect Mr. Haase finds "daunting," and could squelch over time the medical innovation that is the principal advantage of the current system.
- Plans that propose tax credits and purchase of care by individuals are unlikely to be taken up by most Americans or to induce health plans to offer packages that are both affordable and comprehensive.
- Plans that rely on incremental expansion of public coverage such as Medicaid underestimate the vulnerability of such plans to changing fiscal circumstances.
- Reshaping the medical system by focusing on weeding out medical errors and bringing new standards of quality control to bear on hospitals and doctors cannot in and of itself provide a solution to the cost and access problems facing American health care.

Since publishing his proposal, Mr. Haase tells *State Health Watch*, he has heard from legislators in states such as New York and California more than from other stakeholders. "The idea is to get people thinking about alternatives,"

he says, "and that takes time."

While his proposal does not contain a recommended implementation strategy, he says it is clear that employers and governors are the ones who need to be catalysts for change. "My sense is that health care reform is no longer a 'third rail' of American politics," he says. "But we're not likely to get much political momentum before 2008." He says big employers are "clearly fed up" with the current system, while small businesses are mixed. But they need to come together to be catalysts for change.

While some existing organizations, such as the Leapfrog Group, have done good work, they have not moved as fast as they would have liked, and Mr. Haase contends there may be a need for a new organization that could build a bridge between employers and policy-makers.

In calling for a radical restructuring of the system, Mr. Haase says it could come with a strong presidential commitment, especially since there clearly would need to be some type of transition period. Although Medicaid would end under his plan, he sees it remaining in force during a transition period. "It's hard to move people out of programs they're comfortable with," he explains.

Asked what impact the Bush administration's interest in Social Security reform might have on health care reform, Mr. Haase says looking at Social Security "correctly focuses attention on how big a problem health care is. It makes it more likely that in the medium term, there will be more action on this front."

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Fiscal Fitness

Continued from page 1

By implementing a structured plan to help women deliver healthier babies and reduce NICU costs, Monroe has gained national attention and recognition for cutting its 1998 baseline of 108 NICU admissions per 1,000 births to 98 per 1,000 births in one year. By 2003, Monroe had reduced NICU admissions to 57 per 1,000 births and saved $1.8 million in projected NICU costs.

Mr. Stankaitis tells *State Health Watch* the plan concentrates on the NICU because "that's where most of the costs are in prenatal care. We knew we wanted babies to be as mature as possible in terms of development, and we knew we had something that would be pretty easy to measure so we could see how we were doing."

Monroe Plan for Medical Care is an independent practice association representing more than 3,000 providers in the Rochester region. It partners with Excellus BlueCross BlueShield as the Blues Plan's delivery system for publicly financed programs targeting underserved populations.

Monroe provides care for nearly 48,000 Medicaid managed care Excellus enrollees in a program that covers the categories of individuals that include women and children (Temporary Assistance to Needy Families recipients, adults who are unable to work, and a segment of the disabled population). Monroe has 70% market share for Medicaid managed care in the region and is the exclusive community provider for 14,000 enrollees in Family Health Plus, an expansion of the New York State Medicaid managed care program for the working poor

It also is the exclusive community provider for 11,000 children enrolled in New York's SCHIP program.

One of 11 pilot programs

Although Monroe's enhanced quality improvement efforts began in 1997, they became more intense in 2000 when the Center for Health Care Strategies invited the organization to participate in its Best Clinical and Administrative Practices "Toward Improving Birth Outcomes" program, a nationwide group of 11 Medicaid managed care entities committed to developing and pilot-testing best practice models.

In a literature review and discussions with other Medicaid managed care organizations, Mr. Stankaitis said, it became evident there was no single magic bullet for improving birth outcomes. Thus, Monroe decided that sustained improvement would require change in the care delivery system to assist practitioners in doing the right thing at the right time. It adopted a quality improvement approach for its prenatal care improvement activities calling for use of learning cycles to plan and test changes in systems and processes. "Such cycles have been referred to as 'plan-do-study-act' cycles," Mr. Stankaitis wrote, "which will guide improvement teams through a systematic analysis and improvement process."

The focus of such quality improvement programs is to institute organizational system changes to ensure adherence to appropriate practice guidelines through the coordination of care. Such an approach emphasizes organizational and care delivery improvements using existing standards of care. Thus, there was no randomization of enrollees into intervention and control groups, and the services provided were available to all eligible enrollees, who at all times were able

to refuse or terminate any services offered. Identification of high-risk individuals is through a prenatal registration form to be completed by practitioners. With the plan paying $30 per form submitted, there have been annual submission rates of 85% to 98%, but timeliness of submissions remained a problem — forms often came in during a patient's late third trimester, when the ability to mitigate any significant risks was at a minimum.

Tiered payments get forms in

In April 2001, the plan's Healthy Beginnings program implemented a tiered payment for submission of the forms, with a $50 payment for first trimester submission, $30 for second trimester, and $20 for third trimester. Also, program staff visited practitioners' offices to educate personnel about the importance of submitting the form for managing high-risk pregnancies. This intervention led to submission rates consistently higher than 60% in the first trimester.

Staff input the form's data into a care management database that scores the reported findings to reflect the risk for each patient and to engage members in needed medical, behavioral health, and social and support services as identified.

Through the quality improvement process, Healthy Beginnings has evolved its approach to outreach, from using generalized community outreach services (the local county community health care worker program and contracted home health agencies) to instituting a trial of using its own prenatal outreach workers, to finally engaging outreach services through the local BabyLove program in 2002.

"Whenever the Healthy Beginnings perinatal nurse coordinator identifies members at moderate-to-high risk, the coordinator manages these individuals through communications with the practitioners, outreach programs, and referral to Monroe's internal social work program as needed," Mr. Stankaitis writes.

"Individuals with medical complications of pregnancy receive complex care management, home care services, or skilled nursing services as required," he notes.

BabyLove offers outreach

"The perinatal nurse coordinator refers all pregnant enrollees identified as high risk because of psychosocial problems to the BabyLove program. This community-based program has a strong history of working effectively with high-risk pregnant women, with the added feature of social work supervision that is necessary to effectively provide outreach," he points out. "The BabyLove program offers home visits, arranges transportation, provides links to support services and social work services, and connects high-risk pregnant women with other critically needed services."

Mr. Stankaitis reports that with enhanced outreach, Monroe Plan has been able to more effectively connect its pregnant women with medical, mental health, chemical dependency, community-based governmental and social services.

The measurement for program effectiveness is the NICU admission rate for all pregnant women in the plan. NICU admission rates have progressively declined relative to the chosen 1998 baseline rate of 107.6 per 1,000 births. At the same time, NICU admission rates for Medicaid patients in upstate New York have remained essentially the same during the same time period.

Mr. Stankaitis says Monroe officials theorize that implementation of its Healthy Beginnings enhanced prenatal care program in late 1997 and early 1998 has resulted in a marked decrease in the NICU admission rate. Other than this program, he says, there were no known external forces that would have caused a drop in the NICU admission rate, such as a change in NICU admission criteria or coding changes or evidence that the overall population experienced a drop in rates.

Synergistic improvements

The plan's administrators say it is difficult to ascertain if any one intervention led to the improvements. The most likely scenario is that activities enhancing early identification, stratification, and outreach provided a synergistic effect on improving the outcomes.

In its latest activity, Monroe Plan has partnered with the county Department of Public Health on the

Greater Rochester Area Smoking Prevention Program, targeting minorities for smoking cessation opportunities.

Smoking is a recognized major risk factor for poor birth outcomes and the rate of self-reported smoking among Monroe Plan pregnant women has been consistently well above 20%.

Mr. Stankaitis says that previous attempts to mitigate this risk were less than successful because of a combination of practitioner unfamiliarity with evidence-based approaches to smoking cessation and a lack of appreciation of the importance of providing culturally competent counseling.

He says the potential exists for this new effort, which deploys culturally competent peer counselors who have been trained in use of smoking cessation strategies endorsed by the federal Agency for Healthcare Research and Quality, to remedy the problem.

The keys to achieving a significant reduction in NICU rates, Mr. Stankaitis explains, involve these components:

1. having a structure for quality improvement efforts that emphasizes identification and stratification of at-risk patients, outreach to the patients, and interventions;
2. prompting practitioners to ask the right questions that they might otherwise forget about;
3. outreach to engage women to get the care they need.

The importance of outreach and the need for social supports and ancillary care is seen, he points out, in the major drop in NICU rates that occurred after the plan partnered with the BabyLove program.

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Will end-of-life policy change?

While the high-profile end-of-life case involving Terri Schiavo attracted considerable public and official attention in the first months of this year, and in fact over several years, experts say it may not be enough to bring about needed changes in public policy.

"Regrettably, there hasn't been a lot of progress since the late 1990s," medical ethicist Joseph Fins tells *State Health Watch*. "There's been a cultural backlash against people's right to articulate their purpose and preferences."

Mr. Fins, chief of the division of medical ethics at Weill Medical College of Cornell University and director of medical ethics at New York-Presbyterian Weill Cornell Medical Center, says Congress' intervention in the Schiavo case was "an erosive act" in terms of the right of people to make choices about the care they do or do not want to receive at the end of life.

Public policy issues still to be resolved include development of a continuum of care, encouraging people to make their wishes about end-of-life care known, and appropriate funding for end-of-life care.

In the 1990s, Mr. Fins tells *State Health Watch*, many foundations were interested in the issue and funded workshops and presentations at which many of the questions being posed today were raised. But the effort never made it to mature program status within the medical and health care communities, he says, and thus much work remains to be done.

Creating a continuum of care

At forums in the 1990s, Mr. Fins spoke of the need to develop a continuum of care involving palliative care, long-term care, acute care, and preventive care. "My goal as a physician would be to try to avoid the last hospital admission, the terminal admission, when the patient dies.

"And there has been some pioneering work done with palliative care units and palliative care services to identify patients a little bit upstream so they get to die at home rather than in the hospital.

"But all the palliative care units that I know of and palliative care services that I know of are so highly leveraged with philanthropic support that they're not really sustainable without a revenue stream from the federal government. . . . Every hospital that we know of has an intensive care unit. And that's the standard of care. Every hospital also should have some sort of palliative care service or palliative care unit. That should be the standard of care. And I think if we looked at it in the context of a global budget downstream, and not in silos, we would see that it will decrease aggregate spending," he continues.

Even in 2005, Mr. Fins tells *State Health Watch,* palliative care remains outside the mainstream of U.S. medical practice and probably will remain that way until policy-makers start to give incentives to graduate medical education in support of a palliative care context. "It's an orphan topic. It should be everywhere but it may be nowhere."

National Hospice and Palliative Care Organization (NHPCO) CEO Donald Schumacher tells *State Health Watch* there has been no more interesting time for those working in hospice and palliative care than the last four or five years.

"The Schiavo situation raised consumer interest in deciding what they want [for end-of-life care]," he

notes. "One evidence of the increased interest is the number of people who are downloading advance directive materials from the NHPCO web site. There is pressure on consumers to know what their options are and what they want."

Commercial coverage?

Mr. Schumacher also says he is seeing more commercial insurers covering hospice and palliative care.

"There's still not much change at the federal level," he points out, "although Medicare remains very supportive."

He says that a study being conducted at Duke University that should be released in the next few months is expected to show that hospice care is a very comprehensive package of services and saves Medicare a lot of money. An issue that Mr. Schumacher had raised during talks in the 1990s was the opposition of some physicians to hospice and palliative care because it could reduce their income from the services they provide.

He says that today more patients are asking physicians for appropriate referrals for the level and type of care they want.

"We find that it's not that the doctors don't want to refer but that it can be hard to have that conversation," he tells *State Health Watch*.

He also had expressed a need to expand end-of-life care planning to include children, and says that a variety of organizations have attempted to provide concurrent therapy in which end-of-life care is provided simultaneously with aggressive treatment.

"We've met with some success," he says, "and Congress has funded some demonstrations. But there hasn't been enough of a push to remove restrictions on the current funding streams."

Clearly, funding of end-of-life care remains a major issue. One of the complaints some raised about Congress' intervention in the Schiavo case was that many of the lawmakers who wanted steps taken to ensure that Ms. Schiavo remained on a feeding tube were the same lawmakers who argued for significant cuts in Medicaid.

"People talk about a culture of life, but not a culture of care. I'm not optimistic about what's going on right now. There's a sea change in our overall politics, with attention going to laws that restrict our personal choices. They're looking to score political points but not improve the quality of life."

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"At every opportunity, [House Majority Leader] Tom DeLay has sanctimoniously proclaimed his concern for the well-being of Terri Schiavo, saying he is only trying to ensure she has the chance 'we all deserve,'" the Center for American Progress said at the height of the emotional debate.

But DeLay also "marshaled a budget resolution through the House of Representatives that would cut funding for Medicaid by at least $15 billion, threatening the quality of care for people like Terri Schiavo," the Center pointed out.

Patient care at the Florida hospice where Schiavo lived averaged $80,000 a year, according to media reports, but for several years the hospice company absorbed that cost.

Medicaid covered her other medical costs, however, including prescription drugs. U.S. Rep. Debbie Wasserman (D-FL) said Medicaid's share of Schiavo's care was "a big chunk. . . . Gov. Bush and President Bush are both professing deep concern for the rights of one disabled person, yet their rhetoric doesn't match their actions."

Florida's Medicaid budget is about $14 billion, with the state covering about 41%. Florida receives $1.44 in federal funds for every $1 it spends. Gov. Jeb Bush has proposed limiting Medicaid spending and essentially giving beneficiaries a voucher to use in shopping for a health plan. Advocates for the poor and disabled have said the approach would leave the most vulnerable without coverage.

In Washington, DC, House Republicans approved a budget resolution calling for more than $15 billion in Medicaid cuts over five years.

Senators balked at a similar approach, and the two chambers will have to work to resolve their differences. Families USA executive director Ron Pollack said there were ironies in a situation in which congressional leaders were trying to keep Terri Schiavo alive at the same time they were voting to cut the Medicaid program that keeps millions of people alive.

Mr. Fins says it's important that policy-makers look at preserving the right to die while still affirming the right to care for those who have a credible possibility of recovery. "The first step in making these cases

instructive is to engage in diagnostic discernment in which we truly assess a patient's status," he says. "There can be different views of what to do, but the first step is to get a good diagnosis. The diagnosis should not be a moral choice. It is what it is."

Americans are influenced by accurate information, Mr. Fins says. There is ample literature available showing that when people are given accurate information about their status they will make appropriate choices.

Policy changes are likely to come in the future, he says, because today's baby boomers will not be willing to die as their parents did. But he argues that funding should be made available so that all patients can make appropriate choices, not just those who have sufficient resources of their own.

Even though we're facing massive budget deficits, he says, some capital expenditure is needed to improve end-of-life care. "I'm concerned that we could have further stratification," Mr. Fins tells *State Health Watch*. "Those who are well accumulate more resources, but the poor and the sick don't have resources."

He says that while it would be important to build an infrastructure for end-of-life care soon, he doesn't see it happening in the current political climate. "People talk about a culture of life, but not a culture of care," he says. "I'm not optimistic about what's going on right now. There's a sea change in our overall politics, with attention going to laws that restrict our personal choices. They're looking to score political points but not improve the quality of life."

[Contact Mr. Fins at (212) 746-9663 and Mr. Schumacher at (703) 837-1500.] ■

Buy health insurance on-line?

Should Americans be able to buy health insurance online like clothes, airline tickets, and pet medications? Small Business & Entrepreneurship Council chairwoman Karen Kerrigan says yes.

She notes that Americans bought about $95 billion in goods and services over the Internet in 2003, which added to entrepreneurship and the economy's overall health and vitality. "We can buy just about everything else on-line. Maybe it's time that health coverage be added to the list. You might say that such a concept would probably take an act of Congress, and you would be right."

There is, in fact, a groundswell of interest in the concept growing in the Congress, Ms. Kerrigan tells *State Health Watch*. U.S. Rep. John Shaddeg (R-AZ) has introduced legislation, The Health Care Choice Act of 2005 (HR 2355), that would allow people to buy health insurance from any state, regardless of their residence. There are 44 co-sponsors of the legislation from both parties. And in the Senate, Jim DeMint (R-SC) has introduced companion legislation.

Ms. Kerrigan says she hopes President Bush will become actively supportive of the concept. "We've been educating the public and policy-makers on the concept and why the legislation makes sense. It takes a lot of outreach to lay the groundwork so Congress will be willing to consider the legislation."

State legislatures and the federal government have passed more than 1,000 laws that require consumers to pay for various benefits in their insurance policies, she adds. Large businesses and labor unions are exempt from mandated benefits because they are self-insured under ERISA. "That means that individuals who buy their own policies and small employers end up paying the price for these politically popular but very expensive mandates. The situation is intolerable in some states. Families who buy their own health insurance in New Jersey, for example, are forced to pay anywhere from $3,000 to $17,000 per month for a health insurance policy with a $500 deductible. Nobody has this kind of money, so what do people do? They usually go without insurance. When they are sick, they go to the emergency room where hospitals often overcharge them."

Internet commerce a solution?

The solution, she says, is to allow consumers to buy health insurance over the Internet in any state. Thus, New Jersey residents could buy insurance for themselves or their families in Pennsylvania, New Mexico, or Alabama. "Using the Internet, we can tear down the barriers to expensive red tape and regulation and open the door to affordable health insurance for millions of Americans," she says. "People would be able to shop the entire country for health insurance plans that fit their particular needs — it would be a national marketplace. They wouldn't have to pay for benefits they didn't need or want. Costs would come down, and more people could afford insurance, all without a big government takeover of the health care system and the large tax increase that would be needed to fund such a scheme."

Four congressional findings

There are four congressional findings in Mr. Shaddeg's bill:

1. The application of numerous and significant variations in state law

impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

2. Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.
3. In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the states in regulating this coverage.
4. The establishment of risk-retention groups has provided a successful model for the sale of insurance across state lines, as the acts establishing these groups allow insurance to be sold in multiple states regulated by a single state.

One of the key concerns is that currently states have the responsibility for regulating insurance. According to Mr. Shaddeg, "Rather than going through 50 different regulatory processes, this bill will allow an insurance company to go through one process and sell to people in all 50 states. We can help people, not by setting up a massive new government bureaucracy, but by empowering individuals to make the best choice for themselves and their families."

Should states regulate?

Ms. Kerrigan says Congress needs to determine if it still is appropriate for states to have the responsibility for regulating health care. From her perspective supporting small businesses and entrepreneurs, states often create more problems through their regulation of insurance.

"We've called for a gathering of state and federal officials to look at the problems and try to reach agreement on solutions," she tells *State Health Watch*. "The pendulum has swung much too far."

Support for the concept also has come from Manhattan Institute senior fellow David Gratzer, a physician. In a *Wall Street Journal Online* commentary, Gratzer noted the difference in health insurance premiums from state to state, attributing much of the variability to state mandates of covered services.

The consequences, he said, are higher premiums, more uninsured because of the higher premium cost, and reduced labor mobility.

"Some suggest massive tax credits and other subsidies," Mr. Gratzer wrote, "an unlikely possibility in light of the budget deficit. An alternative would be to allow out-of-state purchases of health insurance. The federal McCarran-Ferguson Act of 1945 empowers states to regulate 'the business of insurance.'

"Nothing prevents Congress, however, from allowing interstate sales. The foundation of such a bill would be the Constitution's Commerce Clause. Individuals and small businesses would then be able to shop around and find a low-cost policy — an affirmation of free-market principles since interstate restrictions now leave many Americans at the mercy of a small number of local health insurance carriers," he explained.

"Allowing a competitive market for health insurance won't be a major budgetary expense, but it may prove priceless to the cause of advancing market reforms to better American health care," Mr. Gratzer notes.

While she couldn't predict how soon the Shaddeg/DeMint legislation might move through the Congress, Ms. Kerrigan says she believes cross-border purchasing has a better chance to be adopted than does legislation for association health plans, which has drawn considerable vocal opposition.

[Contact Ms. Kerrigan at (202) 785-0238. Download the legislation from http://thomas.loc.gov.] ■

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

Clip files / Local news from the states

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

Missouri sends out Medicaid cancellation notices

JEFFERSON CITY, MO—The Department of Social Services has sent letters to about 65,000 low-income parents warning that their Medicaid coverage is about to be eliminated.

Similar letters are scheduled to go out next week to other Medicaid recipients as the department begins implementing a budget that is projected to eventually eliminate coverage for 90,600 of Missouri's 1 million Medicaid recipients.

The first batch of letters was mailed May 20. So far, about 400 people have requested hearings appealing the elimination of their coverage, Denise Cross, director of the department's Family Support Division, said Wednesday.

The cuts in coverage to low-income parents take effect with the new state budget on July 1. The Medicaid program will continue covering only those parents whose income — after deducting child care expenses — is no more than $292 a month for a family of three. That same parent currently can qualify for Medicaid while earning up to $1,005 monthly, with the same child care adjustment.

Cuts in Medicaid coverage for the elderly and disabled take effect Aug. 28, as does the elimination of dental care and certain other benefits to most adults. Those cuts required a change in law to take effect, whereas the reduced eligibility threshold for adults did not.

—*The Kansas City Star,* June 1

Maryland joining pool for Medicaid prescriptions

WASHINGTON, DC—Maryland and two other states were given approval by federal health officials to form a purchasing pool for prescription drugs for their Medicaid recipients, a move that could save Maryland $19 million in 2006.

Maryland, Louisiana, and West Virginia become the second multistate purchasing pool approved by the Centers for Medicare & Medicaid Services.

The new group will cover a total of 1.3 million low-income Americans who qualify for free or discounted health care. In most states, the majority of Medicaid beneficiaries are mothers, children, poor elderly, or disabled.

Under federal law, states already negotiate discounts with pharmaceutical companies. But many governors have complained that soaring Medicaid drug costs are devouring state budgets. The new purchasing pool, which will be run by Ohio-based Provider Synergies, should be able to negotiate deeper discounts because of its larger numbers.

Joseph E. Davis, a senior official with Maryland's Medicaid program, said he expects the state's discount to increase by about 20% as a result of the purchasing pool. He said the savings could help prevent future cuts in benefits or eligibility for the program.

Mr. Davis said Maryland asked Provider Synergies to explore pooling options after learning of a similar initiative approved by federal officials last year involving five states. That pool has since expanded to include more states, and he said Maryland's pool could grow as well.

Officials estimate that Louisiana will save $27 million under the new system and that West Virginia will save $16 million.

Medicaid, a joint state-federal program for 53 million people, cost about $295 billion nationally in 2004.

—*Washington Post,* May 23