State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

It's time for policy-makers to think about the underinsured

In all the recent discussions about ways to solve the problem of the uninsured in the United States, little attention has been paid to the plight of the underinsured. But a new Commonwealth Fund study reported in *Health Affairs* estimates that nearly 16 million adults were underinsured in 2003.

And that's a problem because underinsured adults were more likely to forgo needed care than those with more adequate coverage.

Lead author Cathy Schoen, Commonwealth Fund senior vice president for research and evaluation, tells *State Health Watch* that for the past several years, the researchers have observed a steep rise in out-of-pocket health care expenses for insured people younger than 65, often through higher deductibles and greater cost sharing.

"The literature tends to look at it as either you're insured or you're not," she says. "There's been too little attention paid to how well insurance coverage meets the goals of access and protection against large costs," she says.

To date, the study authors say, efforts to redesign insurance have

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Georgia's Community Health Works program improves health, cuts emergency room visits

Community Health Works (CHW) in Forsyth, GA, which works for five hospitals in seven central Georgia counties, has been improving or stabilizing health for its members while generating hundreds of thousands of dollars in fewer annual health care charges.

Fiscal Fitness: How States Cope

Greg Dent, CHW chief operating officer, tells *State Health Watch* the program was developed in 1999 by a number of central Georgia health care leaders who asked themselves how they could work together to better serve the uninsured than they had been doing separately.

CHW serves people between the ages of 19 and 64 who earn less than 200% of the federal poverty level and have no health insurance coverage.

The organization has screened more than 4,500 people since it opened its doors in 2001 and has served more than 2,500 eligibles.

As a nonprofit network of 90 physicians, three clinics, five safety

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Study

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proceeded with little regard to patients' or families' ability to pay or the consequences of exposure to financial risk.

"To the extent that patient cost sharing or benefit gaps leave insured adults without adequate financial protection in the event of a major illness, erosion in the quality of insurance coverage will raise the number of Americans who are underinsured," they write. "If inadequate protection erects barriers to appropriate care, market trends could undermine the central goals of health insurance: to facilitate timely access to care when needed and to protect patients from costs that would be catastrophic relative to their income."

The researchers used data from the Commonwealth Fund 2003 Biennial Health Insurance Survey, a nationally representative telephone survey of 4,052 adults. When surveyed, 36% of all respondents had health problems and rated their health as either fair or poor or had some type of disability or one of four chronic conditions.

Defining underinsured

The study uses indicators of financial risk to define "underinsured." Risk was assessed by comparing cost exposure to family income. Using respondents' estimates of out-of-pocket medical care expenses, plan deductibles, and income, they were classified as underinsured if they were insured all year but reported at least one of three indicators:

1. Medical expenses amounted to 10% of income or more.
2. Among low-income adults (below 200% of the federal poverty level), medical expenses amounted to at least 5% of income.
3. Health plan deductibles equaled or exceeded 5% of income.

Ms. Schoen says the 10% of income threshold was chosen because it was the threshold most commonly used in past studies of the uninsured or analyses of catastrophic costs. The lower 5% threshold for low-income adults was chosen based on the national policy implicit in SCHIP that permits some cost sharing for low-income families but limits total exposure to 5% of income.

The researchers found that three of four people ages 19 to 64 said they were insured all year. When the three underinsured indicators were applied to them, 12% of the insured adults — or nearly 16 million people — were underinsured.

Based on reported expenses and income, about 7% of continuously insured adults spent 10% or more of their income on family medical expenses during the year. Adding low-income adults who reached or exceeded the threshold of 5% of income, 11% of adults had expenses at or above the two income-related out-of-pocket indicators during the past year and 3% faced deductibles that amounted to more than 5% of their income.

When uninsured adults (estimated at 45 million) were added to those who were underinsured based on financial indicators, the researchers concluded that an estimated 61 million adults, or 35% of the population ages 19 to 64, either had no insurance, sporadic coverage, or insurance that exposed them to catastrophic medical costs during 2003.

Adults with lower incomes were more likely to be uninsured and when insured to be underinsured. In total, 70% of low-income adults

(under 200% of the federal poverty level) were either uninsured or underinsured during the year. Similarly, underinsured adults had disproportionately low incomes; 73% had annual incomes below 200% of poverty.

Sicker adults likely underinsured

Underinsured rates also were high among adults with health problems reflecting, the authors say, the use of indicators based on recent out-of-pocket expenses.

Among sicker adults defined broadly, 43% were either uninsured or inadequately insured compared with 31% of healthier adults. African American and Hispanic adults were at high risk of being uninsured and, when insured, were somewhat more likely than white, non-Hispanic adults to have inadequate insurance.

Comparisons of care, satisfaction, and confidence among the three insurance groups revealed the importance of having adequate insurance to facilitate access and more positive medical care experiences, the researchers found.

Relative to adults with more adequate insurance, underinsured as well as uninsured adults were significantly more likely to go without care because of costs, to lack confidence that they would receive high-quality care when they needed it, and to rate care experiences negatively, they note.

Interestingly, despite being insured all year, underinsured adults reported negative care experiences and rates similar to those of uninsured adults.

Having a regular doctor was the only measure for which underinsured adults' responses were similar to those of adults with adequate insurance.

Underinsured adults also were significantly less confident about their ability to get care in the future and less satisfied with the quality of the care received than were those with better coverage.

The researchers said one proof of this was the fact that half the underinsured adults thought they would have received better care if they had been covered by a different insurance plan.

At financial risk

Underinsured and uninsured adults also were at risk for facing collection agencies and enduring high levels of financial stress as a result of medical bills. Access and care concerns reportedly were most acute among adults with health problems who either were underinsured or uninsured.

Two-thirds of sicker adults who were underinsured and three-fourths of sicker adults who were uninsured went without needed care because of costs during the year.

Nearly half of underinsured sicker adults with chronic diseases or poor health did not adhere to medications, and one-third did not follow up on diagnostic treatments or care recommended by their doctors because of cost.

The researchers say the findings reflect the "double jeopardy of health problems and low incomes among the uninsured and problems with policies that entail substantial cost sharing relative to income."

Overall, according to the study, underinsured adults were more likely than those with more adequate coverage to face higher cost sharing, plan limits, and more restrictive benefits. Yet despite more limited coverage, underinsured adults often incurred high annual premium costs.

One-third had annual premium cost shares of $1,500 or higher, and 47% paid premiums that amounted to 5% or more of their annual incomes. According to Ms. Schoen, some policy-makers and researchers have endorsed the move toward greater cost sharing, arguing that encouraging people to pay more of the health care bill will make them more prudent consumers of health care services and help moderate health care cost inflation.

However, her study indicates that without targeted protections, insurance policies that expose patients to costs that are high relative to income are likely to have a negative effect on access and adherence to recommended care. And the risks are particularly high, she says, for low-income patients and those with chronic illnesses.

"A clear consequence of deductibles and cost sharing will be to shift more of the costs of medical care to the sickest patients and their families," Ms. Schoen writes.

"Given the concentration of health expenditures, this shift may do little to address underlying cost trends yet unduly burden families that are already under stress because of poor health," she explains.

Symptoms of more to come

Ms. Schoen says the study findings are likely to be symptoms of more to come. In the survey, a small percentage of insured adults, just 6%, reported deductibles of $1,000 or more.

She suggests that given the public policy push and market trends toward higher deductibles, it will be important to track coverage adequacy and related care patterns over time.

"The United States may well be on a path to where it becomes harder to distinguish the insured from the uninsured if insurance no longer provides either access or financial protection," Ms. Schoen declares.

The survey points to a need for new policy and research attention to health insurance benefit design, Ms. Schoen says, with a focus on assessing design effects on access and financial protection relative to income.

International studies repeatedly find that the United States often lags behind other countries in key measures of health status and timely access to care while leading the world in exposure to medical care costs.

Without attention to insurance adequacy and whether patients receive effective care, an increase in the number of underinsured people could undermine health, productivity, and financial security in the future, she concludes.

Looking like the uninsured

Ms. Schoen tells *State Health Watch* researchers were surprised at how much the underinsured look like the uninsured in terms of financial stress and ability to get needed care.

The research is raising an important policy issue — the importance of considering insurance design as well as ensuring that people have insurance coverage. Insurance protection needs to take into account income, she says.

Because the data for this survey came from 2003, Ms. Schoen says there is a need to update the impact to reflect the sharp jump in front-end deductibles that has occurred.

"We'll look at what happened to modest income families and those with low incomes," she points out.

Ms. Schoen says there are implications for savings and for families' ability to meet other needs such as education and retirement.

[Contact Ms. Schoen at (212) 606-3864.] ■

Fiscal Fitness

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net hospitals, two regional behavioral health providers, district and county health services, local Family Connections, and several county governments, CHW provides medical homes as well as access to needed specialty care, labs, diagnostics, hospital services, and pharmaceuticals for patients with hypertension, heart disease, diabetes, and depression.

The average CHW member has two comorbidities, an 11th-grade education, an annual income of less than $7,000, and a need for five prescriptions per month. Those drugs are delivered for an average cash outlay per month of less than $20.

A program evaluation by William Custer, associate professor of risk management and insurance at Georgia State University in Atlanta, found 95% of the patients served reported stabilized or improved health. And when compared to a national control group of Medical Expenditure Panel Survey respondents with similar characteristics, CHW patient members, who average three chronic illnesses and five prescriptions per month, use the emergency department and hospital services 13% to 27% less than Medical Expenditure Panel Survey respondents who have one chronic illness.

CHW says that translates to more than $500,000 in fewer uncompensated care charges per 1,000 people served, and the trends suggest that utilization will continue to fall.

Mr. Dent tells *State Health Watch* that plan members are referred by either a physician or family member. Once screened and accepted, they are assigned to a primary care doctor and a case manager. The case managers provide links between doctors, pharmacies, and hospitals to keep their patients moving smoothly and effortlessly through the system. They develop care plans that are specific for each of the disease states CHW works with. "We focus on coordinating as much care as possible and finding a way to get that care paid for," Mr. Dent says.

Patients receive regular calls from their case managers timed to the severity of their risk. Thus, those at high risk might be called once or twice a week, while those with medium risk are called once every one to two weeks, and those at low risk are called monthly. For diabetes patients, for instance, case managers will make sure they are watching their diets, using the glucose monitor, and have a sufficient supply of test strips.

The CHW pharmacy benefit works to enroll patients in all available drug company assistance programs as well as other programs and

buys drugs for those who can't obtain them through any other source.

According to Mr. Dent, the services provided by CHW cost $300 to $400 per patient per year and generate savings in excess of that amount through reduced hospitalization and emergency department rates.

He says CHW has more care management capacity available but is limited by physician capacity.

Similar effort for cancer patients

The organization has spun off the Central Georgia Cancer Coalition that covers 25 counties and does a similar kind of work for those affected by nine forms of cancer. It also has become involved in advocating in the public policy arena for the uninsured, who often don't have anyone to speak up for them.

For those in other communities who would like to do what CHW is doing, Mr. Dent says it is important to have committed leadership with a long-term vision of what can be accomplished.

He says CHW has learned that it is easier to deal with not-for-profit hospitals because they understand that they will have to treat the uninsured one way or another. For-profit hospitals have a harder time coming to grips with the concept, Mr. Dent says, because they generally manage for next year and can't see the long-term savings that will accrue by keeping people with chronic illnesses out of the hospital.

He adds that it helps to be able to leverage resources, such as foundation grants or government funds, because seed money helps to bring people to the table to plan and implement a program.

[More information is available online at www.chwg.org. Contact Mr. Dent at (478) 994-1914.] ■

Paying for performance can reduce costs

The old adage that you get what you pay for may have particular meaning in the effort to cut health care costs.

Health care opinion leaders from a number of different disciplines and backgrounds surveyed by the Commonwealth Fund said rewarding more efficient and high-quality providers is likely to be the most effective way to reduce health care costs. Some 57% of the respondents said pay for performance is an "extremely" or "very effective" way to reduce health care costs.

"Pay for performance has been gaining attention as an effective strategy of improving quality of care," said Karen Davis, Commonwealth Fund president, in response to the survey results.

"Health care opinion leaders view pay for performance not just as a way to reward quality, but as a strategy to raise efficiency in health care delivery," she added.

The Commonwealth Fund used Harris Interactive to conduct an online survey of 289 opinion leaders in health policy and innovators in health care delivery and finance.

Respondents were clustered in four major groups: those employed by academic or research organizations, those involved in delivery of health care services, those employed by businesses or the health industry including health insurance companies and managed care plans, and those working for government or labor/consumer advocacy organizations.

The survey — the third in a planned series of six intended to highlight opinion leaders' perspectives on the most important and timely health policy issues facing the nation — focused on potential ways to lower health care spending, addressing key components of spending such as prices charged, utilization levels, and insurance overhead.

Everything can work a bit

In general, majorities of the panelists considered all the options presented to them as somewhat effective. For controlling prices, there was considerable agreement that some type of pay-for-performance approach encouraging providers to lower costs and improve quality would be most effective.

To lower use of health services, panelists believed that better management of high-cost conditions and use of evidence-based treatment guidelines would be most effective. To reduce insurance overhead, they favored having private insurance and public programs work together to streamline and standardize their products and processes.

After using pay for performance to reward more efficient and high-quality providers, the experts favored having all payers adopt common payment methods and rates as the second most effective way to cut costs, with slightly fewer than half of the respondents rating it as extremely or very effective.

Other initiatives receiving less support included promoting best practices and supporting provider learning collaboratives to improve efficiency and quality, making public information available on comparative quality and total costs of care, and providing feedback with comparative information on total resource consumption and quality to doctors and hospitals.

For reducing unnecessary utilization, two options were seen as the most effective, with slightly more

than half of respondents rating them as extremely or very effective. With some small variations among the sectors, improving disease management services for patients with high-cost conditions and enhancing primary care case management ranked as the most effective action (56% of all respondents found this to be a highly effective strategy). That was followed closely by using evidence-based medicine guidelines or protocols to determine when a given test or procedure should be done (52% of all respondents found this highly effective). Expanding use of information technology ranked third.

Fewer respondents believe in the effectiveness of implementing better measures of and reporting on overutilization and having consumers pay a substantially higher share of their health care costs, with about one-third rating them as extremely or very effective.

Increase insurance collaboration

According to respondents from all sectors, the most effective way to reduce high insurance overhead is to increase collaboration among public programs and private insurers to streamline administrative costs, including standardizing insurance products and processes. Some 41% thought this would be highly effective.

However, when presented with all other possible actions, there was considerably more skepticism about their effectiveness and the sectors differed greatly in their opinions on what would and would not work.

Slightly fewer than one-third to about one-quarter of respondents viewed those actions as extremely or very effective: making health insurance a public utility regulated by states, creating a more competitive market with strong competition among different insurers, and creating a state electronic clearinghouse with consolidated electronic information on enrollees and claims.

In her commentary on the survey results, Ms. Davis said the degree of support for rewarding efficient and high quality care was striking, noting that pay for performance has been gaining attention as an effective strategy for improving the quality of care. She said The Leapfrog Group (a group representing major employers) has documented nearly 100 private-sector initiatives tying payment to quality measures. Also, several Medicare demonstrations are in place and more are being planned to test the strategy nationally.

"Health care opinion leaders view pay for performance not just as a way to reward quality, but as a strategy to raise efficiency in care delivery," Ms. Davis explained. "Yet measuring the efficient provision of care over time or over the course of an acute episode is a much less developed science than measuring the quality of care. It will take a concerted effort to develop and implement such metrics."

She also noted the low approval rating for the notion of requiring patients to pay a substantially higher share of their health costs. "Despite the attention given to high-deductible health plans linked to health savings accounts," she said, "only one-third of health leaders from all sectors believe that shifting costs to patients would be an extremely or very effective way to lower the costs of care. This strategy tied for last among those in business, insurance, or another health care industry as a way of reducing inappropriate utilization of services."

According to Ms. Davis, a key message from the survey results is that health care opinion leaders see the supply side of the health care delivery market as showing more promise for long-term success in controlling costs than shifting costs to the demand side — patients.

Promoting collaboration among providers and payers to work together toward a common goal also ranked higher than efforts to instill greater competition among insurers or providers. And supporting best practices and provider learning collaboratives was seen by 40% of leaders in health care delivery and business/insurance/other industry as a highly effective way to control costs.

"These findings are encouraging," Ms. Davis wrote. "Beyond ideological divides and self-interest, there is much agreement on practical steps to enhance value in health care delivery, reduce unnecessary services and administrative costs, and apply the business principles of continuous quality improvement, process redesign, and evidence-based practice. Working together to implement these strategies would be a challenge worth taking up."

Why crisis won't be solved

Helen Darling, president of the National Business Group on Health, said most employers agree that the health care cost crisis won't be solved as long as:

1. We believe we can have it all and someone else will pay for it.
2. We believe we can lead unhealthy lifestyles and the care system will bail us out.
3. We fail to ensure patient safety and quality, thus increasing hospital stays, charges, and redundancies, and losing 44,000 to 98,000 patients a year from avoidable medical mistakes.
4. We reimburse for care even though it is not recommended by experts or based on evidence.

"There is no simple way to address the dilemma of high costs,"

she said in commenting on the survey findings. "But a number of steps hold promise."

Despite its middle-of-the-road ranking by the opinion leaders, Ms. Darling said it will be important to invest in an information technology infrastructure to reduce human errors, prevent duplicative care, increase efficiency and effectiveness, and improve analysis of patient data.

She particularly called for investment in computerized physician order-entry systems, citing a Brigham and Women's Hospital study in Boston that showed a reduction of 55% in adverse drug events and 81% in serious medication errors after such a system was implemented.

Ms. Darling also called for support for efforts to improve patient safety such as the "Save 100,000 Lives" campaign from the Institute for Healthcare Improvement.

"We have to get over the idea that we can or even should afford unlimited health care. There are many types of unnecessary care, including procedures taken even though there is evidence of their inappropriateness, wastefulness, or actual harm," she continued.

"These include prescribing antibiotics for viral diseases or widely prescribing drugs that are most effective for a small number of conditions. Unnecessary care also includes treatment for medical conditions that could be avoided by encouraging lifestyle changes such as healthy eating and exercise," Ms. Darling explained.

The bottom line rules

After providing a laundry list of many other steps to be taken by many different stakeholders, she noted that if corporate America knows anything, it is the bottom line. "If we fail to make hard decisions now, we will pour more and more money into a less than effective and less than efficient health system — wasting valuable resources, making it harder for U.S. companies to compete in the global economy, and lowering everyone's standard of living."

Alan Nelson, former American Medical Association president, who now is a special advisor to the CEO of the American College of Physicians, also commented on the results, noting that controlling health care costs seems much more daunting than providing access or ensuring quality, perhaps because efforts to reign in costs date back at least 70 years.

In the 1920s, he wrote, concerns about the cost and distribution of medical care resulted in formation of the Committee on the Costs of Medical Care, and in 1932, that committee gave the first estimate of national health care expenditures — $3.66 billion or 4% of the gross national income.

In 1971, with expenditures at $81 billion (7.2% of the gross domestic product), President Richard Nixon said there was a crisis in medical costs and the system would collapse unless they were controlled. He imposed price controls and supported legislation aimed at encouraging HMOs, health planning, and professional standards review organizations to monitor quality and utilization and reduce costs.

During the 1990s, the share of gross domestic product made up by personal health care was steady or even declining at just under 12%. Analysts cite three factors that slowed growth: health plans' successful bargaining with providers over prices, managed care plans' use of strategies to control service volume, and competition among plans that restrained premium growth.

Now, with health plan premiums jumping and health spending back at more than 13% of gross domestic product, pressures to control costs are again front and center, Mr. Nelson said. Projected national health expenditures for this year are $1.9 trillion or 15.7% of gross domestic product. There are significant regional variations and equally startling variations among academic health centers.

Limited usefulness

"Some argue that disease prevention efforts can restrain costs," Mr. Nelson wrote. "Such efforts are certainly important, but promoting longer life may only defer expensive final illnesses, with additional consumption of health care services in the intervening years. Some have suggested that increased competition among health plans and providers could be an effective strategy for cost containment. But this theory ignores the fact that competition and marketing often increase the demand for services. While competitive forces may restrain prices, volume drives costs."

Mr. Nelson said he thinks most people would be willing to accept efforts to increase efficiency, defined as the reduction of unnecessary services and care of marginal value. He said that adherence to clinical practice guidelines can improve quality and also raise the value of health spending.

He said he anticipates that pay-for-performance efforts initially will increase costs as efforts are made to identify underuse and encourage delivery of preventive and other appropriate services. At the outset, he said, efforts to increase efficiency likely will take the form of measuring and reporting use of resources.

However, as more research into cost-effectiveness programs guides medical benefit design, regional

utilization variations should decrease, and efforts to reduce cost and simultaneously improve quality should bear fruit.

Mr. Nelson also called for professional liability reform, more and better use of information technology, rewarding primary care providers for coordinating care among various specialists who treat patients with multiple chronic illnesses, and rationalizing system capacity in terms of both facilities and human resources. "In my view, cost increases are to some extent inevitable until the baby-boom generation moves through the health system. . . . Because of this and because of the growth of technology that makes new medical services available, I believe health care costs will continue to increase," he noted.

"This will likely be acceptable to our society only if value increases as well. I believe that most Americans will prefer this to explicit rationing of care, at least in the near term," Mr. Nelson concluded.

Bipartisan congressional support for pay for performance came in legislation introduced by Senate Finance Committee chairman Chuck Grassley (R-IA) and the committee's ranking Democrat, Sen. Max Baucus (D-MT) to create quality payments under Medicare for physicians and practitioners, hospitals, health plans, skilled nursing facilities, home health, and end-stage renal disease facilities.

The proposal would implement recommendations from the Institute of Medicine and the Medicare Payment Advisory Commission to establish pay-for-performance incentives that promote quality care and better value in the Medicare payment system.

(Download the Commonwealth Fund survey report and commentaries from www.cmfw.org.) ■

Pharmacy cost controls reduce access

An unintended consequence of the many steps states are taking to control the cost of prescription drugs in their Medicaid programs is a reduction in access to medications for Medicaid recipients. That's the finding of a study by Peter Cunningham, a senior health researcher for the Center for Studying Health System Change reported in the May/June issue of *Health Affairs*.

"It's not that they are deliberately trying to keep people from drugs they need," Mr. Cunningham tells *State Health Watch*.

"To be fair, most state Medicaid directors want to cut wasteful and inefficient use of prescription drugs, but the rules and regulations they rely on can create more bureaucratic obstacles. And while there are always ways around the obstacles, a lower income population may not know how to get around the system," he adds.

To contain costs, almost all states have implemented one or more strategies aimed at managing prescription drug use or curtailing wasteful and ineffective use, Mr. Cunningham reports.

Cost-sharing, through a copayment, is one of the oldest and most prevalent forms of utilization management, he says, but there are a variety of other methods being used, including prior authorization, preferred drug lists, dispensing limits, mandatory use of generics, and step therapy.

Many states also have tried to contain costs by reducing their reimbursement to pharmacies, negotiating supplemental rebates with manufacturers, and monitoring high-cost users and prescribers of drugs.

The percentage of states using three or more of these control strategies has increased greatly, from about one-third of states in 2000 to about 90% in 2003.

Impact not known

According to Mr. Cunningham, his research was needed because despite the near universal implementation of one or more pharmacy cost-containment strategies, virtually nothing is known about their effect on drug costs, use, and access. Earlier research from the 1970s and 1980s focused on the effects of copayments on Medicaid prescription drug use and spending.

Findings from those studies showed that even a copayment as small as 50 cents per prescription would reduce prescription drug use and spending across a broad range of therapeutic categories, including those covering medications considered to be essential.

"Inferring the effects of recent cost-containment policies on prescription drug use and access from this previous research is questionable," Mr. Cunningham says, "given the rapid increase in the development of new medications, use, and spending since many of the studies were conducted. And since more states have now implemented more than one cost-containment policy, it is increasingly difficult to attribute effects on use and access to any specific policy."

He used data from 2000-2001 and 2003 Community Tracking Study telephone household surveys to compare the extent of prescription drug access problems for adult Medicaid enrollees with the access problems of adults who have other types of insurance coverage or who have no health insurance.

Mr. Cunningham also examined the effects of cost-containment policies and other factors on prescription

drug access among adult Medicaid beneficiaries and the effect of the increase in states' cost-containment policies on changes in access between 2000-2001 and 2003.

The research found that compared with all U.S. adults, Medicare enrollees are somewhat younger, much poorer, more likely to be members of a racial/ethnic minority, and likely to have less favorable health overall and a much higher prevalence of chronic conditions. Lower incomes and high rates of health problems are particularly high-risk factors for problems with affording prescription drugs, Mr. Cunningham says.

Access problems reported

More than one-fifth of adult Medicaid enrollees reported that in 2003, they did not get prescription drugs because of cost. He says the extent of access problems for Medicaid enrollees was more similar to that of people who typically have no prescription drug coverage, including Medicare enrollees with no supplemental coverage and uninsured people.

Those with private insurance, including Medicare enrollees with supplemental private insurance, have by far the lowest rate of drug access problems, Mr. Cunningham continues.

"The high level of access problems for Medicaid enrollees is somewhat surprising given that all states include prescription drug coverage in their Medicaid programs, and cost sharing is lower than in most private insurance plans," Mr. Cunningham reports.

"High levels of access problems reflect, in large part, Medicaid enrollees' much lower incomes and higher prevalence of chronic conditions, factors that are strongly related to increased access problems," he points out.

According to Mr. Cunningham, when estimates are adjusted to control for income, health status, and other factors, rates of prescription drug access problems for Medicaid enrollees are much lower and comparable with those of people with private insurance coverage.

A large and growing percentage of Medicaid enrollees live in states that have implemented various cost-containment policies, the research showed. And even more important is a dramatic increase in the percentage of Medicaid enrollees who live in states with four or five cost-containment policies, up from about 16% in 2000-2001 to 62% in 2003. By contrast, the percentage of enrollees who live in states with two cost-containment policies or fewer decreased from about 34% in 2000-2001 to 7% in 2003.

Prior authorization limits access

Prior authorization as a cost-control strategy increased probability of access problems by 20 percentage points, while requiring use of generic substitutes increased the probability by eight percentage points. Copayments, dispensing limits, or step therapy requirements had no statistically significant effect on access.

Mr. Cunningham says the degree of effect of any individual policy is difficult to interpret since most states have implemented more than one policy, and there is some intercorrelation between the factors and the measures of prescription drug access.

"Since some form of prior authorization is used in most states," he adds, "the large effects observed for this policy may be more indicative of the uniqueness of the small number of states that do not have such requirements. States without prior authorization tend to have very few cost-containment policies of any type, and therefore prescription drug access problems would be expected to be much lower," adds Mr. Cunningham.

"Nevertheless, case studies of states' prior authorization programs have observed that these programs can lead to bureaucratic and communication problems among enrollees, providers, and pharmaceutical benefit management firms under contract to the state, which in turn, can lead to delays and other problems with prescription drug access," he notes.

Mr. Cunningham says it may be surprising that mandatory generic requirements would lead to higher reports of access problems since they don't imply a cost to the enrollee.

He says it is possible that some physicians continue to prescribe brand-name drugs when generics are required because they are unaware of the policy or believe that a brand name is more efficacious than its generic substitute.

Also, some enrollees may specifically request brand-name drugs, meaning they would potentially have to pay the full cost if a generic were available.

That copayments, dispensing limits, and step therapy did not have independent effects on prescription drug access may be because they are correlated with prior authorization and mandatory generic policies, the report says, or because such policies affect relatively few people and both the sample of Medicaid enrollees and the measure of access are too broad to observe those policies' effects.

Cost controls hurting access

Mr. Cunningham concludes that from the perspective of Medicaid enrollees, states' efforts to contain the rising cost of prescription drugs are having negative effects on their access to those drugs.

Although it was not possible in this study to distinguish between essential and nonessential medications, he notes that earlier research on the effects of copayments and prior authorization showed negative effects on use of prescription drugs across a wide range of therapeutic categories, including those considered essential. That the access problems are particularly high for people with chronic conditions, which includes a disproportionately high number of Medicaid enrollees, also suggests at least some unmet need for essential medications, he says.

Effects not proven

Mr. Cunningham predicts continued, if not increased, drug cost-containment policies in response to increasing drug costs and strained state budgets, and says that rolling back such policies is probably unrealistic given the magnitude of Medicaid spending on state budgets, especially when most private insurance plans are trying to contain costs through greater enrollee cost-sharing, preferred drug lists, and incentives to use generics.

He tells *State Health Watch* he thinks the message his research has for state policy-makers is that cost containment is a real issue but there hasn't been enough evaluation to learn the effect of any particular step on access to needed drugs.

"Drug cost-containment efforts have proliferated over the last five or 10 years without any indication of their effect on access," Mr. Cunningham adds. "This should be a red flag that it's time to stop, take a deep breath, and see what we're really doing."

[Contact Mr. Cunningham at (202) 484-5261 or e-mail him at pcunningham@hschange.org.] ■

Leavitt names Medicaid commission members

A Health and Human Services Department (HHS) advisory commission charged with identifying reforms needed to stabilize and strengthen Medicaid will have 13 voting members and 15 nonvoting members. Appointments were made by Mike Leavitt, HHS secretary, including health policy leaders from both major political parties, state health department officials, public policy organizations, individuals with disabilities, and others with special expertise. The commission's first report was due Sept. 1.

Former Tennessee Gov. Don Sundquist chairs the commission, with former Maine Gov. Angus King as vice chair.

Sundquist, a Republican, got into political trouble after advocating a tax increase to help avoid massive cuts in the state's innovative TennCare program. King is a registered Independent and is known as a moderate on Medicaid issues.

Voting commission members include: Nancy Atkins, West Virginia Bureau of Medical Services commissioner; Melanie Bella, Center for Health Care Strategies vice president for policy; Gail Christopher, Joint Center for Political and Economic Studies vice president for health, women and families; Gwen Gillenwater, National Council on Independent Living director for advocacy and public policy; Robert Helms, American Enterprise Institute resident scholar and director of health policy studies; Kay James, former director of the U.S. Office of Personnel Management; Troy Justesen, U.S. Department of Education deputy assistant secretary for special education and rehabilitation services; Tony McCann, Maryland Secretary of Health and Mental Hygiene who was a budget official in the Department of Health and Human Services during the tenure of the first President Bush; Mike O'Grady, HHS assistant secretary for planning and evaluation; Bill Shiebler, former president of Deutsche Bank; and Grace-Marie Turner, Galen Institute president.

Nonvoting members named by Mr. Leavitt include: James Anderson, Cincinnati Children's Hospital president; Julianne Beckett, Family Voices director of national policy; Carol Berkowitz, American Academy of Pediatrics president; Maggie Brooks, Monroe County, NY, county executive; Valerie Davidson, Yukon-Kuskowim Health Corp. executive vice president; Mark de Bruin, Rite Aid senior vice president of pharmacy services; John Kemp,

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Disability Service Providers of America CEO; Joseph Marshall, Temple University Health System CEO; John Monahan, WellPoint president of state sponsored programs; John Nelson, American Medical Association immediate past president; Joseph J. Piccione, OSF Healthcare System corporate director of mission integration; John Rugge, Hudson Headwaters Health Network CEO; Douglas Struyk, Christian Health Care Center CEO; Howard Weitz, Thomas Jefferson University cardiologist; and Joy Johnson Wilson, National Conference of State Legislatures director of health policy and federal affairs counsel.

The slate of nominees was criticized by some Democrats and Medicaid advocates either for not being bipartisan enough or for not being independent from the president's positions.

Ron Pollack, Families USA executive director, said the commission was "a sham that deserves, and will receive, no credibility." And U.S. Rep. John Dingell (D-MI) said the commission "falls short of the unbiased, independent advisory panel" proposed by Sens. Gordon Smith (R-OR) and Jeff Bingaman (D-NM). Bingaman expressed disappointment with the commission appointments and said that any report they produce "is likely to be lopsided, and therefore not a useful tool for Congress."

Even Rep. Joe Barton (R-TX), chairman of the House Energy and Commerce Committee, said he would not appoint a colleague to the commission. Congressional leaders of both parties were to select eight lawmakers to serve as nonvoting members, but Democrats have refused to participate, saying they fundamentally disagree with the commission's charge to find ways to cut Medicaid spending. Mr. Barton said he was satisfied with what he called the diverse makeup of the commission and planned to devote his energies to developing Medicaid reform legislation.

By Sept. 1, the commission was to outline recommendations for Medicaid to achieve $10 billion in reductions in spending growth during the next five years as well as ways to begin meaningful long-term enhancement that can better serve beneficiaries. It also was to consider potential Medicaid performance goals as a basis for longer-term recommendations. A second report, due Dec. 31, 2006, is to provide recommendations to ensure Medicaid's long-term sustainability, addressing issues such as how to expand coverage while retaining fiscal responsibility, ways to provide long-term care to those who need it, eligibility, benefits design and delivery, improved quality of care, choice, and beneficiary satisfaction. Mr. Leavitt has held two seats on the commission for two governors to participate in deliberations for the second report.

(To see the commission's charter, go to www.cms.hhs.gov/faca/mc/default.asp.) ■

Senators want to end fed's erectile dysfunction drug payments

Legislation introduced by Senate Finance Committee chairman Chuck Grassley (R-IA) would prohibit coverage by federal programs including Medicaid and Medicare for erectile dysfunction drugs Viagra, Levitra, and Cialis. The bill would not prevent federal government coverage of those drugs for treatments not related to sexual performance.

The Congressional Budget Office has projected Medicaid and Medicare will spend $2 billion on the drugs between 2006 and 2015. "In my opinion," Mr. Grassley said, "those dollars could be spent more wisely." He said that while some would argue that the erectile dysfunction drugs can improve one's life, and he appreciates that view, we live in a world of limited resources and in such a world, coverage of lifestyle drugs isn't consistent with the need for balance between Medicaid and Medicare beneficiaries and the taxpayers who pay for the beneficiaries' health coverage.

"Obviously, I'm not introducing legislation to prevent those covered by federal programs, such as Medicare and Medicaid, from obtaining prescription drugs prescribed for sexual or erectile dysfunction. Patients wanting to use these medicines to improve sexual performance are welcome to pay for them out of their own pockets." Mr. Grassley said his bill also addresses a controversy that arose in the spring regarding a report indicating that nearly 800 convicted sex offenders in 14 states were obtaining Viagra through Medicaid. State officials had said they believed they did not have authority to deny the prescription coverage.

In a May 23 letter to state Medicaid directors, Dennis Smith, Center for Medicaid and State Operations director, wrote to "remind states there are a number of options to prevent the inappropriate use of such drugs and to inform states that we believe they should restrict the coverage of such drugs in the case of individuals convicted of a sex offense."

He noted that the Medicaid law requires states to prevent fraud,

abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients — a state legitimately could find that use of certain drugs and the treatment of impotence for convicted sex offenders could constitute fraud, abuse, or inappropriate care. "We believe that, in accordance with such provisions, use of these drugs in the case of a sex offender is not appropriate, and Medicaid should not pay for the cost of such drugs in such circumstances."

The letter said states should use their drug review programs and procedures to work with physicians and pharmacists to prevent inappropriate Medicaid payment for such drugs in the case of a sex offender and cautioned that failure to perform such a review and implement appropriate controls could result in sanctions.

While Smith's letter referred only to coverage for sex offenders, three states (New York, Florida, and Texas) went further and temporarily banned Medicaid reimbursements for Viagra for everyone, while Georgia, Louisiana, South Carolina, and Virginia proposed to remove Viagra from the list of Medicaid-covered drugs.

In New York, where an internal audit found that 198 of the state's most dangerous sexual predators were receiving Viagra through Medicaid, Gov. George Pataki temporarily halted all payments for the drug until the legislature could adopt a law to exclude sex offenders.

New York's finding led to an Associated Press survey of states that found that nearly 800 convicted sex offenders in 14 states were reimbursed through Medicaid for Viagra, Levitra, and Cialis. Florida and Texas accounted for the vast majority of cases along with New York, and they also moved quickly to halt payments for erectile dysfunction medications for all Medicaid recipients.

When Viagra first came on the market in 1998, governors protested a federal requirement that state Medicaid programs subsidize the drug. A July 1998 letter from then health financing administrator Nancy DePearle said governors couldn't exclude Viagra from their Medicaid programs, but granted states broad latitude to determine the circumstances under which the drug would be dispensed. While state policy on reimbursements for drugs to treat erectile dysfunction varies, all states until now have provided some form of coverage. That is not changing as a result of the new Medicaid letter from Mr. Smith.

Advocates for the poor have expressed concerns that the controversy over taxpayer-funded Viagra for sex offenders will deflect attention from potentially deeper cuts in Medicaid that could hurt those in genuine need.

National Health Law Program attorney Steve Hitov said Mr. Smith's letter was "just another well-orchestrated stroke toward the overall goal of discrediting the Medicaid program so that when they're trying to gut it later this year, they won't seem so cruel."

(Download the CMS letter at www.cms.hhs.gov/states/letters.) ■

Clip files / Local news from the states

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

State expands Medicaid program

DES MOINES, IA—Gov. Tom Vilsack heralded an expansion of the state's Medicaid program, an initiative that prevents the state from losing $180 million in federal money, while increasing the number of patients eligible for reduced-cost medical care. Iowa is expanding Medicaid at a time when most states are making cuts because of the rapid rise of medical costs. The Medicaid funding crunch is exacerbated by a recent federal crackdown on accounting methods that allowed states to use federal money as matching funds for obtaining other federal money. That would have cost Iowa about $180 million per year, or 9% of the overall Medicaid budget. Iowa averted the loss by getting a waiver from the U.S. Department of Health of Human Services. In exchange, Iowa is expanding its services and testing whether an emphasis on preventive care can lead to greater cost savings down the road. The Iowa Department of Human Services estimates that a minimum of 14,000 people will participate in the new initiative, called Iowa Care.

—*Quad-City Times,* July 18