State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

In This Issue

Trouble lurks as budgets rebound and states create new opportunities

The fifth State Coverage Initiatives' *State of the States* report, summarizing state activities to expand health coverage through the past year, found that 2005 was "unfortunately, not much different from that of last year. Times still are difficult for states and for coverage in general. No progress has been made to address the uninsured in a comprehensive way at the national level, and the numbers keep on rising. But the silver lining is that state leaders continue to be creative in finding new opportunities to expand coverage."

AcademyHealth State Coverage Initiatives director **Alice Burton** says although some state budgets are beginning to rebound, health care costs are a growing portion of state budgets and that many state policymakers believe the solid budgets are unsustainable.

"State leaders recognize that their ability to fully address the problem of the uninsured is dependent on a federal partnership," she says. "There does not appear to be a consensus on a comprehensive national solution to address the uninsured."

Ms. Burton tells *State Health Watch* that analysts found no surprises in the 2005 report.

See ***Budgets*** *on page 2*

Kentucky Medicaid-only plan, Passport, has saved millions by pairing quality, cost savings

Passport Health Plan, a Medicaid-only plan operating in 16 counties around Louisville, KY, has saved the state $191 million in its eight years of operation. The program provides a combination of health management, case management, and utilization management for complex, high-cost, at-risk members.

Fiscal Fitness: How States Cope

"We're most proud of the fact that quality drives the cost savings," says Passport's director of medical management, **Helen Homberger**. "We've been able to show that quality and cost savings go hand-in-hand."

Passport was started and always has been owned by local hospitals and traditional safety net providers. It has contracted with AmeriHealth Mercy Health Plan of Philadelphia to administer its programs serving 135,000 Medicaid members. The health plan provides case management for populations at risk, including mothers and children, adults and children with disabilities, and members with chronic illnesses.

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Budgets

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"This report continues the trend we've been seeing," she says, "building on state activities from the last report."

The theme of the report — Finding Their Own Way — pays tribute to the "creativity and persistence of state policy-makers to keep access to health care on the agenda and expand health insurance coverage. It summarizes strategies states are implementing or considering and their early experiences."

While many state policy-makers are working toward a clear goal of increasing insurance coverage, although through many different ways, such as public expansions and market-based strategies, others are waiting for the policy window to open before trying to strengthen the safety net.

The report found the number of uninsured in the United States grew for the fourth year in a row, reaching an all-time high of 45.8 million people in 2004.

"Had public programs such as Medicaid and SCHIP not enrolled more individuals, the number would have been higher," the analysts said, noting the "percent of individuals covered by their employers has declined to 68.1%, the lowest level since 2000."

Care costs also are still on the rise, driven by high utilization of services and advances in technologies. The report said payers are beginning to focus on targeting the underlying drivers that will decrease costs over the long term.

Budget 'ups and downs'

From a budget perspective, 2005 was a year of ups and downs for states. Financial conditions appeared to improve for many states, demonstrating a gradual recovery following years of intense fiscal stress. The recovery has been signaled by smaller budget shortfalls and stronger revenue growth than in recent years. But many states still face serious challenges, ranging from a backlog of expenditures and spending increases for many programs to the uncertain economic impact of the 2004 major hurricanes.

"And then there is Medicaid," the report declared. "States have been aggressive in containing costs in the Medicaid program as it continues to be a growing portion of their budgets. They have focused on strategies that encourage more cost-effective use of services, but have also had to rely on more traditional methods that reduce eligibility, cut benefits, or reduce payments to providers. While some states cut benefits or eligibility, a few states, including Washington and Texas, were able to restore eligibility and benefit reductions from prior years."

States developed new ideas for mandating coverage. Maryland passed legislation to require employers to pay their "fair share" and Massachusetts considered an individual mandate. Some states built on the purchasing power of large groups for lower cost, higher-quality coverage. Several examined the New York model for public reinsurance to make premiums more affordable. And Pennsylvania developed a partnership with the Blue Cross plans to fund coverage through the state's adultBasic program. Maine, Oklahoma, New Mexico, and West Virginia implemented new coverage initiatives in 2005 and worked through start-up challenges.

Because of continuing budget challenges and the threat of federal changes to the program, many states have developed Medicaid reform proposals. States also have looked to

community-based coverage strategies as a major part of efforts to address the ever-present dilemma of the uninsured.

Number of uninsured rising

The report's section on Uninsurance in America said that while no one report card exists on how the United States is faring on health insurance coverage, it is clear the number of uninsured is rising.

"The reasons for the increase in the uninsured are complex," analysts said, "including the state of the economy, the labor market, the cost of health care, and the availability of insurance in the private market and through public programs."

The 2004 figure of 45.8 million uninsured represents 15.7% of the population, according to data from the Current Population Survey released last year.

The report cites an Urban Institute analysis of insurance coverage changes between 2000 and 2004 that found lack of insurance coverage is beginning to affect middle- and higher-income Americans. They found the number of uninsured nonelderly adults grew by more than 6 million between 2000 and 2004, with one-third of the growth in uninsurance occurring among those above 200% of the federal poverty level.

The decrease in employer-sponsored coverage is occurring across the states, with declines even in states with traditionally high levels of employer-sponsored insurance.

Statistics relating levels of uninsurance and underinsurance are important, the report said, because they attest to our nation's health.

"There is a well-documented connection between insurance coverage and access to care and health," the report said. "The uninsured are more likely to go without needed care and have poorer health outcomes than those with insurance. There is a cost to the nation as a whole for failing to address the number of uninsured — at least $35 billion in uncompensated care is absorbed by providers and ultimately results in higher costs for those with insurance."

New challenges not yet clear

Looking ahead, Ms. Burton says it is unclear what challenges and opportunities will come in 2006 for state coverage efforts. She says it is clear there will be implications for states in the budget reconciliation bill that made Medicaid changes to save an anticipated $4.8 billion over five years. With budget reconciliation behind Congress, most people agree that further comprehensive federal action on coverage issues is unlikely.

States are expected to continue to grapple with their Medicaid programs as those budgets continue to consume more and more state funds.

"We are likely to see more far-reaching Medicaid reform proposals with enhanced flexibility provided under the federal budget reconciliation," the report said. "The implementation of the Medicare Part D benefit is also of concern and will require states to become accustomed to a new set of protocols and may incur more costs."

On a more positive note, Ms. Burton sees new state initiatives playing out this year. Massachusetts has come close to approving an individual mandate for coverage and a broader strategy to decrease the number of uninsured. And Illinois moved forward with its All Kids initiative to provide access to health insurance for all children.

States' ability to sustain their programs depends largely on the constituency base that they build, and in measuring and demonstrating the ongoing success and impact of these initiatives.

"Getting from where we are now to where we want to be will depend on many things, including the nation's economic situation and garnering political support to address the issue of the uninsured," Ms. Burton concluded. "2006 will be a year of elections for many state governors. The election results may be a barometer, reflecting how the country will fare with respect to coverage. Looking onward to 2006, it is almost impossible to predict where roads will lead us. Some say it will get worse before it gets better."

[Information on earlier reports and analyses is in previous issues of State Health Watch. *Contact Ms. Burton at (202) 292-6733. The report is available from AcademyHealth online at www.statecoverage.net.]* ■

Fiscal Fitness

(Continued from cover)

The case management department is staffed with nine nurses and two social workers, each carrying an average caseload of 45-50 members. Passport Health has a separate disease management program that refers members to case management if they have extensive needs. Case managers all are cross-trained to work with members with various diagnoses.

Everybody has an area of expertise, but all case managers have varying cases, even with special programs such as HIV-AIDS, chronic obstructive pulmonary disease, or palliative care, says case and utilization management manager **Randy Simmons**.

One of the reasons Passport is so successful is that in addition to helping coordinate health care for members, providing member education, and encouraging members to follow their treatment plan, case

managers also may help members find housing, food, transportation, or assistance in paying for prescriptions. For example, case managers coordinated the care of an infant with respiratory problems and who was ready to be discharged from the hospital, but the home environment was inappropriate and was likely to exacerbate the illness, resulting in another inpatient stay. The team worked with the local housing authority and other community agencies to find housing for the child and his mother so they wouldn't have to live with 12 family members, many of whom smoked.

"These types of activities separate what we do from more traditional types of case management," Ms. Homberger says.

Many referral sources

Referrals to the case management program come from physicians, area hospitals, members themselves, and sources within the health care plan. When case managers receive a referral of a member for case management services, they make every effort to contact the member by telephone. If that doesn't work, they check claims data for a recent address.

"This population is very transient," Ms. Homberger explains. "Their telephone number on the date of enrollment often is not valid by the time case management gets involved."

Case managers work closely with community advocacy groups in meeting members' needs.

"These members have so many psychological and social issues combined with their medical needs that it is sometimes difficult to meet these needs because they are outside of the benefits coverage," according to Ms. Homberger. She also notes that educating members to comply with their treatment plan is a big issue for Medicaid recipients. "One of our greatest challenges is getting members to follow up with their primary care physician or a specialist on a routine basis rather than seeking urgent care for what could be handled in a physician's office."

Medicaid recipients may not be compliant with a diet because they don't have money to buy the right foods.

"We determine what is important to the member and begin to work on those," Ms. Homberger says.

Last fall, the Centers for Medicare & Medicaid Services (CMS) extended Passport Health's federal waiver. It has been operating as a demonstration project with the goal of improving Medicaid patient access and controlling rapid Medicaid cost increases.

"The Kentucky partnership is among the highest-performing Medicaid managed care demonstrations in the country," said CMS administrator **Mark McClellan**. "It is especially gratifying to see documented improvements in access to health care by children and an overall improvement in health outcomes for all enrollees."

Excellent accreditation

CMS reported that Passport exceeded performance goals set by the National Committee for Quality Assurance (NCQA) in 87% of its measures. NCQA has determined that plans meeting standards at 90% of its measures are the very highest-performing plans. NCQA designated Passport as receiving Excellent Accreditation again in 2005, the highest accreditation status for services and clinical quality given to a health plan that meets or exceeds NCQA's rigorous requirements for consumer protection and quality improvement.

Passport spokeswoman **Jill Bell** tells *State Health Watch* the plan was established with two goals: 1) improve health outcomes for the Medicaid population; and 2) control the rising cost of health care for the Medicaid population.

Ms. Homberger says the plan's care management efforts include the typical asthma and diabetes programs as well as a coronary artery program for Medicare beneficiaries and a chronic obstructive pulmonary disease program for the plan's new Medicaid Advantage effort for those who are dually eligible for Medicaid and Medicare.

Mr. Simmons says they have not done a cost-benefit analysis on all the programs.

"We're impacting the health of our members and the outcomes speak for themselves," he says. "We're finding we may lower costs in one area but increase them in others, such as pharmacy. And then several years later, our members get the benefit of the changes."

Passport is more able to see the benefits over time than many other plans can because it keeps its members longer because it is a sole-source contractor. Some members have been part of Passport for the full eight years. There also is a lower marketing expense.

One of Passport's newest programs is a pilot dealing with childhood obesity.

"If a child is 10 years old and weighs 300 pounds, there is no immediate impact," Mr. Simmons says. "But we will see two to 10 years down the road that our efforts are preventing diabetes, cardiovascular issues, and a potential future need for rehabilitation services."

Asked what factors are most responsible for Passport's success, Mr. Simmons notes that being a sole-source contractor allows it to take on cutting-edge programs and chart success over time.

"There are opportunities for research studies," he says, "such as

the palliative care program with early interventions and hospice care for end of life issues."

Under that program, a grant is being used to educate the entire staff on special end-of-life issues such as pediatrics and HIV.

Another key success factor is the plan's sponsorship by traditional safety net providers. University Health Care executive vice president **Robert Slaton**, one of three physicians who did a lot of the initial work in bringing Passport together, tells *State Health Watch* that when Kentucky's waiver was approved, there was a threat that the state would bid the work to private carriers if providers didn't form partnerships to take it on.

When primary care physicians were capitated, it was hard to get doctors to buy into the arrangement initially, Mr. Slaton says, and it helped to have an incentive pool and a menu of additional fee-for-service services. Over time, he says, they came to realize they were doing as well financially, if not better.

And a lot is accomplished through a partnership council that brings together many provider specialties with advocates and Passport members.

"Committees oversee clinical and quality programs," Mr. Simmons says. "They are the people on the front lines and they let us know if something isn't working."

Committee members are given meals, but aren't paid for their committee work and Mr. Simmons says it is their commitment to the members that makes the system successful.

A third success factor is that Passport looks beyond a member's illness or health condition to environmental and psychosocial factors that have a bearing on members' ability to follow-through with prescribed medical care.

Case managers either can be nurses or social workers. They regularly break down traditional barriers to find services their members need.

Typical efforts involve housing issues and basic sanitation in the home. They also used to provide transportation services but that responsibility now lies with other local agencies and Passport coordinates with them. Case managers often attend clinic appointments with patients as their advocate and to help them ask questions.

A day-to-day sense of wellness

"For many of our members," Mr. Simmons says, "their sense of their wellness state extends only to the day they are living in. They aren't looking long range. They are dealing with many other issues such as no running water, or no heat or light. It's hard to manage your disease process if you're worried about the basics."

The basic impediment to success cited by Mr. Simmons is the transient nature of the membership. People often move, he says, changing their phone number and not leaving a forwarding address. Passport looks for innovative ways to track members, such as following where members have prescriptions filled and seeing if a better address has been given to the pharmacist.

Mr. Slaton says from the provider perspective, the key success factors have been: 1) Passport's mission and the fact that people love what they are doing and want to provide good health care to the Medicaid population; 2) tracking short-term actions that improve health and eventually save money; and 3) the involvement of providers.

With more plans trying to implement disease and care management programs, the Disease Management Association of America says it is working on a uniform method for measuring and evaluating outcomes of such programs.

"This certainly stands among the disease management community's most significant research efforts to date," said association Quality and Research Committee chair **Don Fetterolf**. "Reaching consensus on a relevant and scientifically valid standard for evaluating clinical and financial outcomes is vital to the continued strong growth of disease and care management."

Underscoring the importance of the effort is an agreement among the companies and individuals involved to support the final methodology and put on hold independent standards development projects already under way.

Initial work on the project will involve a survey of the disease management community to collect data on how disease management organizations and others now measure outcomes. The association said it will reach out to a broad coalition of public and private quality and standards-setting entities to enlist their assistance and support as the project moves forward.

Plans creatively coordinating care

A report from America's Health Insurance Plans says its members are coming up with innovative ways to coordinate care for the Medicaid population. An analysis of numerous studies found that managed health care for Medicaid recipients saves up to 19% when compared to Medicaid fee-for-service.

The trade association for managed care plans says the Medicaid population is difficult to manage and presents challenges case managers typically don't see in the commercial population. They tend to be sicker and have more comorbidities. They are less likely to seek routine medical care, instead going to emergency departments and becoming so ill that they require hospitalization.

"These members have tremendous psychosocial needs that make it impossible for them to seek care in a timely manner and comply with their treatment plans," America's Health Insurance Plans CEO **Karen Ignani** said. "Many Medicaid recipients don't even have basic needs such as food and shelter on a regular basis."

[Contact Ms. Homberger and Mr. Simmons through Ms. Bell at (502) 585-7983. Information on the Disease Management Association of America's evaluation is available from Carl Graziano at (202) 737-5781. Information on America's Health Insurance Plans is available on-line at www.ahip.org.] ■

Lessons from New York's Disaster Relief Medicaid plan used after 9/11

In the wake of the devastating 2005 hurricanes, some analysts have suggested New York's Disaster Relief Medicaid plan that was used after the 9/11 attacks be used as a model for other large-scale disasters. But while that program worked very well, United Hospital Fund of New York president **James Tallon** tells *State Health Watch* he isn't sure there are sufficient parallels to make it worthwhile.

"Every disaster," he says, "has its own character."

Former United Hospital Fund vice president **Kathryn Haslinger** analyzed the Disaster Relief Medicaid program in the January/February issue of *Health Affairs*, saying the time-limited (fourth months) experiment in radical simplification "met with an extraordinary response and, however unintended, offered a new way of thinking about public health insurance programs."

At the time of the 2001 attacks, she said, New York already was facing a serious coverage problem. Before 9/11, an estimated 1.6 million New Yorkers did not have health insurance. Most of the uninsured had low-wage jobs that did not offer coverage, and many had incomes within the limits of New York's public health insurance program.

New York had been in the forefront of state efforts to expand eligibility, she said, but not to streamline enrollment requirements.

"Unlike some other states," she wrote, "New York still used most of its old program rules for adults. The state had developed a new application form that, while shorter, was still eight pages long. Adult Medicaid applicants still faced a resource test and daunting requirements for documenting income, assets, and many other elements."

But in the face of a crisis, officials made the extraordinary decision to put the Disaster Relief Medicaid program in place. The city, state, and federal governments agreed to temporarily suspend annual recertification requirements for many of those already covered and to forgo most of the questioning and documentation in the application process, so that a New York City resident could apply on a 1-page form.

Not close to business as usual

Complicating the effort was that after 9/11 nothing in New York City operated in a business-as-usual manner. Phone lines and transfer stations were severely damaged. City Medicaid offices had no access to the state's Medicaid computer system. Many people living or working near the disaster site could not get to their homes or offices; and even for those distant from the site, simple errands took hours.

"Under these extraordinary circumstances, New York's officials announced an approach to administering a public benefit that went far beyond any policy prescription ever proposed," Ms. Haslinger said. "This presented the opportunity to make this bold stroke widely known throughout the city and to enable organizations working with low-income New Yorkers to help them get health insurance."

The program was in operation by late September 2001, with applicants required to go to one of 22 special Medicaid offices to complete the special Disaster Relief Medicaid application. Medicaid workers were instructed to review the form, verify only the applicant's identity, not requesting any other documentation, and then make a decision. Most applicants received Medicaid authorization at the end of their eligibility interview.

Ms. Haslinger said two elements mark the difference between Disaster Relief Medicaid and what had been in place before 9/11: 1) the application was just one page with virtually no documentation requirements; and 2) coverage began immediately.

Three-part strategy

Working with a coalition of community-based organizations, advocates, and representatives of health care providers and managed care plans, United Hospital Fund devised a three-part strategy to support Disaster Relief Medicaid implementation, Ms. Haslinger said:

1. Getting the word out. The first announcement of Disaster Relief Medicaid was in a Sept. 19, 2001, press release from New York Gov. **George Pataki**. Those involved were concerned that the state government did not seem to be planning to widely disseminate information about expedited coverage and so started their own multipronged

campaign to make sure that potential beneficiaries as well as providers were familiar with the new temporary program. First came two training efforts to explain the new rules, one directed toward organizations working with potential applicants and the other aimed at providers. There also was a public information campaign with ads at bus stops, on billboards, and in newspapers, and stories were pitched to national and local media outlets.

2. Supporting local government. Ms. Haslinger said offers of assistance with public education, outreach, and enrollment were, not surprisingly, met with ambivalence by a stressed and stretched city administration. "Where we saw potential for expanding public participation through community education," she said, "the city saw increased demand and potential breaches in program integrity. They rejected proposals to allow providers to submit Disaster Relief Medicaid applications on behalf of their clients, fearing that the emergency paper system would be too easy to abuse. City administrators did accept our offer to help pay for messengers to move the volume of paper generated by the temporary process. Although this might seem like an unusual expense in the 21st century, we were dealing with a process designed to work without any local computer support because the computer system did not work."

3. Advocacy and compromise. Working together on the emergency program, advocacy organizations and the city government developed a closer working relationship than had been the case before. Ms. Haslinger said it was a risky process for both sides. Advocates provided rapid feedback on developments on the ground, and city administrators shared a candid picture of operational challenges. "Through dialogue, compromises, and accommodations were developed that strengthened Disaster Relief Medicaid implementation," she said.

As enrollment numbers rose, planners began to think about what would happen when the program's four-month enrollment window closed. People who enrolled on Oct. 1, 2001, were slated to lose coverage at the end of January 2002. A transition plan was devised in which new enrollments ended Jan. 31, but coverage for those already enrolled continued beyond the original end dates. Disaster Relief Medicaid enrollees were required to complete a new state application covering Medicaid and New York's Family Health Plus Program, provide all required documentation, and appear for a personal interview at a Medicaid office.

Diverse group enrolled

When enrollment in the disaster program closed Jan. 31, 2002, nearly 350,000 people had gained health coverage through it. Preliminary findings arising out of efforts to profile those who enrolled indicated they were a diverse group. Only about 25% spoke English as their primary language, and most said they had not applied for Medicaid in the past. Nearly one-third said they hadn't tried to apply for Medicaid before because they had been covered through their job or because their financial circumstances recently had deteriorated.

Ms. Haslinger concluded that the Disaster Relief Medicaid program "did not design new strategies for increasing program participation while ensuring program integrity. It was not the obvious next step in a carefully choreographed incremental strategy for reducing enrollment barriers. As a Medicaid policy for ordinary times, it arguably went too far and created a sense that no one was watching."

But she also said it did what outreach campaigns, TV ads, and incremental reform have failed to do — it got people excited enough to press their friends and family to go down and get in line and demonstrated that low-income people need and want health insurance and will apply when the program operates on terms that make sense to them: an application that can be completed within minutes and an answer that comes right away.

"The challenge going forward is to begin our program design discussions from a new starting point," Ms. Haslinger wrote. "Now we know what a simple health insurance application looks like. It does not ask you to explain how you manage on a paltry income; it does not demand that you prove that potential sources of income do not exist, or that you do not have resources that are found in less than 1% of the households in your income range; and it does not require you to offer information that might subject you to unwanted contact with a child's absent parent.

"Instead of starting with the full list of welfare-based questions and requirements and asking what could be eliminated, the Disaster Relief Medicaid experience instructs us to start from the model that works and determine which elements absolutely must be added to address legitimate concerns with program integrity," she continued.

Even as the Disaster Relief Medicaid program can be used as a template for Medicaid reform, the question also arises whether there are lessons for future disasters. Mr. Tallon says the New York experience of 2001 may have been unique because even though there was a significant loss of life and substantial disruption, the infrastructure and health care providers remained basically in place, unlike the situation at the Gulf Coast, where much of the health care system and infrastructure disappeared.

"There was an extraordinary difference," he tells *SHW*. "The Gulf Coast infrastructure was destroyed and the people were relocated."

It also was significant, Mr. Tallon says, that the commitment that New York City had made to health coverage for the poor before 9/11 was a major factor in how the city dealt with 9/11.

Waivers already had been approved to provide coverage for adults up to 100% of the federal poverty level, parents to 150% of poverty, and children to 200%. And a court decision ordering coverage for legal immigrants was being implemented.

"There was a comprehensive payment system in place," Mr. Tallon says, "that was in some process of being implemented on 9/11. The structure was a comprehensive coverage structure. We were dealing with emergency conditions and the significant challenge of how to simplify the application process. And all that was in the context of the city's commitment to major coverage. You need to contrast that with the commitment the federal and state governments had made in the Gulf Coast."

Mr. Tallon says there were some similarities in that coverage and health care among the poor got a lot more attention in the months after the event. In the midst of the feelings of terror that came from the 9/11 attack and the anthrax incidents in early October, there was a general desire to have health insurance available to everyone. There was a genuine sense of community and support for the idea of getting people coverage, he says.

"We haven't solved all the problems since then," Mr. Tallon concludes, "but the number of uninsured is declining modestly. In general, the use of public programs is demonstrating some continuation of the attitude to provide coverage."

He notes that in a disaster it's not possible to change attitudes that existed before the disaster. There was no debate over the New York City plan, Mr. Tallon notes, because there already were waivers for expanded eligibility and a court order on legal immigrants.

"There didn't have to be a policy debate because that debate had already been held," he says.

Looking to the future, Mr. Tallon says that when faced with a disaster, people really do see the importance of getting people health care.

"It takes just one avian flu epidemic to remind us how important coverage is," he says.

[Ms. Haslinger's article is on-line at http://content.healthaffairs.org. Contact Mr. Tallon at (212) 494-0700.] ■

Manipulating drug copays affects health, costs

Studies conducted by the RAND Corporation and Express Scripts show how reducing drug copayments can keep some patients healthier, and increasing copayments leads to reduced drug costs and more use of generics.

The RAND study, published in the January 2006 *American Journal of Managed Care*, found that reducing copayments for patients taking cholesterol-lowering medication can keep the patients healthier and cut U.S. medical costs by more than $1 billion annually. Express Scripts found that a pharmacy plan benefit design that increases the differential between brand and generic copayments by $10 can expect to achieve a three to four percentage point increase in the generic fill rate, which can translate to a three to four percentage point decrease in drug costs.

RAND's researchers based their findings on estimates of 6.3 million American adults with private insurance or Medicare coverage who take cholesterol-lowering medication. They said reducing copayments for the sickest patients would avert nearly 80,000 hospitalizations and more than 31,000 emergency room visits each year, to account for the estimated $1 billion savings.

"There are obstacles to these policies, but our research suggests they should receive wider consideration," said study lead author **Dana Goldman**, RAND Health director of health economics.

The study was issued as Congress considered allowing states to charge higher copayments to Medicaid beneficiaries. Opponents have said that increasing copayments for Medicaid beneficiaries may discourage them from receiving medical care that could help avoid costly medical complications later.

RAND found that patients who had $10 per month copayments for their cholesterol-lowering medication were 6% to 10% more likely to fully comply with doctors' orders to take the drug than patients who had $20 per-month copayments. The researchers also found that high-risk patients were less likely to be influenced by higher costs. In looking for a link between patients' drug compliance and their use of medical services for up to four years after starting cholesterol-lowering therapy, researchers found that patients who took their medication regularly had lower hospitalization rates and emergency department visits, particularly if they had a higher risk profile.

The analysts cautioned there are

some potential problems not addressed by their study. Health plans with lower drug copayments for high- and medium-risk patients may attract higher numbers of sick patients, while discouraging healthier patients who may feel they are being penalized by being charged higher copayments, the analysts concluded.

Mr. Goldman said while benefit managers have been adopting policies intended to reduce drug use so as to save money, such plans can adversely affect plan enrollee health and a more promising approach links copayments to therapeutic benefit. The notion is that patients most likely to benefit from a drug or class of drugs, as determined by the best available clinical evidence, would have the lowest copayments, while those for whom the therapeutic benefit is modest, or the evidence is mixed, face higher copayments.

"By linking copayments with individual clinical need, plans can encourage cost-effective care without unpopular utilization controls such as prior authorization," Mr. Goldman said.

He cautioned the benefit-based copayment plan in the study only looked at patients who already had started therapy. But changing copayments would affect the number of patients starting therapy, either increasing or decreasing the numbers depending on the type of copayment applied.

He also said those planning to consider such an approach need to refine the relevant risk groups. The researchers experimented with many different risk classifications and benefit designs and found that in all cases, a benefit-based copayment could improve aggregate health outcomes without raising health plan pharmacy payments.

Another consideration, according to Mr. Goldman, is that charging more to patients in relatively better health can attract patients in worse health and discourage those in better health, although he said the reality is that such concerns are likely to be modest.

A final consideration is that not all drug classes are amenable to a benefit-based copayment design.

"Clearly, information is needed on how treatment efficacy differs across patients, and these data must be inexpensive to collect," Mr. Goldman said. "Cholesterol-lowering therapy is a useful prototype because coronary heart disease risk and cholesterol levels are easily monitored and reported at low cost. However, if risk stratification required an expensive genetic test or medical procedure, the cost savings from a benefit-based copayment design might not justify collection of the clinical information, and would alienate patients if it were done solely for the purpose of determining copayments."

Copay affects generic use

Meanwhile, pharmacy benefit manager Express Scripts' study indicated that the difference between a plan's generic copay and branded drug copay is a key driver in increasing use of generic drugs. Express Scripts director of benefit design and modeling **Jake Cedergreen** said the results are "another example of how benefit design can effectively reduce drug costs by aligning the interests of the member and the plan sponsor around the low-cost prescription alternative."

When copayments for generic medications are slightly reduced and copayments for brand medications are increased by the same amount, the average plan can typically achieve "member fair share" and an appropriate brand/generic differential, without increasing the overall cost to members," Mr. Cedergreen said.

He noted that more than $50 billion worth of branded drugs are expected to lose their patent exclusivity over the next five years. In the next year alone, $11 billion in drug sales are expected to lose patent, making generic alternatives available for at least 15 drugs. The largest-selling drug losing exclusivity this year is Zocor, the cholesterol-lowering blockbuster that had more than $3 billion in U.S. sales in 2004.

Mr. Cedergreen said his study found a steady increase in the generic fill rate as the copayment differential increases, and no significant decrease in overall utilization.

"The findings of this study indicate that the larger the copayment differential, the greater the impact on generic fill rate," he said. "For every $10 incremental difference in generic and preferred-brand copayments, clients may expect an increase in generic fill rate of up to three to four percentage points. This supports the theory that, when designed appropriately, tiered copayment structures can induce members to choose lower-cost options. Also influencing generic fill rate was whether the plan had implemented step therapy. Clients implementing at least one step-therapy program had, on average, a 2.7 percentage point increase in their generic fill rate. Programs such as step therapy that encourage first-line use of equally effective, lower-cost generics before stepping up to higher-cost, branded products have been shown to be one of the most effective tools in pharmacy-trend management. Three-tier plan designs appear to have a greater impact on moving generic fill rate than nontiered coinsurance or two-tier plan designs. These latter two plan designs may not provide a clear indication to members of lower-cost options, and therefore are less effective at encouraging generic use." ■

Study: Pain of uninsurance rising in middle-, higher-income Americans

The number of uninsured Americans rose by 6 million between 2000 and 2004, primarily because of a drop in employer coverage. While about two-thirds of the increase was among people below 200% of poverty, the remaining one-third was among those above 200% of poverty, meaning the lack of health insurance clearly is beginning to affect middle- and higher-income Americans, according to a study by the Urban Institute's **John Holahan** and **Allison Cook** reported in a *Health Affairs* web exclusive.

Mr. Holahan and Ms. Cook said much of the increase in uninsurance occurred among young adults, whites, and the native-born. About 50% of the uninsurance growth was among those ages 19 to 34, about 55% among whites, and about 73% among native-born citizens.

"Thus, rising uninsurance is clearly not a problem affecting primarily racial and ethnic minorities and noncitizens," they wrote. "Further, more than half of the increase in the uninsured occurred in the South, where uninsurance rates were already the highest in the country."

The researchers said the decline in employer coverage is likely to continue. Increases in health care costs and thus health insurance premiums are likely to continue to grow faster than workers' earnings. The decline in employer coverage will be further exacerbated if the shift from working in large and midsize firms to small firms and self-employment and from high- to low-coverage industries continues.

"The problems of the uninsured can be addressed in many different ways," according to Mr. Holahan and Ms. Cook, "such as tax credits or public program expansions, but doing so is likely to prove very difficult. Federal budget deficits are large, which will limit the federal government's ability to act for the foreseeable future, and all indications are that the government will pursue spending cuts to address the huge cost of hurricane recovery in the coming years. States also face serious budget problems in part because increases in health care spending outpace the growth in state revenues, a trend that is likely to continue. As a result, it is difficult to envision a reversal of the trends we have described in this paper."

Is federal spending keeping pace?

During a Kaiser Commission on Medicaid and the Uninsured briefing on the *Health Affairs* report, the Urban Institute's **Jack Hadley** offered an analysis addressing whether federal spending on the health care safety net has kept pace with growth in the number of uninsured. The are three reasons, he said, why that question is important — 1) federal spending is the dominant source of health care safety net funding; 2) knowing how much is spent on the health care safety net has implications for the debate over expanding health insurance; and 3) to determine whether uncompensated care makes up for lack of insurance. The short answer to the final question, according to Mr. Hadley, is that uncompensated care is a substantial share of the care received by the uninsured, but does not make up completely for the lack of insurance.

"We estimate that about half of the care received by the uninsured, through one way or another, comes in the form of uncompensated care," he said, "but in spite of that substantial subsidy, an uninsured person still receives about half as much medical care as an insured person."

He said the gap in care received translates into using fewer preventive services and receiving fewer screening services. As a consequence, when the uninsured do enter the health care system, they tend to be in poorer health or at a more advanced disease state, but still receive fewer therapeutic services, even for serious health conditions.

"Unfortunately," Mr. Hadley declared, "what that translates into ultimately is poorer public health outcomes, both in terms of mortality and morbidity and, as a consequence, lower annual earning, for children poorer performance in school, and so forth."

According to Mr. Hadley's analysis, federal safety net spending comes mostly from Medicaid and Medicare, disproportionate share payments, Medicaid upper payment limit payments, and direct medical education payments. Those items together account for about 70% of total federal safety net spending. The next two largest sources of federal money for the safety net are the Veterans Affairs and the Indian Health Service. And the next two income sources are community health centers and the Ryan White Care Act, which is devoted to people with HIV/AIDS. The final two income sources are the Maternal and Child Health Bureau and the National Health Service Corps.

Between 2001 and 2004, the analysis showed, disproportionate share payments increased from $5 billion to $7.4 billion. However, most of that growth was due to a technical change in implementing the legislative formula, increasing payments to small hospitals, and not

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necessarily resulting in increased care of the uninsured.

Overall, he said, Medicare and the direct care programs increased between 2001 and 2004, and those increases offset decreases in Medicaid, with the result that total federal spending on the safety net increased from $19.8 billion in 2001 to $22.8 billion in 2004, a 15.4% increase in total federal spending. Over the same period, however, there was some 14% inflation in health care costs, so the 15% increase in federal spending doesn't translate into a 15% increase in real resources received or real care received.

"When we make the adjustment for inflation, what we see is that it shrinks to 1.3% in constant 2004 dollars," Mr. Hadley explained. "When we put this alongside the trend in the number of uninsured between 2001 and 2004, the total uninsured population increases by about 11.2%." In terms of constant dollars, he said, federal safety net spending per uninsured person fell by almost 9%.

Mr. Hadley said he expects the number of uninsured to continue to increase, mainly because of the rising cost of private insurance and employer cutbacks, and little or no expansion in state Medicaid programs.

George Washington University Department of Health Policy chair **Sara Rosenbaum** called attention to Mr. Holahan's briefing chart superimposing the decline in per capita payment against growth in the number of uninsured. And she said the funding available for safety net patients with very significant health problems is far less-than-average Medicaid spending on an adult without a disability.

"Right now," she said, "when a health center gets federal funding, the financial allotment is figured at $250 to $275 per person. … There is simply not a chance of being able to provide anything that cannot be found in the four walls of a health center clinical site. It is an extraordinary problem to be able to find sources of charitable care for people who need dialysis."

Ms. Rosenbaum said while many such patients become eligible for Medicare, there is no way to secure care for cancer and other services.

The briefing also discussed examples of care problems in the Washington, DC, area to make the point that behind all the numbers and statistics are real people who have real health care needs that are not being met because of the growth in the number of uninsured and inadequate funding of safety net services.

(The Health Affairs web report is available at www.healthaffairs.org. Kaiser Commission briefing papers and slideshows are available in the HealthCast area of www.kaisernetwork.org.) ■

Out-of-pocket health costs up, according to study

Family out-of-pocket health care costs rose at a much higher rate than income between 1996 and 2002, according to Commonwealth Fund research. As a result, by 2002 nearly 15% of families experienced high out-of-pocket costs relative to their incomes. That represents some 18 million families or 35 million individuals nationwide with high health care costs relative to income. Adding premiums to out-of-pocket costs for medical care, nearly one-quarter of all families devoted high levels of their total income to health care in 2002, representing some 27 million families.

Researcher **Mark Merlis** says the dramatic rise in out-of-pocket health care spending, which increased an average of 35% between 1996 and 2002, far outpaced the 20% increase in average family income during that time period. Mr. Merlis tells *State Health Watch* his research followed a similar study he did several years ago.

"People are paying on average roughly the same share for health care services as they did in 1996," he says. "The problem is that medical spending is growing much faster than income so the burden is increasing."

The researchers defined high health care costs as equal to 10% or more of income for all families, or 5% or more of income for a low-income family (below 200% of the federal poverty level). Out-of-pocket costs are defined as deductibles, coinsurance, or copayments, and payments for services not covered by insurance. Family health care costs are defined as out-of-pocket costs for health services plus premiums paid by families, including single individuals.

The proportion of families having high out-of-pocket spending was highest among elderly families. But it also was notably high and rising among nonelderly families with low and modest incomes. As of 2002, 41% of nonelderly families with incomes under twice the federal poverty level spent more than 5% of their income on out-of-pocket costs and premiums.

Mr. Merlis says while uninsured families are more likely to experience high out-of-pocket costs, insured families also are at risk. Among families who have private coverage, 36% of low-income families had high out-of-pocket spending when considering just medical care bills. Adding premiums, some 65% of these privately insured families spent a high share of their income on medical care and insurance.

Facing an untenable choice

"Today, families with low or modest incomes who are able to buy at least some health insurance coverage face an untenable choice: either stretch their budgets to take on unaffordable premiums for insurance that will protect their family and assure access to care, or purchase a plan that exposes them to very high costs and hope nobody gets sick," said Commonwealth Fund president **Karen Davis**. "Meanwhile, since 2000, an additional 6 million adults have lost insurance altogether, increasing the total number of uninsured to 46 million. We need a fundamental change to our health care system to bring health and economic security to all Americans."

Mr. Merlis says the rapid increase in premiums and cost-sharing in employer coverage since 2002 signals a trend that means many more families, especially low-income families, will need to devote a steadily larger share of their budgets to health care. He said the consequences can include reduced access to care, loss of insurance, and increased medical debt or bankruptcy.

"While changing incentives for consumers may play some part in the solution to growing health care costs, it is also vital to assure that the most vulnerable families are adequately protected against the risk of unsustainable medical bills," Mr. Merlis says.

He tells *SHW* out-of-pocket expenses are one measure of the financial burden that families face in paying for medical care. "People with serious problems are being hit hard in the current system," Mr. Merlis says. "With interest growing in health savings accounts and other things that call on people to increase their out-of-pocket payments for medical care, it's important that we not lose sight of those who are already being hit hard under the current system."

[Mr. Merlis may be contacted at (215) 862-9450.] ■

Correction

The January 2006 issue of *State Health Watch* misstated the name of Washington state's governor. Her name is **Christine Gregoire**. ■