State Health Watch

Vol. 13 No. 1 *The Newsletter on State Health Care Reform* January 2006

THOMSON AMERICAN HEALTH CONSULTANTS

Medicaid update: Some positive news, some not so positive news

The fifth annual Kaiser Commission on Medicaid and the Uninsured surveys of Medicaid status produced mixed results, according to commission executive director **Diane Rowland**, with "some positive news and some not so positive news."

At an Oct. 19 Washington, DC, briefing, Ms. Rowland noted that the surveying was done before Hurricane Katrina and before congressional budget reconciliation activities affecting Medicaid, and thus did not reflect the effect of those events on states.

Health Management Associates principal **Vern Smith** identified three key themes from the budget survey results for 2005. In contrast to the previous four surveys, there was good news to report in that state budgets are rebounding somewhat and Medicaid spending and enrollment growth are slowing. "More states than in the past are able to enact positive changes in provider rates, benefits, and eligibility," he said.

There still are challenges. Economic recovery has been

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Study tentatively supports quality pay for performance

Publication of the first study to assess the effects of quality incentives in a large health plan has added to the optimism over the promise of pay-for-performance to improve the quality of health care. But the lead researcher says it may still be too early to make policy based on the results.

Fiscal Fitness: How States Cope

Harvard University School of Public Health researchers looked at a pay-for-performance program implemented by PacifiCare Health Systems, one of the nation's largest health plans, in a Commonwealth Fund study. They found that for one of three clinical quality measures studied, a physician network that was offered bonus payments outperformed another network that was not.

As reported in "Early Experience with Pay-for-Performance: From Concept to Practice" in the Oct. 12 *Journal of the American Medical Association*, physicians who were part of the incentive program performed the same or slightly better

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State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

Back issues of *State Health Watch* may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to State Health Watch, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.
E-mail: ahc.customerservice@thomson.com.
Web site: www.ahcpub.com.

Subscription rates: $399 per year. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Back issues, when available, are $67 each.

Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

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Medicaid

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uneven across the states and Medicaid continues to grow faster than the state revenues that help support it.

The outlook for the future is mixed. While they have some optimism about the future, state Medicaid directors still are very concerned about factors that are beyond their control but have an impact on their spending and enrollment growth, such as continuing growth in health care costs, increasing poverty rates, continued erosion in employer-sponsored health insurance, declining federal matching rates, and the possibility of changes at the federal level that could shift more costs to the states.

Mr. Smith reported that for each of the past three years, Medicaid spending growth has been slightly less than that for the previous year, and the 7.5% rate of growth in 2005 was the slowest since 1999. "Even though Medicaid spending has been growing faster than state revenues, both on an overall basis and on a per-person basis, Medicaid spending has been growing considerably slower than that which has occurred in the private health insurance marketplace," he said.

Slow spending growth reasons

He said Medicaid spending growth has been slowing not just because enrollment growth has slowed, but also because states have been very aggressive in their cost containment actions "and when you look across the range of actions that states have taken, it's very impressive. Every possible thing that held a hope of slowing the rate of growth in Medicaid spending, states have undertaken."

Georgetown University Health Policy Institute project director **Jeff Crowley's** presentation focused on prescription drug policy, which Mr. Smith reported has been one of the key cost-containment actions states have pursued.

He showed that prescription drugs represent 10% of overall Medicaid program spending and nearly half of that amount is spent on prescription drugs for dual eligibles. "When the Medicare prescription drug program is implemented, essentially half the drug spending in Medicaid will be transitioned into Medicare Part D," he said. "That will have a fairly significant impact potentially on the Medicaid program."

He said the overarching survey result was that states have many tools available to them to manage the pharmacy benefit and are using many, if not all, of them. Thus, nearly all states have dispensing limits on the quantity of drugs they will dispense at one time. And there has been a significant increase since 2003 in the number of states with preferred drug lists. Of the 37 states that responded to the survey, all require prior authorization for at least some drugs, and nearly all require use of generic drugs where appropriate.

Donna Cohen Ross reported on survey results tracking eligibility rules, enrollment and renewal procedures, and cost-sharing policies in Medicaid and SCHIP programs for children and families.

"Last year, with only very few exceptions, our findings were pretty bleak," she said. "States were still in the thick of their fiscal crisis and while they had received federal fiscal relief funds that helped stave off Medicaid eligibility cuts, we saw for the first time last year that states were beginning to unravel some of

the progress that they had made on making Medicaid and CHIP more accessible to children and families. They were rescinding simplification procedures, freezing enrollment, putting financial barriers in place. We called these actions 'beneath the surface cuts.' The obstacles that states were putting in the way of accessing coverage amounted to cuts; they were ways for states to curtail spending. But this year, while there are still problems, we do have some encouraging news from a number of states."

Medicaid, SCHIP doing their job

Ms. Ross said that while the nation's efforts to reduce the number of uninsured people suffered a setback in 2005, once again Medicaid and SCHIP stepped in, especially for children. Some 20 states took steps to increase access to health coverage and nine states actually reopened doors to health coverage they had previously closed. "This is a new development, a significant development," Ms. Ross declared. "Essentially, these nine states restored eligibility, reversed procedural barriers, or relaxed financial barriers."

But there also were some setbacks because 14 states took actions making it more difficult for children and families to get covered and remain covered.

With respect to children's coverage, 11 states took some action to make it more difficult for eligible children to enroll in or retain coverage. Ms. Ross said that approach to managing caseloads still persists after last year, but it was not as prevalent an approach as it was in 2004 when 23 states used methods like increasing premiums, making procedures more complicated, and freezing enrollment.

"Most of these actions took place in the SCHIP programs since Medicaid beneficiaries are protected from some of these premiums and freezes, except under waivers," she said. "Each of the types of actions we looked at was a bigger problem last year than this year, although increasing the cost to families through increased premiums, for example, is still the most common action that states took and this is something to keep an eye on. All the states that had frozen enrollment last year reopened their programs except for Tennessee, which has frozen enrollment for children under its Medicaid waiver. This is a finding that continues to be a problem. Low-income parents are still less likely to qualify for coverage than children, and this year the disparity between the level of parent eligibility and children's eligibility actually widened."

Looking at what happened in states that reversed earlier decisions to restrict coverage, Ms. Ross said their stories give an optimistic outlook for the future. "In some states," she explained, "a brighter financial picture helped drive the decision to restore coverage, but in others, even when the budget was still under pressure, states were persuaded to change course when they saw that previous decisions had led to some very serious drops in enrollment, much bigger than they had projected."

In Wisconsin's BadgerCare, she said, the state implemented a new verification process in which applicants and beneficiaries who wanted to keep their coverage for the first time had to get their employer to complete and return a form verifying the employee's income and also a form verifying that the employer does not offer health insurance. Employers weren't returning it turned out the forms and enrollment plummeted. Ms. Ross said a state report on reasons for the decline found the new procedure was the key reason that health coverage was being denied and also found that those being denied appeared to be eligible. Wisconsin has made some changes to the process, she said, but hasn't removed the form so it still isn't clear whether the procedure will remain a barrier.

In Washington state, officials implemented some restrictive procedures and saw enrollment of children plummet. The changes put additional verification requirements in place and also required that families renew children's coverage twice a year rather than annually. They also eliminated 12-month continuous eligibility that guaranteed a full year of coverage.

"When they put these measures in place for budgetary reasons, they anticipated that they were going to see a fall-off in enrollment, but in fact the drop was more than twice as much as they had projected," according to Ms. Ross. "Concerned about the ramifications for children's health, Gov. Greg Warr ordered a return to 12-month continuous eligibility that guaranteed first-year coverage, so they have reversed some of the procedures based on the concern they had about this enrollment drop. Washington also studied the reasons for the drop and found that more than half of the decline was due explicitly to the new procedures."

The state also determined that among the children who lost coverage, 90% still were eligible. They looked at the experience of children who left the program and found that those who were uninsured were less likely to have seen a doctor and twice as likely to have used a hospital emergency room than children who were insured.

In Texas, she said, budget cuts led to increased SCHIP premiums. The state has since eliminated premiums for families with children below 133% of the federal poverty line

and reduced the amount of premiums for other families. Again, it was the cost to families that was largely responsible for the drop in enrollment and so the decision was reversed, Ms. Ross said.

She said New Jersey provides probably the most optimistic story, dealing with leadership and setting priorities. The legislature approved restoring parent coverage that had been cut in 2002, and over the next three years, eligibility is scheduled to increase so that 75,000 patents will be able to benefit from health coverage. They also have a new package that includes making it easier for children and families to apply, making it easier for them to keep their coverage, including guaranteeing a full year of coverage for kids, and they are once again investing very heavily in outreach, which is a new development.

Four overall themes

National Academy of State Health Policy president **Alan Weil** tried to pull all the survey results together, saying he saw four major themes:

• **Medicaid is working precisely as designed. The** program has functioned in a countercyclical way. Spending on Medicaid increased when the economy turned down, coverage increased as people lost employer-sponsored coverage, and losses in private coverage were offset, particularly for children, by increased public coverage.

• **The core problem in Medicaid today is financing.** "Obviously, this is a problem in the aggregate," Mr. Weil said. "Medicaid costs are rising as are health care costs in general, but I am struck by the share of the financing problem in Medicaid that is really about allocation of costs between the federal government and the states, and to be blunt about it, I am struck in these reports by how much the federal government is doing to make the problem worse. The federal government's decision to supply a prescription drug benefit to Medicare eligibles would have been an opportunity to alleviate some of the budget stress that states experience, and that opportunity did not come into place.

• **We are perilously close to the breakdown of a national framework and a national model for what the Medicaid program should look like.** Mr. Weil said although states demanded flexibility on eligibility when Medicaid was first approved, over the years the federal government has played a larger role in defining a federal floor, and in recent years there have been many more areas of variability in how states are looking at and administering their programs. "We have the traditional variability of income eligibility, but we are now seeing variability around benefits, around delivery systems, around the relationship to the employer-sponsored insurance system, and more and more, and so we are losing, I believe, some of the sense of this being a national program," Mr. Weil said. "The rhetoric has been we are protecting the core mandatory populations and mandatory benefits and that federal commitment is intact, but…the mandatory core of this program is quite small relative to the optional components and therefore if that is the entirety of the federal commitment, it is much smaller than it would have been viewed of as in the past."

• **We have to ask what proposed Medicaid reforms will yield.** He said reform is going on in two very distinct ways: 1) state-by-state waivers under the name of research and demonstration that still are yielding fundamental long-term changes in the program; and 2) there are a series of federal proposals for modifying the Medicaid program.

"If the mantra today is that the costs of this program are unsustainable and we choose a new design in which public costs are sustainable but health care cost growth is not, how is that gap going to be bridged?" Mr. Weil asked. "Who is the burden going to fall upon in filling the gap between sustainable public costs and unsustainable private costs? Finally, what degree of interstate variability are we willing to experience, do we want to experience as a nation? How much does interstate variability help improve the program through experimentation as clearly some of it does?"

(Watch the briefing on-line at www.kaisernetwork.org. Also at that site are a transcript and PowerPoint slides.) ■

Fiscal Fitness

(Continued from cover)

on the other two clinical quality measures studied, although the difference between the two groups was not significant, according to study lead author **Meredith Rosenthal**. "The early results suggest that pay for performance has some effect, but there is not a big, dramatic change," she tells *State Health Watch*.

While quality improvement was modest, the bonuses also were modest, and improvement was assessed over a relatively short period of time — five quarters.

In 2003, PacifiCare began offering bonuses to some 172 medical groups in its California network if the groups met or exceeded 10 targets for clinical and service quality. The

bonuses averaged a relatively modest 5% of PacifiCare's payments to the medical groups. The researchers compared the California network's performance with PacifiCare's Pacific Northwest network of 33 medical groups in Oregon and Washington, which did not have an incentive program. The study centered on three clinical care measures — cervical cancer screening, mammography, and hemoglobin testing for diabetic patients.

Although the California groups improved on all three measures, the Pacific Northwest group also improved. Overall, the only significant differences between the two groups was in cervical cancer screening, where the California network's quality score improved by 5.3%, compared with 1.7% in the Pacific Northwest. In total, the plan awarded $3.4 million (27% of the amount set aside) in bonus payments for all three measures during the program's first year.

When Ms. Rosenthal and her colleagues divided the California network into three performance levels, a clear pattern emerged — the group that began the program at the lowest performance level (more than 10% below the target) showed the most improvement but received the least in bonus payments, while the group that was performing at or above target at the outset received much more in bonus payments, although it improved the least of the three groups.

"Approximately 75% of incentive payments went to practices already performing at or above the baseline level before the incentive program was implemented," Ms. Rosenthal wrote. She tells *State Health Watch* the California groups remained on the same general trajectory as before. "They are improving quality but aren't moving off the trend line."

She and her co-researchers speculated that the groups that began the program with performance levels above the targeted threshold appeared to understand that they needed only to maintain the status quo to receive bonus payments. She said a more surprising finding was that the low-performing groups improved as much as they did, given their relatively low short-term chances of receiving a bonus.

One possible reason, she said, was that the low-performing groups may have viewed the program as a larger signal of a changing environment in which they faced increasing pressure to improve.

Ms. Rosenthal said an incentive program that pays explicitly for quality improvement, rather than strictly rewarding achievement levels, would alter the incentives for high-performing and low-performing groups, distribute bonus dollars more toward the low-performing groups, and possible increase incentives' overall impact. However, some health care organizations and payers might object to that idea, reasoning that it essentially condones low performance levels and fails to reward or even penalizes high achievers.

The researchers said it is possible to reward both performance and improvement through carefully designed incentive programs that draw on evidence and best practices.

"There is widespread consensus that existing financial incentives in the U.S. health care system are misaligned and fail to reward high quality," commented Commonwealth Fund president **Karen Davis** on the study. "It is encouraging to see some initial evidence that rewarding good performance can lead to improved systems helping ensure that Americans receive regular preventive care. We need to move from just paying for services that get rendered, to rewarding delivery of the right care for helping Americans live long and healthy lives. Rewarding high quality both provides the resources for improving quality and motivates change."

Significant potential for the future

Ms. Rosenthal said her research leads to a conclusion that pay-for-performance "has significant potential to improve the performance of the health care system, where reimbursement has historically failed to reward, and in some cases penalized, high quality. To achieve the critical goals of improving both the affordability and quality of care we will need to look not only to well-designed payment reforms, but also to such promising efforts as public reporting of quality and cost information, tiered benefit designs that give consumers incentives to choose higher quality and lower cost providers and treatments, and disease management."

She tells *SHW* she would caution those who look at the study results to realize it is too early to draw conclusions from what are first generation pay-for-performance programs. Ms. Rosenthal says a Centers for Medicare & Medicaid Services (CMS) study of hospital pay-for-performance programs took place in a "highly unusual environment with self-selected hospitals so they were trying hard to make it work."

Ms. Rosenthal notes that PacifiCare was trying to meet other goals with its program besides pay-for-performance and says improvement in quality measures will be an issue for future managed care contracts for the company.

She says while some doctors say it will take more than 18 months to bring about needed culture changes so groups can do better on quality measures, "I sometimes wonder if they really need to change culture to change their practices and increase cancer screenings."

In the first-generation programs, Ms. Rosenthal says, there is no real incentive for groups that are doing well or very poorly on the quality measures. "Going forward," she says, "we're going to need to make quality improvement an explicit goal for bonus systems. There is no reason to continue to pay groups to maintain the status quo. It's good to be sure that everyone has to stretch to reach a goal."

Earlier in 2005, Ms. Rosenthal testified before a U.S. House of Representatives subcommittee on employer-employee relations that looked at pay-for-performance and other trends in employer-sponsored health care. She said then that pay-for-performance has significant positive potential in the health care sector, where reimbursement has traditionally been based only on utilization of services and patients often are not in a position to discern high quality from low.

Pay-for-performance challenges

Ms. Rosenthal said payers faced a number of challenges in implementing pay-for-performance programs. First, there is little guidance in the literature for purchasers and health plans to reference when they set out to design a pay-for-performance program.

"An analysis of the features of the first generation of programs indicates that there are opportunities to improve the cost-effectiveness of pay-for-performance and increase the likely gains in quality and value," she said. "To help them design more effective pay-for-performance programs, purchasers and health plans need timely evaluations of a broad range of programs and targeted decision support."

"We are seeing increased quality of care for patients, which will mean fewer costly complications, exactly what we should be paying for in Medicare."

A second challenge, according to Ms. Rosenthal, is that coordination among payers on the clinical domains and specific quality measures to target is desirable. If only a few of the many payers that a provider contracts with are paying for performance, or if each payer focuses on a different measure set, pay-for-performance's effects may be diluted.

According to Ms. Rosenthal, CMS leadership is central to furthering the goal of increasing pay-for-performance, as private payers have historically emulated many of Medicare's more significant payment reforms. CMS could also support pay-for-performance efforts, she testified, by contributing "de-identified" data to an all-payer data set from which more reliable performance evaluation could be conducted.

Last fall, CMS reported that quality of care had significantly improved in hospitals participating in the Premier Hospital Quality Incentive demonstration, a Medicare pay-for-performance demonstration project.

"We are seeing that pay-for-performance works," said CMS administrator **Mark McClellan**. "We are seeing increased quality of care for patients, which will mean fewer costly complications, exactly what we should be paying for in Medicare."

The agency has awarded $8.85 million to hospitals that showed measurable improvements in care during the demonstration's first year. he said improvement in evidence-based quality measures is expected to provide long-term savings because of their demonstrated relationship to improved patient health, fewer complications, and fewer hospital admissions. It is the first time that Medicare has awarded monetary bonuses to health care providers in a pay-for-performance demonstration, and it provides statistical evidence that the model works to improve health care quality, Mr. McClellan added.

Quality of care improved in all five areas for which it was measured in the demonstration. Thus, between the first and last quarters of the demonstration's first year, composite quality scores went from 87% to 91% for patients with heart attack, from 65% to 74% for patients with heart failure, from 69% to 79% for patients with pneumonia, from 85% to 90% for patients with coronary artery bypass graft, and from 85% to 90% for patients with hip and knee replacement.

Hospitals in the top 10% for each condition were given a 2% bonus on their Medicare payments for that condition. Those in the second 10% got a 1% bonus. Hospitals in the remainder of the top percent were recognized for their quality but were not paid a bonus.

Composite quality scores were

calculated for each demonstration hospital by combining individual measures into an overall quality score for each clinical condition.

Wide variety in top performers

CMS said there was a wide variety in the top performers. Two hospitals were in the top two deciles for all five clinical conditions — Hackensack (NJ) University Medical Center and McLeod Regional Medical Center in Florence, SC.

The top hospital for heart attack care improvement was Fairview Lakes Hospital, MN. Top hospital for heart failure was Lourdes Hospital in Paducah, KY. St. Francis Hospital in Broken Arrow, OK, was top hospital for pneumonia care. Top hospital for coronary artery bypass graft was Greenville (SC) Hospital, while top hospital for knee and hip replacement was Oklahoma City's Bone and Joint Hospital.

"We are examining the first-year data and working with our partners in the quality improvement community to share and apply the lessons learned," Mr. McClellan said. "But the major early finding is that the project did substantially improve important areas of health care quality at participating hospitals."

American Hospital Association executive **Carmela Coyle** said the results suggest that paying hospitals more for quality and having them focus on how they treat patients can improve care. "I think it shows rewarding excellence works," she said.

A similar experiment among physicians who treat Medicare patients at their offices began in 2005. The hospital experiment is now in its second year with preliminary results showing continued improvements in quality.

[Contact Ms. Rosenthal at (617) 432-3418. More information is available from the Commonwealth Fund web site at www.cmwf.org and from the CMS web site at www.cms.hhs.gov.] ■

Medical bills drive people into debt

An estimated 77 million Americans — some 37% of U.S. adults — have difficulty paying medical bills, have accrued medical debt, or both, according to a new analysis of the 2003 Commonwealth Fund Biennial Health Insurance Survey.

Working-age adults incur significantly higher rates of medical bill and debt problems than do adults 65 and older, with rates highest among the uninsured, said Commonwealth Fund senior analyst **Michelle Doty** and colleagues in a Fund Issue Brief. Even working-age adults who are continually insured have problems paying their medical bills and have medical debt. The analysts said unpaid medical bills and medical debt can limit access to health care, with two-thirds of people with a medical bill or debt problem going without needed care because of cost, nearly three times the rate of those without financial problems.

Ms. Doty said the 77 million with some type of health care financial problem in 2003 included an estimated 61 million people with problems paying their medical bills and an estimated 29 million adults with current or accrued medical debt. Some 12.4 million reported having problems paying bills and accrued debt.

Because medical bill problems affect those who are insured as well as the uninsured, Ms. Doty said policy-makers need to look more closely at the quality of insurance coverage and benefit design.

The Commonwealth Fund survey captured the information by asking several questions not asked in its previous surveys of this type: 1) did respondents have difficulty in paying, or were they unable to pay, medical bills; 2) had they been contacted by a collection agency about owing money for medical bills; and 3) did they have to change their way of life significantly to pay for medical bills.

Some 20% of adults surveyed (an estimated 43 million people) reported problems paying their medical bills, and a similar number said they were contacted by a collection agency about owing money for medical services. One in seven adults said they had to change their way of life significantly to pay for their medical bills.

Adults ages 65 and older, even if they had relatively low incomes, were much better protected from medical bill problems than working-age adults, according to the survey. While nearly one-third of working-age respondents reported any medical bill problems, just 14% of elderly respondents reported such problems. Also, a significantly higher proportion of low-income working-age adults (48%) reported medical bill problems in the past 12 months than did low-income seniors (20%).

Those with high rates

Ms. Doty said rates of medical bill problems also are high for women, African American adults, and adults with health problems. While seniors with health problems have medical bill problems at a rate three times greater than that for healthier seniors (16% vs. 5%), they are better protected than their younger counterparts.

The survey also looked at the extent to which individuals were grappling with recently incurred and long-term medical debt. Respondents who currently have medical bill problems were asked whether they had incurred large credit card debt or had taken a loan against their home to

pay off medical bills in the past year. In addition, individuals without current bill problems were asked whether they had any medical debt in the past three years that they could not pay right away and were paying off over time.

In total, 14% of adults reported recently incurred or past debt problems, representing an estimated 29 million people nationally. Working-age adults were more likely to have medical debt (16%) than adults age 65 and older (4%). Some 7% of adults (about 15 million) reported that their current year medical problems forced them to run up large credit card debt or take out a loan against their home. A similar number had currently or in the past three years amassed medical bills or medical debt that they could not pay right away and were paying off over time.

Not surprisingly, according to Ms. Doty, people ages 19 to 64 who lacked health insurance coverage during the year had significantly higher rates of medical bill problems and debt than did those with continuous health insurance coverage — rates of medical bill problems for the uninsured were twice those for the insured.

"Any lapse in health insurance is a significant predictor of medical bill problems and medical debt, even after adjusting for health, income, age, gender, and race/ethnicity," the researchers wrote. "And even when they have insurance, American families still shoulder medical bill burdens and incur medical debt, likely the result of having inadequate insurance."

Bankruptcy study findings true

Thus, 57% of adults who had current year bill difficulties and 70% of those reporting debt said they were insured at the time their problems began. The researchers said these findings confirm results of a recent bankruptcy study that found many patients were insured when debt was incurred. This latest study found that medical bill problems and medical debt are strongly linked to less comprehensive insurance benefits. Insured adults, whether younger or older than age 65, who lack prescription drug coverage, for example, are significantly more likely to have medical bill and debt problems than those without drug coverage. High deductibles and premiums also are linked to medical bill problems and debt.

"Any lapse in health insurance is a significant predictor of medical bill problems and medical debt."

Half of adults who have yearly deductibles of $500 or more also have medical bill burdens and debt, while less than one-third of adults with deductibles below $500 face these kinds of difficulties. Similarly, two-thirds of working-age adults paying 10% or more of their household income on insurance premiums reported medical bill problems or debts. Such difficulties occurred less than half as often among adults who did not pay as much for their premiums.

The study found that medical bill burdens and medical debt not only reduced the financial security of American families, but also compromise their access to health care. Some 63% of adults with any medical bill or debt problems went without needed care in the past 12 months because of cost, compared with 19% of adults without such problems. Rates of not visiting a doctor when sick or skipping recommended medical tests, treatment, or follow-up were disparate as well, according to the study. Some 43% of working adults with bill or debt problems did not fill a prescription because of cost, compared with just 9% of adults without such problems.

"This study shows that continually insured adults who have any gaps in their coverage, such as high deductibles or no prescription drug benefits, have greater bill problems and accrued debt than their counterparts with more comprehensive insurance coverage," the authors told policy-makers. "More important, in terms of the overall and long-term effects on health, unpaid medical bills and medical debt have consequences for subsequent health-seeking behavior, especially among those made vulnerable by low income or health problems. As other studies have noted, the link between medical bills, debt, and access problems may reflect a more hostile reception of patients with outstanding bills, or fears among patients that their medical bills and debt will prevent them from receiving subsequent care."

Issues for policy-makers

The study authors said policy-makers have to address what we as a nation do about the fact that many American families can't afford to pay their medical bills and, as a result, experience financial problems, ration health care, or simply forgo needed care. While policy-makers should be concerned about the uninsured, who are at greatest risk, the study indicates that the plight of the underinsured also must be addressed. According to the study report, health plans that expose patients to high medical costs whether through the absence of key benefits, high cost-sharing, or denial of claims, contribute to families' bills and debt problems.

[More information is available online at www.cmwf.org. Contact lead author Michelle Doty at (212) 606-3860 or e-mail: mmd@cmwf.org.] ■

Report: Health disparities not well understood

While a global movement has stimulated a substantial effort to reduce health disparities by increasing apparent equity among disparate sub-populations, a recent report from the Public Health Policy Advisory Board, an independent public health advocacy group founded and chaired by former Health and Human Services secretary **Louis Sullivan**, raises questions about the level of understanding about possible risk factors, causal agents, biological factors, or statistical or data anomalies that lead to health disparities, as well as the efficacy of interventions often used in trying to reduce disparities.

Mr. Sullivan and his colleagues said health disparity statistics can be misleading and confusing since they reflect neither an understanding of the reasons for baseline differences between particular subpopulations nor an indication of why the differences fluctuate. "In fact," the report said, "the intransigence of health disparities in the U.S., given the amount of effort and resources expended so far, would seem to be reason enough to question exactly what is really known about the phenomenon of U.S. health disparities."

What the Public Health Policy Advisory Board recommends is that the health disparity movement identify and prioritize specifically those health disparities that are amenable to prevention and that available data show to be significant from a public health perspective. For those that are identified, the report said, intense scientific effort should be made to understand the degree of an association of a health disparity with specific risk factors and potential causes, followed by development of scientifically evaluated interventions.

"A scientific approach is essential because little is known, and much remains to be learned, about the dynamic interaction of complex biological, behavioral, and environmental factors that are believed to create health disparities," the report said. "This understanding is crucial to the development and use of effective interventions."

PHPAB executive director **John Cohrssen** tells *State Health Watch* we are learning there are a number of different reasons for differences in health outcomes and it can be difficult to identify specific causes. "It can be misleading to conclude that the United States isn't doing as well as other countries," he says, "because such a statement doesn't account for the diversity in populations in different countries and also the different ways in which health is measured."

Examples of U.S. health disparities cited in the report include: women outliving men by an average of six years; people from households with an annual income of at least $25,000 living an average of three to seven years longer, depending on sex and race, than do people from households with annual incomes less than $10,000; Americans in different geographic regions of the U.S. having dissimilar rates of death and disease. Internationally, disparities occur among, as well as within, countries.

Reasons poorly understood

"Although much has been said and written about the phenomenon of health disparities, the reasons for particular disparities remain poorly understood," the report declared. "For example, in 2002, the leading cause of death, heart disease, killed 26.8% of black, non-Hispanic Americans, whereas it killed 29.2% of white, non-Hispanic Americans. This statistic says nothing about the real reason for the difference. Indeed, there could be many possible reasons for the disparity, including differences in treatments received for heart disease by these subpopulations, differences in the way death certificates are filled out, differences in the geography where they live, and biological differences.

"Some causes of health disparities are obvious, such as malnutrition, unsanitary conditions, and epidemic diseases that ravage parts of the world. For these conditions, more often found in developing countries, effective interventions are well known. There the challenge is to get the resources and manpower to put these interventions into effect. In modern industrialized countries, however, insufficient information may be known about what leads to population differences in morbidity or mortality, beyond obvious causes such as smoking, other high-risk behaviors, and exposure to infection and other identified hazards."

Mr. Sullivan's team pointed out that health disparities address risk factors, which lead to overall differences in a population's susceptibility to death or disease, but said that caution must be exercised in characterizing risk factors as causes. For example, they said, obesity and tobacco use are well-known risk factors associated with a greater risk of premature mortality and increased susceptibility to disease. But public health prevention efforts may

oversimplify those concepts by equating "risk" with "cause" as a way to encourage less risk-taking behavior and presumably reduce disease frequency. "Media reports often misleadingly imply that a correlation between a factor and increased disease prevalence means that the factor caused the increase," the report said. "These oversimplifications and misleading conclusions can lead to public confusion and inefficient interventions."

The Public Health Policy Advisory Board said health experts are able to identify today causes of health disparities with reasonable confidence from well-understood threats to health such as high lead levels in the environment. However, the board said, the level of confidence becomes less and less for the validity of a proposed cause of a health disparity or a proposed intervention to address it as the complexity of the interplay of different possible causes increases.

Factors identified by the group as potentially having a bearing on health disparities include disparities in treatment, behavioral factors, biological causes, effects of population and immigration, and data factors.

Disparity/diversity correlate

Board Distinguished Fellow **J. Donald Millar**, former director of the National Institute for Occupational Safety and Health and former director of the Centers for Disease Control and Prevention's National Center for Environmental Health, said health disparity data indicate that "disparity correlates directly with diversity," and led him to observe that 1) greater diversity among subpopulations will be reflected in greater disparity on health status measures; and 2) reduction of health disparities may be limited or more difficult to address comprehensively by the extent to which the overall population is characterized by subpopulation diversity.

"The U.S. government has established a worthwhile goal of improving health for Americans," the report said. "However, the national thematic approach to improve health based on the elimination of health disparities is based on a view that different subpopulations can or should experience similar if not identical rates of morbidity and mortality. Indeed, health disparity data show that subpopulations, which by definition have different attributes, also experience varying patterns of death and illness. . . . This does not mean, however, that every effort should not be made to provide interventions that work for those who suffer ill health and death unnecessarily from correctable conditions. . . . (But) more serious work needs to be done to better understand the phenomenon of health disparities. Fundamental research could look at disparities that arise when environmental and ethnic diversity variables are controlled.

The Public Health Advisory Board made nine far-reaching recommendations:

1. Public health goals need to be driven by science rather than by politics and personal agendas.

2. Public health leaders must be willing to set priorities that make best use of scarce resources, even if it means changing popular but ineffective efforts.

3. While comparisons among subpopulations may point out discrete health disparities, effective public health efforts need to target the particular unmet needs of vulnerable populations.

4. Because harmful behavior causes poor health and increased medical costs, particular attention must be given to reducing those behaviors that not only make individuals sick, but also burden society with their costs.

5. To establish the prerequisite solid foundation for public health, government must ensure availability of adequate numbers of well-trained health scientists, such as epidemiologists and ecology-versed health professionals, who can better identify and determine the significance, if any, of differing health indicators in subpopulations.

6. To gain a fundamental understanding of complex phenomena such as health disparities, government needs to make appropriate investments in both basic genetic research that can reveal the biological bases of differences and similarities among subpopulations in susceptibility to disease and amenability to treatment, and in other research that can assess the contribution of nongenetic factors to disease's distribution and impact.

7. Government should critically evaluate the cost and effectiveness of interventions to eliminate or reduce health disparities.

8. Public health leaders should exercise restraint in use of politically correct formulistic demands such as "health equity" and "health justice," since these concepts, although useful in characterizing the plight of the disadvantaged, are polarizing and inexact for setting priorities to meet specific public health needs.

9. To better understand and address health disparities, health professionals need to work close to the community level of the affected population to benefit from, for example, community-driven priority setting and community-based participatory research.

Mr. Cohrssen tells *State Health Watch* the board is now looking at

other studies it can do to advance some of the most important areas covered in this report.

[Download the report from www.phapb.org/healthdisparity/healthdisparity. Contact Mr. Cohrssen at (202) 775-1110 or e-mail: john.cohrssen@phapb.org.] ■

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Malpractice claims dropping in reformed states

The frequency of malpractice claims has decreased by 1% from the 2004 figure, even as the severity of claims continues to rise, growing at an annual rate of 7.5%, according to the 2005 Hospital Professional Liability and Physician Liability Benchmark Analysis prepared by Aon. The analysts said it is the first time in the study's history that the frequency trend decreased in claims for both hospitals and physicians.

Study author **Greg Larcher**, assistant director and actuary of Aon Risk Consultants, said, "We believe that legislative reforms in several states over the last few years are contributing to the reduction in claims. In addition, the medical malpractice availability and affordability crisis of the last several years has resulted in a rapidly growing alternative market. Health care systems now have a greater financial incentive to reduce their cost of risk."

Aon Healthcare COO **Greg Morris** said, "Actions taken by healthcare systems to improve quality of care and a heightened awareness of how quality care and patient safety tie directly to the cost of risk have also played a role in the decline."

The study examined more than 200,000 hospital bed equivalents and represents some 10% of the hospital professional liability market, and 15% of the alternative segment of the market.

In total, the analysis database contains 53,000 non-zero claims representing $4.5 billion of incurred losses, and includes historical claims information for the 10 years from 1995 to 2004. It also includes breakouts of claims costs and frequency trends by facility type, including university, specialty, religious, publicly traded, and community.

Mr. Larcher tells *State Health Watch* there are three elements to be considered in the decreasing claims frequency: 1) the AON database shows that California, Florida, Pennsylvania, and Texas are the leading states experiencing a decline; 2) the rapidly growing self-insurance market creates an incentive to reduce the cost of risk by investing in quality initiatives; and 3) consumer attitudes are changing.

The four states, Mr. Larcher says, have undertaken various types of malpractice reform that are leading to a decline in claims. "Texas is leading the charge," he tells *SHW*, "with an 18% decrease over the last several years."

Because various states have undertaken different types of reforms — including use of experts, statutes of limitations, caps on damages, and limits on attorney fees — Mr. Larcher says it's not possible to know which provisions are the most effective at cutting claims.

Despite the uncertainty about the most effective approach, Mr. Larcher says it's safe to conclude that other states could see a decline in malpractice claims if they enacted comprehensive reforms.

"The number of claims is a leading indicator," he says. "It will take a number of years to see the effect of malpractice reform on settlement values."

[Contact Mr. Larcher at (312) 381-3920.] ■

Clip files / Local news from the states

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

Michigan women rank low for good health practices

LANSING, MI — Michigan's 5.1 million women aren't taking care of themselves as well as they should. The state was ranked in the worst one-third nationwide for the number of deaths due to heart disease, lung cancer, and breast cancer among Michigan women, according to the results of a recent study done by the Institute for Women's Policy Research in Washington, DC.

"Women tend to look at the guidelines for men and make sure the men are taken care of, but they have to consider themselves first," said Maureen Sheppard, director of Healthwise University at Ingham Regional Medical Center.

The study assigned Michigan women a grade of D+ for health and well-being and D- for reproductive rights.

— *Lansing State Journal*, 11/18/04

University of South Alabama receives disparities grant

MOBILE, AL — The University of South Alabama's Center for Healthy Communities has received a $1.2 million grant from the National Institutes of Health to address health care disparities in minority and underserved populations in the area.

Programs to be funded include a church-based exercise project, home-monitoring of certain medical conditions for inner-city residents, and a summer enrichment program for minority high school students to help them become competitive applicants for careers in biomedical sciences, according to Dr. Martha Arrieta, associate director of the Center for Healthy Communities.

The three-year grant is from the National Center on Minority Health and Health Disparities' Project EXPORT, whose awards "support the development of resources and infrastructure . . . as a prelude to initiating full-scale health disparities research, community outreach and training aimed at eliminating health disparities." What that means, according to Arrieta, is that institutions receiving the grants can test health interventions and programs, and the results become public knowledge and can be duplicated.

— *Mobile Register*, 11/18/04

Study shows increase in uninsured workers

TALLAHASSEE, FL — The percentage of working people without health insurance in Florida increased over the past five years, mostly because they couldn't afford rising premiums, a new state study has found. Nearly 20% of the state's working-age population is without health insurance, compared to about 17% five years ago, according to a study by the state Agency for Health Care Administration.

Of those, more than half went without insurance for a year or more, and 63% blamed unaffordable premiums. State officials point to one bright spot: The number of low-income Floridians with insurance increased, primarily because of state-subsidized programs such as Healthy Kids.

The study was intended to provide lawmakers with information as they move to overhaul Medicaid, the state-federal insurance program for the poor, and search for ways to make health insurance more affordable.

— *St. Petersburg Times*, 11/18/04