State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

Flu pandemic: Not if, but when — and will the U.S. be prepared?

If a moderately severe strain of a pandemic flu virus hits the United States, more than 500,000 Americans could die and more than 2.3 million could be hospitalized, according to state-by-state figures from a model developed by the Centers for Disease Control and Prevention and used by Trust for America's Health (TFAH). (**See chart, p. 3.**) The model also projects 66.9 million Americans at risk of contracting the disease.

"This is not a drill," says Shelley Hearne, TFAH executive director. "This is not a planning exercise. This is for real. Americans are being placed needlessly at risk. The U.S. must take fast and furious action to prepare for a possible pandemic outbreak here at home."

The urgency comes because the TFAH report — "A Killer Flu? 'Inevitable' Epidemic Could Kill Millions"— found that the U.S. has stockpiled only 2.3 million courses and has placed orders for an additional 3 million courses of antiviral pharmaceuticals (produced as Tamiflu by Roche Pharmaceuticals), which would

*See **Flu pandemic** on page 2*

California group creates insurance products and expands access for low-income citizens

Working with an initial grant from the Robert Wood Johnson Foundation, the Alameda County (CA) Health Care Services Agency has been working to improve coverage and access to care for a number of targeted populations.

Fiscal Fitness: How States Cope

Agency director David Kears tells *State Health Watch* the agency has succeeded by collaborating with other public and private groups in an effort that is both business-driven and value-driven. "We've been very successful doing things to create access," he says.

The agency serves some 1.5 million people in a highly diverse community with many ethnic populations, including 22% Asian, 20% Hispanic, and 15% African American.

With receipt of the Robert Wood Johnson Foundation grant of $700,000 in 2001, the Alameda Health Consortium (Alameda County Health Care Services Agency, Alameda County Medical

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Flu pandemic

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likely be available in 2006. This would be enough to cover 5.3 million Americans, leaving more than 60 million who could be infected and would not be able to receive medication before an effective vaccine to combat the flu strain is identified and produced.

The urgency also comes because people such as House Government Reform Committee chairman Tom Davis are saying that experts say the next flu pandemic "is a matter of when, not if. No one knows exactly when it might strike, or whether the next worldwide pandemic will be a version of the avian flu . . . or a different influenza strain.

"What is not up for debate is that the stakes — in dollars, resources, and human lives — are enormous. According to experts, the next pandemic could be worse than the Spanish flu, which is estimated to have caused the deaths of 40 million to 50 million people worldwide from 1918 to 1919. Given the global integration of today's economic markets and the capacity for rapid travel from one corner of the globe to another, a pandemic could move around the world in the same amount of time it takes to fly from New York to Tokyo. This occurred in the case of the SARS outbreak two years ago."

Despite such warnings, many people in the United States either don't know or don't care about a potential outbreak.

A Harris Interactive poll for the *Wall Street Journal's* Online Health Industry Edition found that 53% of U.S. adults are either not very or not at all familiar with the avian flu and that 41% are not very or not at all concerned that the United States might be part of an avian flu pandemic in the near future. But despite this lack of familiarity and concern, majorities of adults believe that particular steps should be taken to prepare for a potential pandemic, including:

1. Develop plans to quickly provide critical medical supplies to areas of the globe that experience avian flu outbreaks (71%).
2. Develop plans to limit spread of avian flu via quarantines, travel restrictions, etc. (65%).
3. Invest government dollars in development and production of avian flu vaccines (61%).
4. Stockpile antiviral drugs that might slow an outbreak of avian flu (62%).
5. Stockpile critical medical supplies (such as surgical masks and gloves) that can help slow the spread of avian flu (55%).

Additional TFAH findings included:

- While there are estimates that more than 2 million Americans may need to be hospitalized during a pandemic outbreak, the United States currently only has some 965,250 staffed hospital beds.
- The United States has not adequately planned for the disruption a flu pandemic could cause to the economy, daily life, food, and supply distributions or homeland security.
- The United States lags in pandemic leadership compared to Great Britain and Canada based on an examination of leadership, vaccine development, vaccine and antiviral planning, health care system surge capacity planning, coordination between public and private sectors, and emergency communications planning.

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Potential Pandemic Influenza Deaths and Hospitalizations from a Mid-Level Pandemic Flu*				
State	*Projected Dead*	*Projected Hospitalized*	*Number of Cases*	*Number of Cases Without Tamiflu*
Alabama	8,886	38,591	1,079,789	994,263
Alaska	886	4,558	152,328	140,263
Arizona	9,223	39,675	1,138,742	1,048,547
Arkansas	5,350	22,660	630,705	580,749
California	60,875	273,090	8,067,075	7,428,119
Colorado	7,192	32,978	973,161	896,081
Connecticut	7,054	29,932	817,465	752,717
Delaware	1,507	6,560	182,895	168,409
District of Columbia	1,155	4,974	132,241	121,767
Florida	35,737	142,386	3,663,486	3,373,318
Georgia	13,655	62,912	1,871,561	1,723,323
Hawaii	2,446	10,571	296,651	273,154
Idaho	2,279	10,157	302,558	278,594
Illinois	23,720	103,738	2,973,962	2,738,408
Indiana	11,817	51,711	1,466,027	1,349,910
Iowa	6,233	26,090	713,106	656,624
Kansas	5,373	22,946	654,335	602,508
Kentucky	7,930	34,748	977,031	899,645
Louisiana	8,334	37,148	1,087,942	1,001,771
Maine	2,651	11,333	310,513	285,918
Maryland	9,958	44,500	1,273,572	1,172,698
Massachusetts	13,136	56,038	1,529,313	1,408,183
Michigan	19,622	86,005	2,443,473	2,249,937
Minnesota	9,304	40,786	1,171,387	1,078,607
Mississippi	5,362	23,531	682,625	628,558
Missouri	11,274	48,240	1,350,515	1,243,546
Montana	1,804	7,787	219,703	202,301
Nebraska	3,441	14,697	414,218	381,409
Nevada	3,243	14,455	419,202	385,999
New Hampshire	2,333	10,301	293,177	269,956
New Jersey	16,980	72,791	2,013,212	1,853,755
New Mexico	3,244	14,504	432,438	398,186
New York	37,701	162,490	4,534,307	4,175,165
North Carolina	14,987	65,637	1,856,296	1,709,267
North Dakota	1,371	5,795	160,221	147,530
Ohio	23,197	99,979	2,796,583	2,575,078
Oklahoma	6,833	29,376	829,273	763,590
Oregon	6,724	29,047	810,872	746,646
Pennsylvania	27,185	112,658	3,004,915	2,766,910
Rhode Island	2,234	9,263	246,857	227,305
South Carolina	7,474	32,983	940,045	865,589
South Dakota	1,559	6,599	184,493	169,880
Tennessee	10,875	47,678	1,342,050	1,235,752
Texas	35,124	160,648	4,859,834	4,474,909
Utah	3,393	15,906	514,787	474,013
Vermont	1,185	5,213	147,245	135,582
Virginia	13,104	58,872	1,683,499	1,550,157
Washington	10,910	48,610	1,402,591	1,291,498
West Virginia	4,049	17,014	453,947	417,992
Wisconsin	10,620	45,842	1,292,419	1,190,053
Wyoming	915	4,086	119,936	110,436
U.S. Totals	**541,433**	**2,358,089**	**66,914,573**	**61,614,573**

Projections are based on CDC's FluAid 2.0 program. The estimated deaths are for a pandemic strain three times more lethal than the 1968 pandemic, on which the default FluAid numbers are based. The hospitalization rate is three times the default 1968 rate. The "Dead" and "Hospitalized" numbers represent the "most likely" FluAid projection at a 25% rate of contraction. The "Number of Cases" is the projected number of residents contracting the flu, based on a 25% rate of contraction. State population numbers are from FluAid, using U.S. Census data gathered in 1999. Updated population data were not used to ensure consistency with estimated "Dead" and "Hospitalized" numbers. "Number of Cases Without Tamiflu" is based on state-by-state proportional distribution of the 5.3 million courses of Tamiflu ordered or currently in U.S. federal government possession. For example, California, with approximately 12% of the U.S. population, receives 12% of the Tamiflu in the above projection.

Source: Trust for America's Health, Washington, DC.

As the highest populated state, California could feel the greatest impact, with more than 60,875 deaths, 273,090 hospitalized, and more than 8 million infected people.

With 5.3 million courses of antivirals evenly distributed among states, California could face a shortfall of more than 7.4 million infected people who could not receive medication. As the least populated state, Alaska could have 866 deaths, 4,558 hospitalized, 152,328 cases, and an antiviral shortfall of 140,263.

Take steps now

"We believe that Congress and the administration must take steps now to ensure that the nation's public health system and the health care delivery system will be able to respond to a major health crisis, even beyond some of our fears of bioterrorism or chemical terrorism," Ms. Hearne testified before Mr. Davis' committee.

"While experts predict a pandemic flu may be inevitable, subsequent death rates predicted to be in the millions are not. What will make the difference? We need strong, directed, and rapid federal leadership; we must convert national and state pandemic influenza plans into operational blueprints; and we should increase vaccine production and capacity, procure adequate vaccines and antivirals for treatment, and stockpile additional medical supplies and equipment. Simply put, U.S. pandemic influenza preparedness is inadequate. Both the federal pandemic plan and various state pandemic plans are insufficient blueprints for an effective national response to a pandemic influenza," she continued.

TFAH breaks down its detailed recommendations into:

1. crucial immediate steps that must be taken to minimize loss if a pandemic occurs in the near term, including outbreak tracking, stockpiling medical supplies, and communications plans;
2. intermediate steps that must be considered if a pandemic occurs with several years to prepare, including stockpiling antivirals and developing additional surge capacity plans for hospitals and other medical providers;
3. longer-range steps that should be undertaken if there are a number of years to prepare, including increasing vaccine production and development of new vaccine technologies.

Ms. Hearne tells *State Health Watch* that because TFAH has been positioned for several years as an honest broker about issues of public health defenses, the report is seen as a concrete statement of the problem and what needs to be done and has received considerable support. "I've never seen public health experts as spooked as they are by the H5N1 avian influenza A virus," she says. "People are being challenged to find ways to get all the public and private sectors to take this issue seriously."

According to Ms. Hearne, the report has been heard at many levels in the federal government but needs to become a greater priority, starting with the White House.

She says it will be important to have a White House-chartered federal commission so the issues are clearly understood by everyone.

She praises the Department of Homeland Security for recognizing a flu pandemic as a major threat to the country and for creating a chief medical officer position within that agency.

The need for wide-ranging coordination is imperative, according to Ms. Hearne, because a flu pandemic is not just a public health problem, but will have major societal and economic consequences.

"Schools and workplaces may have to close," she explains. "People may not be able to show up for critical infrastructure jobs. Law enforcement will have a primary need for treatment. We could see a grinding halt to the economy. There will be a need for a clearly defined organizational structure and chain of command. The president needs to create a cabinet-level center with someone in charge."

In the near future

Pressed on how much time we may have, Ms. Hearne hedges a bit but finally offers the notion that "in the near future, we will see something of significant consequence." But she hastens to remind policymakers that any planning that is done will pay off with whatever flu strain finally hits us and whenever that may be.

Testifying before the Government Reform Committee, Mary Selecky, Washington state secretary of health who was representing the Association of State and Territorial Health Officials, said state health officials are concerned that public health agencies are being asked to take on pandemic flu activities on top of existing priorities already established for the federal preparedness cooperative agreement funding.

"If the federal government is truly committed to enhancing our pandemic flu response," she said, "we need significant increases in resources for state and local efforts. Vaccines and antivirals are an important part of the answer but not nearly enough by themselves. All the preventive and therapeutic measures in the world are useless without the ability to get them to those who desperately need them."

She said development of national guidelines is critically important to ensure a consistent response across

the country, but the guidelines need to be flexible enough to allow each state to address its specific needs and essential services.

While states were required to have pandemic flu plans completed by July 2005, Ms. Selecky said that work had been made more difficult because the federal plan wasn't completed and available for use as a guide for state planners.

She left the committee with four key messages:

1. Pandemic flu preparedness is a critical issue for public health to address as part of its overall prevention, detection, and response efforts for any natural or terrorist event.
2. Collaboration among all levels of governmental public health is essential for influenza pandemic preparedness.
3. Reducing federal funding for preparedness is exactly the wrong thing to do at this time because a sustained federal commitment to preparedness is vital.
4. Progress has been made, but there is much more to be done.

[Download the TFAH report from www.tfah.org. Contact Ms. Hearne at (202) 223-9874. Download testimony before the House Government Reform Committee from http://reform.house.gov/GovReform/Hearings/EventSingle.aspx?EventID=29304. Download the Harris Poll from www.harrisinteractive.com/news/newsletters_wsj.asp.] ■

Fiscal Fitness

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Center, Alameda Alliance for Health, and the Kellogg Foundation-funded Community Voices Project) committed $8.1 million to subsidize Family Care, an insurance product for uninsured families under 300% of the federal poverty level. As part of the total effort, the county supervisors allocated another $2 million per year of its share of the tobacco settlement funds to expand health care coverage; and the Alliance received a $300,000 grant from The California Endowment to provide coverage for undocumented immigrant children who are not eligible for Medi-Cal or Healthy Families, California's SCHIP program.

As of August 2002, there were 7,400 members enrolled in Family Care, well above the original estimate of 2,000 members after five years. Officials said the membership numbers highlight their extreme success in enrolling members and the value people in the community place on affordable coverage.

Mr. Kears says the effort has hit some bumps in the road. A plan to expand coverage to parents of covered children was "too ambitious [and] far too costly."

He points out there are programs to help kids with special needs, but not for adults who have high health care costs.

"We've all learned that we're really not successful by ourselves," Mr. Kears says, reflecting on why broad-scale collaboration works. "That's the hard reality." He says that many health and human services people who have been working in the systems for 15 to 20 years see the limitations in a hierarchical structure. "If you look at the outcomes you want, you need to work with others. The culture to work with others evolves over time. The hard part is integrating government into the mix."

Mr. Kears says it is important to learn to measure success differently, not looking only at what each group can control. "The question is whether our citizens are better served," he says. "Is there a diversity of providers and a diversity of locations?"

As the groups have achieved successes, that has led to additional efforts and even more successes. They have learned, he says, the value of ownership of problems and the commitment to find answers together. They've also learned that pooled resources go further since foundations prefer not to give money directly to governmental entities.

None of the stakeholders who were approached declined to participate, according to Mr. Kears, because they didn't want to be left out when everyone else was moving forward.

Looking to the future, Mr. Kears says the problems being addressed and the products being developed may change over the next several years, but he doesn't expect to see any movement away from the model. "That doesn't mean that we all have to agree, but communications and openness are the key."

[Contact Mr. Kears at (510) 618-3453.] ■

Charging Medicaid patients more causes problems

States looking to save money on Medicaid by adding or increasing premiums and implementing a copay structure may end up creating additional health and financial problems, according to results of an Oregon study.

"It's kind of bad news in some ways," lead researcher Bill Wright, a sociologist at Providence Health System Center for Outcomes Research and Education, tells *State Health Watch*. "If you look at the cost-share initiatives that Oregon implemented, there are consequences. Our findings send a message to state officials to look for other ways to save money such as drug plans and managed care because there are pretty stiff consequences when you use cost sharing."

The Oregon study, funded by The Commonwealth Fund, is timely because many states and the federal government are looking at cost-sharing initiatives as a way to gain control over Medicaid costs. The study is based on actions taken in 2003 that increased premiums, reduced benefits, and implemented copays for a substantial portion of Oregon Health Plan (OHP) members. OHP also eliminated premium exemptions and instituted a six-month lockout policy for those who missed premium payments. In 2004, OHP rolled back some of the changes, eliminating copays and reintroducing some benefits.

"The survey findings so far suggest that even small changes to premiums, cost sharing, or benefit structures can have a dramatic effect on enrollment," Mr. Wright says. "After the initial cost-sharing increases and benefit reductions, nearly two-thirds of individuals surveyed had lost their coverage, many as a direct result of the increased premiums and cost sharing. Those who left the program because of the premium and cost-sharing policies reported worse access to care, less primary care utilization, more emergency department utilization, and greater financial hardships than those who remained enrolled or left OHP for other reasons. Among those who left OHP and did not find other insurance, overall health status declined over the course of the study. The unemployed and those with very low incomes were hardest hit. All of these effects were evident 18 months after the initial policy changes. Analysis of gaps in coverage for those who left OHP suggest that the most severe impacts associated with loss of coverage may be reduced considerably if coverage is restored, or new coverage is found, within three to six months."

State lawmakers said they hoped their plan to overhaul OHP in the face of a severe state financial crisis would permit them to maintain or even expand eligibility. They split OHP into two distinct benefit packages: OHP Plus and OHP Standard. OHP Plus was designed to serve the categorically eligible Medicaid population, including children, pregnant women, and parents receiving TANF, as well as the elderly and disabled. OHP Plus was spared benefit reductions and cost-sharing changes except for a $3 copayment for some services.

Those qualifying under the "expanded eligibility" of Oregon's Section 1115 waiver were moved into OHP Standard, which covered poor adults not receiving TANF general assistance. It paired a slimmer benefits package with increased premiums and cost-sharing requirements, including:

1. a premium increase for couples, with new premiums ranging from $12 to $40 per month depending on income;
2. elimination of premium exemptions for the homeless, those with zero income, or those who experienced crime, domestic violence, natural disasters, or a death in the family;
3. more stringent administrative rules mandating a six-month lockout for missing a premium payment;
4. introduction of wide-ranging copayments for services and medications, ranging from $5 for an outpatient physician visit to $50 for a hospital emergency department visit and $250 for a hospital inpatient admission;
5. benefit reductions, including elimination of coverage for outpatient mental health and substance abuse benefits, durable medical equipment, dental, and vision.

Mr. Wright reports that the months after the initial program change were marked by a large decline in enrollment for OHP Standard. Slightly more than half of those surveyed who started out on OHP Standard remained continuously enrolled until the first survey six months later, compared with 87% of the OHP Plus group. Not only were OHP Standard members more likely to leave the plan, they also were less likely to find other coverage after they left. Some 28% of OHP Standard group members were without health insurance coverage for more than 12 of the 18-month study period, compared with 5% of OHP Plus members. Also, OHP Standard members were far more likely to be uninsured at the second survey (31%) than OHP members (9%).

All respondents who left OHP during the study were asked why they left. Mr. Wright says responses were collapsed into two categories — reasons related to the program redesign, which included not being able to afford the new premiums or copays, owing back premiums, or leaving because a benefit was lost, and other reasons, including income over the eligibility limit, finding other insurance, or paperwork problems.

Overall, 53% of those who left OHP Standard identified one or more reasons related to the program redesign when asked why they had lost coverage. Premium and cost-sharing reasons were much more important than benefit cuts as a reason for leaving OHP, suggesting, according to Mr. Wright, that affordability was the key driver of loss of coverage rather than the declining value of the benefit package. "Results suggest that the combination of higher premiums and cost-sharing increases was more important than any single policy change," he says.

Reasons clear

Higher premiums and cost sharing were seen as particularly critical as a reason for leaving among the most economically vulnerable OHP members, according to the survey.

Among those who left OHP, the unemployed and those with extremely low incomes were far more likely to have done so for reasons related to increased premiums and cost sharing than their counterparts. Mr. Wright says this could reflect a combined effect of three specific policy changes: increased premiums, elimination of a zero-income exemption from premiums, and implementation of a six-month lockout for not paying premiums.

"Taken together," he adds, "these three policy changes seem to have contributed to widespread loss of coverage among those with the fewest financial resources."

The study used "unmet need" as its principal measure of access, defined as "needing health care but being unable to get it at some point in the past six months." OHP Standard members who left the plan experienced significantly higher unmet need than those who remained continuously enrolled, if they experienced a coverage gap of more than three months.

"These results provide compelling evidence of the importance of insurance continuity in maintaining access to care," the study said. "Short periods without insurance [three months or less] were not associated with increased unmet need, but coverage gaps of four months or more were. Moreover, unmet need was just as high among those who experienced a four-to-six-month coverage gap as it was for those with a much longer gap, suggesting that the negative impact of coverage loss on access to care occurs relatively early."

To help assess the specific impact of policy changes on access to care, respondents who experienced unmet needs were asked why they had not been able to get care. Among those who remained continuously enrolled in OHP, 65% of those with unmet needs identified cost as the reason. Among those who left OHP, 89% of those with unmet needs reported cost as the reason.

Analysis of health care utilization took into account primary care visits and emergency department visits. Over the 18-month period, 86% of the OHP Standard members who were continuously enrolled had at least one primary care visit, but primary care utilization began to erode with coverage gaps of seven or more months. However, hospital emergency department utilization did not vary by coverage pattern. While loss of coverage itself was not associated with higher emergency department utilization, policy-related loss of coverage was. "When the reason that an individual left OHP is taken into consideration, it becomes clear that those who left due to the policy changes were significantly more likely to have used the hospital emergency department at least once during the study than those who left for other reasons," the report concluded. "This again may suggest that those who left due to the policy changes represented a particularly vulnerable group of OHP members whose circumstances make emergency department use more likely."

Actions reversed policy goal

Mr. Wright says the end result of increased premiums and cost-sharing paired with stringent administrative rules may have been to reverse one of the policy goals of an expanded Medicaid program—instead of the least needy members being transitioned into private insurance, the most needy were more likely to leave the system.

Increasing premiums and cost-sharing risks created a highly unstable, newly uninsured population with significant dependence on safety net providers and charity care in hospital emergency departments, according to Mr. Wright. Also, for those who leave, how long they remain uninsured is critical. Thus, negative access, utilization, and financial outcomes are minimal with very short coverage gaps, but all begin to appear with coverage gaps of three to six months.

Results suggest that access to care begins to erode and medical debt levels to rise after three months of uninsurance, while utilization of primary care starts to decline after six months without insurance. Coverage gaps of more than six months also were associated with

declines in overall health for those who did not find other insurance.

"Given how quickly these impacts begin to take shape after coverage loss, there may be a need to re-examine use of a six-month lockout period like the one Oregon uses," Mr. Wright notes. "If lockout periods are to be used, a much shorter lockout period may help to encourage payment of premiums without creating unmet need for care and damaging the financial situation of beneficiaries."

Mr. Wright says attempts to redesign Medicaid systems must take into account the likely effects of redesign on individuals and systems. As policy-makers nationwide consider premium and cost sharing increases as a strategy for ensuring Medicaid solvency, he says, Oregon's experience may hold important lessons on the potential impacts of such an approach.

Officials from many states have expressed interest in the findings, Mr. Wright tells *State Health Watch,* and Oregon officials are seriously considering some of the recommendations, such as not requiring premiums from lower income beneficiaries.

While his survey did not address the question of how much of an impact the changes had on uncompensated care, another researcher in his consortium has been looking into that issue.

Preliminary results from that study found a significant increase in uncompensated care in hospital emergency departments after implementation of the OHP cost sharing, Mr. Wright reports, and it appears to be associated with the 50,000 people who left the plan after the changes.

[Contact Mr. Wright at (503) 215-7184 or e-mail: bill.wright@providence.org.] ■

Health coverage expansion varies in states

Efforts to expand health coverage generally express the potential impact in national terms, ignoring that states differ greatly in demographic and economic circumstances and in health insurance markets and thus will experience different impacts from any expansion strategy.

To demonstrate that uniform national strategies that target the uninsured do not generate uniform national outcomes, researchers at Columbia University's Mailman School of Public Health reported in a June 7 *Health Affairs* web exclusive on their comparison of the effects of a standard tax credit and Medicaid expansion proposals.

Sherry Glied, department chairman for health policy and management, tells *State Health Watch* she and her colleagues examined the state-by-state impacts of five types of insurance expansion policies — refundable tax credits for the non-group market, tax credits for small-firm workers and their dependents, expansion of Medicaid eligibility to include all low-income adults, an expansion to low-income uninsured children not now eligible for SCHIP, and an extension of Medicaid eligibility to all parents of SCHIP-eligible children.

"There is no such thing as an 'average' state," she says. "Thus, the national effects of policies can be misleading. A policy that serves one state well may be relatively ineffective in a neighboring state. Some states would do relatively well — and others would do relatively poorly — under all of the federal reform proposals considered in the study."

According to Ms. Glied, the characteristics of each state that are most important in assessing the varying impact of different expansion proposals include:

1. **Percentage of the uninsured living in poverty**

Proposals targeting the uninsured and determining eligibility based on income establish eligibility cutoffs nationally, but national income cutoffs don't account for state level differences in cost of health care or cost of living generally.

"Although absolute incomes are much higher in Alaska than in Oklahoma, for example, the much higher cost of living in Alaska leaves the two states with similarly high uninsurance rates but very different eligibility for income-based expansion proposals," Ms. Glied writes. "The percentage of a state's uninsured population with incomes below 100% of poverty is an important indicator of the extent to which income-based coverage policies would expand eligibility in that state. There is a nearly twofold difference among states in the percentage of the uninsured earning less than 100% of poverty. Identical income-targeted policies will expand eligibility much more in Hawaii, where 43% of the uninsured earn less than 100% of poverty, than in New Hampshire, where only 24% do.

2. **Percentage of uninsured people tied to small firms**

The firm-size distribution of employment is a function of local industrial patterns and population density. Small firms are more common in rural than in urban areas. Policy proposals targeting the small group market will be more effective in states with a small-firm oriented distribution of employment than in states with more large firms. Thus, in Vermont, Idaho, and Montana, about 60% of uninsured people have a connection to a small firm, while in states such as Virginia and

Louisiana, as well as Washington, DC, fewer than 40% of the uninsured are linked to small firms.

3. **Cost of nongroup health insurance**

Controlling for income, according to Ms. Glied, states with higher health care costs tend to have higher uninsurance rates.

In public program expansions, public payers absorb cross-state variation in costs. In Medicare, thus, costs per beneficiary are more than twice as high in Miami as in Minnesota. The higher costs in Miami are spread among taxpayers nationally. And in Medicaid, the federal match means that additional expenses associated with higher health care costs are divided between state and federal taxpayers.

In the tax credit proposal, by contrast, the amount of the individual subsidy is fixed nationally and individuals, rather than the state or federal governments, must bear the burden of higher-than-average health care costs. A tax credit will cover a larger share of the cost of insurance, and thus presumably lead more people to take up coverage, in areas where existing nongroup premiums are relatively low. Ms. Glied and her colleagues estimated that nongroup premiums average less than $2,000 per person in Utah and Kansas, but more than $4,000 per person in Maine, New Hampshire, New Jersey, and New York, meaning an equal size tax credit would have much smaller effects in the latter states.

Ms. Glied says the problem of high health care costs is compounded in the states with high health insurance costs that also have high costs of living and a distribution of income that is above the national average.

4. **Eligibility levels of public insurance programs**

States differ greatly in the degree to which they already have expanded their Medicaid and SCHIP programs.

The researchers estimate that 11% of the currently uninsured population (4.6 million people) would gain health coverage under the tax credit proposal, reducing the overall uninsurance rate by 17%.

Declines in the uninsurance rate by state would vary by a factor of nearly 5, from 4.4% in New Hampshire to 20.5% in Utah. States such as Utah, Kansas, and Oregon that would see the greatest percentage declines in their uninsured populations share two features — a low average nongroup premium and a large proportion of the uninsured earning less than 100% of poverty and thus eligible for the full tax credit.

Limited impact for small firms

The small-firm tax credit proposal would have a much smaller aggregate impact than the individual tax credit, according to the study. It is estimated to increase the number of newly insured Americans by 14 million people or 3.3% of the uninsured.

The effect across states varies by a factor of 2.4, from 2% of the uninsured in Washington, DC, to 4.7% in Montana. States that would experience a greater than average increase in their insured population have relatively large proportions of their nonelderly, uninsured populations employed on, or dependents of employees in, small firms.

Expanding public coverage to adults with incomes below 133% of poverty would decrease the U.S. uninsurance rate by 1.9 percentage points and increase the number of insured Americans by 4.7 million or 11.5% of the uninsured population.

But the range of effects across states is much wider because several states have already enacted expansions for this population.

The decrease in the uninsured population ranges from no effect in states with existing adult Medicaid eligibility limits above 133% of poverty, such as Vermont, Utah, and Massachusetts, to a high of 18.3% in Alabama and West Virginia.

Expanding SCHIP could help

In aggregate, expanding SCHIP to children under 300% of poverty would make 1 million of the 9.3 million uninsured children eligible for SCHIP. Some 420,000 of the newly eligible children would be expected to take up public insurance; however, because historically SCHIP take-up rates have been inversely proportional to income, so that expansions to higher income children tend to have smaller effects.

The range of effects on the entire uninsured population is expected to vary from zero in states where eligibility already exceeds this level, such as New Jersey, Missouri, and Maryland, to 4.7% in states with low existing SCHIP eligibility, such as South Carolina.

Although the immediate aim of a proposed Medicaid expansion policy to parents of SCHIP-eligible children is to provide uninsured adults with health coverage, it also would affect uninsured children because children are more likely to be enrolled in coverage if their parents also are eligible. This proposal is estimated to increase the number of insured Americans by some 2 million or 5.2% of the U.S. uninsured population. The effects by state range from 0.7% of the uninsured in Tennessee to 10.3% in Arkansas. The effects are greatest in states with the largest population of low-income families.

According to Ms. Glied, states with low nongroup premiums, low average incomes, and few prior

expansion efforts would tend to do well under all the proposals. But others, such as Maryland, Massachusetts, New York, and Wisconsin, which already have undertaken expansions and have high nongroup premiums, would do relatively worse than average under all proposals.

States with relatively low health-care costs and moderate incomes, such as California, Oregon, and Washington, would do better with tax credits than with public expansions, while lower-income states with moderately high health costs, such as Alabama, Kentucky, and West Virginia, would do relatively better under public expansion.

Ms. Glied notes that some analysts argue that federal health policy-makers have greater health care expertise, better revenue collection abilities, and the ability to avoid the race to the bottom inherent in intrastate competition, while others say that state policy-makers can use their understanding of local conditions to craft policies that best reflect states' value and priorities.

But, she says, the study results suggest that in the context of expansion to low-income uninsured populations, theoretical dichotomy between the federal and state governments doesn't apply.

"The factors that generate variation in uninsurance rates among states will themselves affect the application of federal policy," Ms. Glied writes.

"Uniform federal income eligibility limits will leave more people uninsured in high-income states where the cost of living is high. Uniform expansion in eligibility will have less effect on uninsured people in states that generously subsidize safety net providers and have expanded public program eligibility. Uniform tax credits will provide less benefit to people in states where the cost of medical care is high," she points out.

"In each of these situations, layering uniform national policies over the existing differences among states will not necessarily narrow these differences. Instead, a policy goal of interstate uniformity in outcomes may require interstate variability in policies," Ms. Glied adds,

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

Slow progress made in preventing medical errors

Five years ago, the authors of the Institute of Medicine's landmark report on medical errors, *To Err is Human*, said it would be "irresponsible to expect anything less than a 50% reduction in errors over five years." But Harvard School of Public Health adjunct professor Lucian Leape, a co-author of the report, and Karen Davis, president of the Commonwealth Fund, have looked at the situation five years later and concluded that, irresponsible or not, we haven't seen anything approaching a 50% reduction in errors. "The most we can say is that we've made progress," they said in a Commonwealth Fund President's Report. "Slow progress."

In response to the Institute of Medicine report, hospitals have launched programs to prevent errors and improve safety. The Joint Commission on Accreditation of Healthcare Organizations has identified and incorporated new safe practices into its inspections and

The Hospital Quality Alliance (HQA) Ten Measure 'Starter Set'

Performance Measures	Measure Description — For additional information including inclusions and exclusions, click on the Performance Measure
AMI — Aspirin at Arrival	Acute myocardial infarction (AMI) patients without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival.
AMI — Aspirin Prescribed at Discharge	Acute myocardial infarction (AMI) patients without aspirin contraindications who are prescribed aspirin at hospital discharge.
AMI — ACEI for LVSD	Acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) contraindications who are prescribed an ACEI at hospital discharge.
AMI — Beta Blocker at Arrival	Acute myocardial infarction (AMI) patients without beta blocker contraindications who received a beta blocker within 24 hours after hospital arrival.
AMI — Beta Blocker at Discharge	Acute myocardial infarction (AMI) patients without beta blocker contraindications who are prescribed a beta blocker at hospital discharge.
HF — LVF Assessment	Heart failure patients with documentation in the hospital record that left ventricular function (LVF) were assessed before arrival, during hospitalization, or planned for after discharge.
HF — ACEI for LVSD	Heart failure patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) contraindications who are prescribed an ACEI at hospital discharge.
PNE — Initial Antibiotic Timing	Pneumonia patients who receive their first dose of antibiotics within 4 hours after arrival at the hospital.
PNE — Pneumococcal Vaccination	Pneumonia patients age 65 and older who were screened for pneumococcal vaccine status and were administered the vaccine prior to discharge, if indicated.
PNE — Oxygenation Assessment	Pneumonia patients who had an assessment of arterial oxygenation by arterial blood gas measurement or pulse oximetry within 24 hours prior to or after arrival at the hospital.

Source: Centers for Medicare & Medicaid Services, Baltimore.

requires hospitals to disclose errors to patients. Congress has appropriated $50 million a year for patient safety research, greatly increasing work in the field and helping to build and support a research infrastructure.

Mr. Leape and Ms. Davis said that all of this is still far short of what's needed.

They said error prevention efforts are isolated and uncoordinated and federal funding for patient safety research is only "a tiny fraction of what it should be."

They said the nation loses more lives each year to medical errors than are saved by the technological advances of the National Institutes of Health, a statistic that calls for creation of a National Institute of Health Safety.

"When it comes to improving patient safety, we have plenty of recognition of the problem but no real commitment to solving it," they wrote in the Commonwealth Fund column. "As a result, hospitals are still dangerous places to be if you are sick. Even if you live across the street from a world-class hospital, you are at risk for receiving poor care. For example, up to 2 million hospital patients a year [one of 20 of all those admitted] contract serious infections while in the hospital."

Mr. Leape and Ms. Davis noted that Pennsylvania recently became the first state to collect data on hospital-acquired infections. That state's Health Care Cost Containment Council, using conservative measures, found that nearly 12,000 Pennsylvanians contracted infections during 2004, resulting in at least 1,500 preventable deaths and costing an extra $2 billion in care.

"We can't afford this kind of health care anymore," the two wrote, "and we shouldn't pay for it." They called attention to the decision made by Minnesota HMO HealthPartners to stop paying for 27 major medical mistakes from a list developed by the Washington, DC-based National Quality Forum. They said they are mistakes that never should happen, such as surgery performed on the wrong body part or serious harm from contaminated drugs or medication errors.

Paying for performance only can inject reason into the current reimbursement system, they said, which now blindly compensates for services provided, including defects. "By saying no to unacceptable errors, payers will strengthen incentives for hospitals, doctors, and other health care professionals to provide high-quality, safe care. When hospitals are paid more for getting it wrong then for getting it right, it's clear we have a perverse system of incentives."

They also noted that Medicare's fee-for-service payment system penalizes providers who try to improve quality. As an example, they pointed to hospitals that set up programs to help coordinate post-discharge care for patients with congestive heart failure. Such patients have a chronic condition that can't be cured but can be treated, and they can be encouraged to maximize quality of life and minimize acute episodes resulting in expensive hospitalization. However, Medicare payment is not set up to encourage such coordination. While Medicare pays for outpatient visits, it does not pay for coordination activities or reimburse providers for the costs of these activities. And since Medicare pays only for visits and hospitalizations, if a hospital succeeds in preventing re-hospitalization, Medicare will pay it less than for inferior care that results in repeated hospital care.

"Indeed," Mr. Leape and Ms. Davis wrote, "most payers pay for volume rather than quality because volume is easier to measure. To encourage payers to pay for quality, we need to develop better measures of quality. Medicare and other payers are working on this. The Centers for Medicare & Medicaid Services has posted information on 10 measures of hospital quality on its web site (**see chart, p. 11**), and many managed care plans, nursing homes, and home health agencies also have posted quality measures on-line. But much more information needs to be made available and widely disseminated. Infection rates for individual hospitals should be made available to the public at large, just as access to the National Practitioner Data Bank maintained by the Health Resources and Services Administration should be publicly available.

(More information is available from The Commonwealth Fund at www.cmwf.org.) ■