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The Newsletter on State Health Care Reform

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Medicaid cutbacks lead to growing ranks of the permanently uninsured

What happens to people who have health care coverage through public programs such as Medicaid and SCHIP and then lose it, for instance, through state budget cutbacks?

Until now, little has been known about the implications of losing coverage on the insurance status of those no longer eligible for public coverage. It has been an open question as to how many will obtain private coverage and how many will become uninsured when public coverage no longer is available.

A January Kaiser Commission on Medicaid and the Uninsured study found that the vast majority

of current enrollees affected by cutbacks in eligibility for public programs, particularly those with the lowest incomes, are likely to remain uninsured.

Urban Institute policy researchers **Sharon Long** and **John Graves**, who conducted the study for Kaiser, said only 8% of the low-income working-age adults currently covered by public programs would have the possibility of obtaining employer-sponsored insurance, and less than 1% would likely find nongroup premiums costing less than 5% of their family's income.

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Medicaid/SCHIP cuts saves money up front but emergency departments take up the slack

Cuts in funding for Medicaid and SCHIP programs that reduce eligibility and enrollment are likely to achieve cost savings largely by reducing access and shifting costs away from the two programs, creating a larger pool of uninsured who are likely to turn to hospital emergency departments for care.

That's the analysis of **Peter Cunningham**, a senior health researcher at the Center for Studying Health System Change, writing in the January/February

Fiscal Fitness: How States Cope

2006 Health Affairs.

"Because the uninsured are already more dependent on emergency departments for their care compared with their insured peers, Medicaid cuts that raise the number of uninsured people could result in a surge of uncompensated care by EDs," Mr. Cunningham wrote. "The effects would be particularly high on public hospitals and other safety net hospitals that provide a disproportionately large amount of care to uninsured and low-income people."

Since many physicians already are

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Cutbacks

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"Altogether we estimate that no more than 9% of these low-income adults would have access to an alternative source of insurance in the absence of public coverage," Ms. Long and Mr. Graves wrote. "It is only when income is above 150% of the federal poverty level that other coverage options become available for more than a handful of adults who currently have public coverage. And even then, only one in four of the parents and fewer than two in five childless adults would have an alternate insurance option."

The policy brief is based on the 2002 National Survey of America's Families, which provides detailed economic, health, and social characteristics for a representative sample of some 45,000 families.

With few exceptions, the authors say, public insurance only is available to low-income U.S. citizens who are pregnant women; children and, at lower income levels, their parents or caregivers; and aged, blind, and disabled individuals. Only a few states have extended eligibility beyond these populations to cover low-income childless adults more generally.

Thus, the researchers didn't find it surprising given those eligibility criteria that low-income, working-age adults with public coverage tend to be women (66%), in families with children (51%), and U.S. citizens (85%). More than 40% say they are in fair or poor health, while 50% report a physical or mental health problem limiting their ability to work. Although annual family income is quite low (averaging \$10,669), 38% of the adults either work themselves or are in a family with a worker.

Childless adults are much more likely to report that they are in fair

or poor health (53% vs. 33%) or that they have a physical or mental health condition limiting their ability to work (7% vs. 31%). Further, only 23% of the childless adults have a worker in their family, compared to more than half of the parents with public coverage.

In the absence of public coverage, an individual's coverage options narrow to obtaining employer-sponsored coverage through their own employer or a spouse's employer or, for some young adults, a parent's employer. The researchers reiterate that only 8% of low-income working-age adults had the possibility of obtaining employer-sponsored coverage, and less than 1% would likely face nongroup premiums that were less than 5% of their family income.

"When we look at the potential coverage options for parents and childless adults," according to Ms. Long and Mr. Graves, "we find that 12% of parents have access to employer-sponsored coverage, compared to only about 4% of childless adults."

The authors say this finding is not surprising given that nearly all working-age childless adults with public coverage qualify for that coverage because of a disability that limits their ability to work.

While the extent to which low-income adults have potential insurance options beyond public coverage increases with income, Ms. Long and Mr. Graves say, it is rare for any adults with income below 100% of the federal poverty level to have access to employer-based coverage or to affordable nongroup coverage in the absence of public coverage. When income increases above 100% of poverty, the share of adults with access to employer coverage or to affordable nongroup coverage rises, particularly for parents. However, even for these adults, only 20% of parents and 10% of childless adults

would have access to employer coverage. And this is despite the fact that more than two-thirds of parents and nearly 40% of childless adults with income between 100% and 200% of the federal poverty level have at least one worker in the family.

Ms. Long and Mr. Graves say that in the face of cutbacks in public program eligibility, the vast majority of the low-income adults currently enrolled in the programs would have few options for insurance coverage. Employer-sponsored insurance offer rates are low for this population, they say, and have been falling over time, particularly among the smaller firms that are more likely to employ low-income workers. Also, as premiums for employer sponsored coverage have continued to climb, such insurance has become less affordable for low-income workers.

The average annual employee contribution in 2005 was \$2,713 for family coverage. With average family income for low-income adults with public coverage projected to be below \$12,000 in 2005, that employer-sponsored premium would account for nearly 25% of the family's income. Nongroup coverage, the other potential coverage option, also is unlikely to be affordable for most low-income adults, with many facing premiums in excess of 25% of their family's income.

The authors say that while premium assistance programs or tax credits could help make the non-group coverage option more affordable, the premium subsidies would have to be substantial to bring the cost down to levels likely to generate much enrollment. And premium subsidies or tax credits address only one of the costs of nongroup coverage. Unlike Medicaid, which has no deductibles and minimal copay requirements, nongroup coverage often requires both high deductibles and high copayments when using

care, making the coverage even less affordable for low-income families.

Ms. Long and Mr. Graves say there are policy implications for the fact that cutbacks in public programs will increase the ranks of the uninsured because there is ample evidence that the uninsured have higher rates of morbidity and mortality than insured persons, as they are less likely to obtain screening and prevention services, are more likely to delay seeking care when sick, and, even when seriously ill or suffering from identified chronic conditions, receive less care.

"While it is clear that the poorer health of the uninsured has a significant impact on individuals and their families," they say, "it also has a significant economic impact on their communities. As the share of the community that is uninsured and, thus, in poorer health increases, local businesses face higher absenteeism and lost productivity, and there are increased demands on the local health care system to meet the demands of those who lack insurance. (See related story on the impact on hospital emergency departments, cover page.)

Ms. Long tells *State Health Watch* there has not been a strong response to the study and its findings.

"It's probably hard for people to deal with the consequences," she says. "They believe there are other options, such as employers and safety net providers. But it's not clear what using other options would cost or what the benefits package would look like."

Ms. Long says it's important to either provide a public support system or boost the private sector.

"Leaving people on their own is not a solution," she declares. "People don't think through the implications. It's easier to think about cutting people off."

Meanwhile, a Texas public

opinion survey demonstrates the fear that people have of becoming uninsured. The survey, sponsored by the Texas Hospital Association, found that 86% of the state's residents favor making health insurance more accessible and affordable because of a fear of losing their own health benefits.

"The lack of accessible and affordable health care insurance worries Texans, and for good reason," commented Texas Hospital Association CEO **Richard Bettis**. "More than 5 million Texans lack even basic health benefits, a higher percentage of the population than in any other state. Employer-sponsored health coverage in Texas is lower than the national average. And there are more children uninsured in Texas than in other states. This is a serious problem that affects not only uninsured Texans, but also the health care and pocketbook of every other resident in the state."

The survey results were released as part of the Cover the Uninsured Week, held May 1-7, which was sponsored nationally by the Robert Wood Johnson Foundation to highlight the need for broad coverage.

Another Cover the Uninsured Week report revealed that an increasing number of employees are declining their employer's offer of health insurance, as the cost of individual premiums increased dramatically over the last five years. Some 3 million fewer workers who are eligible for employer-sponsored health insurance enrolled in it in 2003, compared to 1998.

"This report should be as alarming to Congress as it is to the American people," said Robert Wood Johnson Foundation CEO **Risa Lavizzo-Mourey**, "because employer-sponsored health insurance is the backbone of America's health care system. As costs go up, fewer individuals and families have

insurance and fewer businesses can afford to provide coverage for their employees, which means that the number of uninsured Americans will continue to increase. It is way past time for our national leaders to take action."

The report's findings included:

- Individual insurance premiums are rising, showing a 42% increase from \$2,454 in 1998

dollars adjusted for inflation to \$3,481 in 2003.

- More workers are declining employer offers of health insurance, down from 85.3% in 1998 to 80.3% in 2003.

- Employers still pay the great majority of the insurance premium, as they did five years ago, but the cost burden has increased substantially for both employers

and employees.

Contact Ms. Long at (202) 261-5656. Download the Kaiser issue brief from www.kff.org/medicaid/7449.cfm. The Texas report is available on-line at www.thaonline.org/issues1/Uninsured. More information on that report is available from Amanda Engler at (512) 465-1050. The Robert Wood Johnson report is available on-line at www.covertheuninsured.org. ■

EDs

Continued from page 1

reluctant to accept Medicaid patients because of low reimbursement, and further cuts could reduce the number of physicians who care for Medicaid patients, the result could be increased ED use, he said.

Although the availability of community health centers and other free clinics could mitigate the effects of reduced access to office-based physicians, reductions in Medicaid revenue, from which community health centers derive more than one-third of their income, could reduce community health center capacity in some areas and thus also lead to increased ED use.

Mr. Cunningham reports that compared with privately insured and uninsured people, Medicaid/SCHIP enrollees are much younger, poorer, more likely to be in single-parent families, and more likely to have health problems. "Differences in health status for adults are especially notable," he says.

About 40% of adults with Medicaid/SCHIP describe their health as fair or poor, compared with 25% for uninsured and 13% for privately insured people. Also, more than 25% of adult Medicaid/SCHIP enrollees report multiple chronic conditions, compared with 5.9% for uninsured and 9.5% for privately insured adults.

"The high rate of health problems

among adult Medicaid/SCHIP enrollees likely reflects the fact that many qualify for Medicaid through disability and Medically Needy programs, while most children qualify based on income eligibility," Mr. Cunningham wrote.

Higher rates of health problems by Medicaid/SCHIP enrollees likely account for at least some of their higher levels of ED use compared with other low-income people, according to the study. More than one-third of Medicaid/SCHIP adult enrollees had an ED visit in the previous year, compared with about 20% of both uninsured and privately insured adults. Overall, ED visits per adult Medicaid/SCHIP enrollee are 2½ to three times those of privately insured and uninsured adults. Although adults in fair or poor health have higher levels of ED use across all coverage groups, ED use for Medicaid/SCHIP adults in fair and poor health is still about twice as high as for their privately insured and uninsured peers.

ED use for Medicaid/SCHIP and uninsured children is more similar and somewhat higher than it is for privately insured children, which Mr. Cunningham said may in part reflect the fact that Medicaid/SCHIP and uninsured children are more similar in their health status than they are to privately insured children. As with adults, ED use by low-income children in fair and poor health is much higher than for all children.

High ED use by Medicaid/SCHIP enrollees is consistent with their high use of health care in general, the survey found. Physician visits for adults with Medicaid/SCHIP are on average about twice as high as for privately insured adults and almost four times higher than for uninsured adults. Differences in physician use are generally smaller for children, although use by Medicaid/SCHIP enrollees still is higher compared with privately insured and uninsured children. Physician visits also are much higher for people in fair/poor health across all coverage and age groups, although Medicaid/SCHIP enrollees in fair or poor health have much higher use than other low-income people in fair or poor health.

ED use by Medicaid/SCHIP adults still is higher than for privately insured and uninsured adults, even after health status differences, other individual characteristics, and health system factors are extensively controlled for, according to Mr. Cunningham. Differences in health status and other factors account for more than half of the differences in ED use between Medicaid/SCHIP adults and uninsured and privately insured adults. "These results suggest a net decrease in ED use for adults who lose Medicaid coverage," Mr. Cunningham explains, although the decrease will be much smaller than implied by the actual differences in ED use.

Mr. Cunningham tells *State*

Health Watch that a somewhat surprising finding is that both ED and physician use continues to be higher for Medicaid/SCHIP adults than privately insured adults, even after individual characteristics and health system factors are controlled for. Also, use differentials between privately insured and uninsured adults are much smaller than those between Medicaid/SCHIP and uninsured adults, perhaps reflecting the fact either that Medicaid/SCHIP enrollees have no copayments and deductibles for medical care use, or that the copayments are nominal compared with those for privately insured people.

"This is a very high-use population," he says. "Adults enroll for coverage because they have health problems."

Mr. Cunningham says a sizable reduction in Medicaid/SCHIP enrollment would have little impact on overall ED use among low-income people, although it likely would greatly increase the proportion of visits made by uninsured people. Thus, among low-income adults, a 25% decrease in Medicaid/SCHIP enrollment nationally would result in a decrease in ED visits by fewer than 600,000. However, while providers in general might see little change in ED volume, a higher share of those visits would come from uninsured patients. The percentage of all ED visits made by uninsured people would increase about five percentage points, from 24.4% of all ED visits to about 29%.

To the extent that enrollment reductions concentrate on people in fair or poor health, such as if changes were made to the state's Medically Needy program, he says, then the decrease in ED volume would be about one-third larger (900,000 visits). However, the increase in both the number and proportion of ED visits by

uninsured people also would be larger, comprising about 30% of all visits by low-income people.

And the increase in the proportion of ED visits by the uninsured would be even greater if Medicaid/SCHIP enrollment reductions were focused on children, reflecting the fact that average ED use between Medicaid/SCHIP and uninsured children is more similar than for adults.

"The high use of EDs by Medicaid beneficiaries should be of concern to policy-makers," Mr. Cunningham says, "especially since about half of ED visits are for nonurgent medical problems. Redirecting much of this care into more appropriate primary care settings not only will save on program costs, but also could lead to improved access to and quality of care. Moreover, reducing nonurgent ED use and making care delivery more efficient are much more likely than enrollment reductions to achieve cost savings without shifting costs elsewhere."

Mr. Cunningham tells *SHW* that as state budget problems have eased, there has been a change in how state agencies view Medicaid/SCHIP, with several states moving to reverse earlier program cuts. For instance, he says, Illinois has undertaken a major effort to provide universal coverage to children, and Massachusetts has passed a coverage mandate. And there are other examples of states retreating from looking at any possible cost-cutting measures.

"State officials seem more mindful of the impact of the loss of coverage on individuals and on the health care system," he says, "and they realize that cuts also affect providers."

American College of Emergency Physicians board member David Seaberg, MD, associate chairman of the emergency medicine department

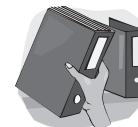
at the University of Florida in Gainesville, tells *State Health Watch* hospital emergency departments already are struggling to meet the increased burden on safety net hospitals without any further increases in the number of uninsured coming to the facilities.

"Medicaid and SCHIP protect vulnerable populations with medical illnesses," he says. "They should be getting into more standardized care. But if they lose their coverage, they have nowhere else to go. This population should be protected. It's hard because providers don't want to see more Medicaid patients. The emergency departments provide good episodic care, but the answer lies in directing these patients to more appropriate primary care. Taking them out of the insurance pool makes no sense."

Contact Dr. Cunningham at (202) 484-4242 or e-mail pcunningham@hschange.org, and Dr. Seaberg at (352) 265-5911 or by e-mail seaberg@emergency.ufl.edu. Download the study report abstract at <http://content.healthaffairs.org/cgi/content/abstract/125/1/237>. The full text is available for Health Affairs subscribers or through pay-per-article. ■

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States adopt varied programs by using HIFA waivers

Understanding state initiatives developed under the Bush administration's Health Insurance Flexibility and Accountability (HIFA) waiver policy can be important, according to Urban Institute researchers, because many of the proposals being advanced for Medicaid overhaul include features of the HIFA initiative, and several states are implementing waivers that build on the HIFA model with broader programmatic changes to Medicaid.

Urban Institute principal research associate Teresa Coughlin and colleagues looked at HIFA demonstrations in 10 states (Arizona, California, Colorado, Idaho, Illinois, Maine, Michigan, New Jersey, New Mexico, and Oregon) to learn how and why states designed their demonstration projects as they did. The results of their study were reported in an April 25 *Health Affairs* web exclusive.

Under the HIFA initiatives, the Centers for Medicare & Medicaid Services (CMS) is giving states broad authority to restructure their Medicaid and SCHIP programs, including limiting enrollment, modifying benefit structures, and increasing beneficiaries' cost-sharing. States also are encouraged to maximize use of premium assistance programs. In exchange for this increased flexibility, states are expected to expand health insurance coverage.

Ms. Coughlin tells *State Health Watch* the bulk of the study findings come from case studies carried out between January 2003 and April 2005. Researchers used a structured, open-ended protocol in interviewing Medicaid and SCHIP officials, policy-makers, health plan representatives, providers, and the business community, market observers, and consumer advocates in each of the

10 study states.

She says she was somewhat surprised to find that states often took advantage more of the benefit and cost-sharing flexibility offered to help finance the state share of Medicaid rather than cutting enrollee benefits.

"To a large extent," she says, "they kept existing benefits intact."

And even with precarious state fiscal situations, some study states still find money to expand their programs.

Expanding coverage main goal

Among the study states, according to Ms. Coughlin, the principal motivation for pursuing a HIFA waiver was to expand coverage and not, as some had feared, to control costs. In particular, she says, for many states the impetus for pursuing a HIFA demonstration originated in a state mandate developed before the HIFA waiver authority became available.

Under HIFA, states are expected to reduce uninsurance by expanding coverage to low-income people — those with income below 200% of the federal poverty level. HIFA allows states to expand coverage to groups not traditionally eligible under Medicaid or SCHIP, including higher-income parents and childless adults.

The study states obtained approval from CMS to expand coverage to a variety of populations, so that five of the 10 states, driven by a desire to provide equitable access to all low-income groups, expanded coverage to childless adults. The size of planned coverage expansions varied considerably across the states. Thus, Illinois expanded coverage to parents with incomes up to 185% of poverty and low-income people enrolled in several state-funded

insurance programs, reaching an estimated 300,000 additional people, while New Jersey undertook a one-time expansion to a maximum of 12,000 parents.

Under HIFA policy, states are permitted to offer varied benefit packages and cost-sharing provisions to different groups of Medicaid and SCHIP enrollees. In particular, they can decrease benefits and increase cost-sharing for some current Medicaid and SCHIP enrollees. And states are granted even broader flexibility in designing the benefit package and setting cost-sharing levels for HIFA expansion enrollees. At a minimum, however, they must offer primary care, including physician services. Coverage of hospital inpatient care is not required and HIFA sets no limits on the level of cost-sharing required of expansion enrollees.

Ms. Coughlin says a central theme of the HIFA initiative is to encourage states to include a premium assistance component in their demonstrations, with the goal of leveraging private dollars to help finance health insurance for the low-income population. Premium assistance programs also are seen as a way to develop ties between public and private insurance sectors. States differ way in the extent to which they have made premium assistance part of their HIFA demonstrations.

At one end, she says, Arizona was reluctant to implement a program, saying that it was not practical because small firms, which tend not to offer health insurance benefits to their employees, dominate the state's economy. Also, state officials feared a premium assistance program would tax the state Medicaid program's administrative capacity.

In contrast, Idaho, Illinois, New Mexico, and Oregon made

premium assistance a focus of their demonstrations, with strong political backing and direction to develop initiatives using private sector dollars as the foundation for expanding coverage to the uninsured.

New Mexico developed a new premium assistance program called the State Coverage Insurance program in which the state, partnering with health plans, created a commercial insurance product that businesses can buy and offer to their low-income employees and that individuals can buy on their own.

Ms. Coughlin and her colleagues estimate that nationally some 300,000 people were covered under the 10 HIFA demonstrations by the end of 2005. Reflecting their interest in expanding coverage, most states committed new funds to finance the coverage expansions, which she says is particularly noteworthy given state's difficult fiscal climates. Moreover, the majority of states did not reduce benefits or increase cost-sharing for current Medicaid or SCHIP enrollees to have pay for the coverage expansions. And all but two states provided their standard Medicaid or SCHIP benefit package to expansion enrollees who received direct coverage.

An important exception to that national picture was Oregon, which had wanted to cut state costs as well as broaden coverage. Because of budget problems, most of the effort in Oregon has been on the reducing cost side of the equation, so that almost all of the benefit flexibility has been used, while coverage expansion has been limited. As documented earlier in *SHW*, the net result has been that tens of thousands of Oregonians have disenrolled from Medicaid, benefits have been cut for many others, and the state has closed enrollment to most nonmandatory participants.

Finding state funds huge obstacle

To date, according to the report, the biggest obstacle to states in implementing coverage expansions has been finding state funds. At the same time, Ms. Coughlin says, in several of the states the political will to expand and maintain coverage was sufficiently strong that substantial new state dollars were committed to HIFA initiatives, despite the very difficult fiscal situation.

"With federal reform efforts moving slowly, states have taken center stage and are fundamentally

reshaping Medicaid along all key program dimensions from eligibility to benefits to financing," Ms. Coughlin says. "With so many changes taking place in Medicaid at the state level, it is particularly important for health care policymakers to carefully track the consequences of the changes for program beneficiaries as well as the broader health care system."

She tells *SHW* the diverse reform efforts being undertaken by states could be seen as a problem by those who want a uniform or nationalized health care program for low-income people. "But if the feds are not moving, it is incumbent upon the states to do what is necessary."

Ms. Coughlin says officials in states that want to expand coverage should be looking to those already further down that road for lessons learned, even as they recognize that programs have to be shaped to fit each state's particular situation, depending on politics, the balance of power, and where the Medicaid program currently is.

Download the report at www.healthdecisions.org/Medicaid/News/default.aspx?doc_id=64437. Contact Ms. Coughlin at (202) 261-5639. ■

Health gap is seen between insured and uninsured

Government data confirm a significant gap exists in the amount of health care accessed by people who do and do not have health care coverage. Nationally, according to a report that was released by the Robert Wood Johnson Foundation during May's Cover the Uninsured Week, uninsured adults are nearly four times more likely not to see a doctor when they need one, compared to people who have health coverage.

The state-by-state report identifies

the extent of disparities in access to health care coverage between insured and uninsured Americans and confirms that not receiving needed care is taking a toll on the millions of Americans who don't have health coverage. Across the nation, it said, a far greater percentage of uninsured adults report being in "poor" or "fair" health, compared to adults with health insurance.

"This report gives a warning to our state and national leaders by showing that our neighbors, friends,

and relatives without health coverage live sicker, and will likely die younger, than those who have insurance," said Robert Wood Johnson Foundation CEO Risa Lavizzo-Mourey. "When insured people get sick, they go to the doctor and they get better. When women with insurance are in their 40s, they start getting mammograms regularly. But for people without health coverage, it's a different world. They cannot access basic care or diagnostic screenings because of the cost, so their minor

illnesses become major ones. Ultimately, they may require extensive and expensive care because early care was delayed. Our nation's leaders need to realize that this is penny-wise and pound-foolish and finally make health coverage for uninsured Americans their top priority. The alternative is to continue to let the health of millions of our citizens erode and let our health care system creep closer to insolvency."

The report showed that the uninsured not only miss needed medical care due to cost, but they are also far more likely to miss important health screenings that can detect cancer in its earliest, most treatable stages.

Countering the popular opinion that the uninsured are overwhelmingly young and healthy, the analysis showed that an increasing number of Americans older than 50 are finding themselves without health care coverage. According to the most recent figures, about one in six adults ages 50-64 are uninsured, a total of 7 million people, which is an increase of more than 2.6 million over 10 years. Among the report's findings:

- Uninsured adults are unable to see a doctor and get medical care when needed.
- Disparities in access exist in every state between insured and uninsured residents.
- States where the most uninsured adults report not being able to see a doctor when needed due to cost are West Virginia (57%), Oregon

(56%), Kentucky (54%), Washington (48%), and Maryland (47%). States where the fewest uninsured adults report not being able to see a doctor when needed due to cost are North Dakota (24%), Montana (32%), Wisconsin (33%), Nebraska (33%), and Massachusetts (34%).

- Uninsured adults are much less likely to have a personal doctor or health care provider.

• Nationally, 57% of adults without health coverage say they do not have a personal doctor or health care provider, compared to 16% of people with health coverage.

- Adults who are uninsured are much more likely to report being in "fair" or "poor" health.

• Nationally, the percentage of uninsured adults who say their health is fair or poor is nearly twice as high as adults with health coverage (23% vs. 12%).

- Uninsured adults are less likely to receive screenings to detect cancer than adults with coverage.

Adults with health coverage are far more likely to have received recommended cancer screenings. Women with health coverage ages 40-64, for example, are more than twice as likely to have had a mammogram within the past two years as are uninsured women (51% of insured women vs. 23% of uninsured women). States with the largest percentage of uninsured women not receiving mammograms in the past two years are Missouri

(68%), Idaho (66%), North Dakota (64%), Oregon (63%), Utah (61%), and Oklahoma (61%).

The number of Americans older than 50 without health coverage is increasing. The percentage of uninsured Americans ages 50-64 has increased to nearly 15% from about 13% from 1994 to 2004. Although 40% of adults ages 50-64 without health insurance live in the South, the number of uninsured adults older than age 50 in the Midwest is significantly increasing. The Midwest has more than 1.3 million uninsured adults ages 50-64, an increase of nearly 535,000 in 10 years.

Said Former Health and Human Services Secretary **Louis Sullivan**, "I have worked in health care and health policy long enough to know that usually Congress won't act until the people do. We need millions of Americans to call for change in order to get real action from Washington. Cover the Uninsured Week helps us understand how serious it is to live without health coverage and underscores the terrible consequences this problem puts on families, individuals, employers, and the effectiveness of our health care system. Our leaders need to rise above politics and finally address this long-standing problem."

State-by-state statistics are available at www.covertheuninsured.org. ■

PwC report: Hospital charity care is increasing

The community benefit provided by hospitals may be underestimated because of the challenges hospital face in determining who is eligible for charity care. That's the conclusion reached by PricewaterhouseCoopers Research Institute in a report, "Acts of Charity: Charity Care Strategies for Hospitals

in a Changing Landscape."

The report said the amount of free health care provided by U.S. hospitals to poor and uninsured Americans rose to \$27 billion last year, up 30% from the \$20.7 billion in 1999. But, it said, hospitals have been on the receiving end of bad publicity over discrepancies in charity care policies,

aggressive bill collection practices, and a broken health care pricing system.

"There are 45 million Americans with no health insurance in this country, and the hardest hit are the working uninsured who are not covered by government programs but who make too much money to

qualify for hospital charity care," said PricewaterhouseCoopers Health Industry Advisory practice partner Reathaah Clark. "The latter includes a growing population of 'underinsured' families who are covered by employer health insurance but can't afford the increased copayments and deductibles that employers are shifting to individuals. Much of the negative press against hospitals has focused on hospitals' reportedly aggressive attempt to collect on their debts and criticism that the uninsured are charged higher prices for services than the discounted prices negotiated by managed care plans or what Medicaid and Medicare pay. Few hospitals have the profit margin to provide substantial charity care and write off bad debt without regard for whether patients actually can pay. Complicating the matter is that while hospitals apply discounts to the uninsured, hospital charges bear little resemblance to actual costs. At issue for our nation's health leaders and policy-makers is how to make health care pricing transparent and understandable to consumers."

Ms. Clark said hospitals are responding to criticisms from lawmakers and the news media by changing or clarifying their pricing, billing, and collection policies to expand coverage for uninsured Americans and to protect their goodwill reputation.

A PwC survey of 100 hospital executives found that 70% said their hospitals provide the uninsured with discounts off standard charges and 15% charge the uninsured their average managed care rate.

Some 76% of hospital executives surveyed by PwC report charity care in terms of charges rather than costs, and an additional 9% use a combination of charges and costs. PwC said all those approaches are appropriate under generally accepted accounting principles, but the lack of consistent

reporting make it nearly impossible to evaluate community benefits.

Many more people eligible

The report also suggests that many more uninsured Americans are eligible to receive charity care from hospitals, but because of personal disclosures required to determine financial eligibility, candidates are reluctant to complete the necessary paperwork. Also, a lack of regulatory

"There is much that hospitals can do on their own to improve their charity care policies, but they also need to be proactive in demonstrating the amount of charity care and community benefit they provide."

— **Robert Friz**
PwC Washington National Tax Service Partner

guidance regarding patients' qualification has resulted in a patchwork of policies and practices that have led to patient frustration and public outcry.

The PwC survey showed that hospitals report providing charity care equivalent to an average of 5% of their net operating income, but 85% said part of their bad debt could be classified as charity care. Bad-debt expense is the write-off hospitals take when patients who haven't qualified for charity care are unable or unwilling to pay for services they receive. While charity care is considered a community benefit, bad debt is not.

"Not-for-profit hospitals need to be able to respond to challenges to their eligibility for state and local income tax exemptions, as well as federal income tax exemption, which, among other privileges, allows for

access to tax-exempt financing," said PwC Washington National Tax Service partner Robert Friz. "If the tax exemption for not-for-profit hospitals were modified or eliminated because hospitals fail to demonstrate their community benefit, the increased tax costs could significantly deplete the resources hospitals need to fulfill their charitable missions, including providing charity care."

"There is much that hospitals can do on their own to improve their charity care policies, but they also need to be proactive in demonstrating the amount of charity care and community benefit they provide. In this regard, the lack of uniform standards for quantification and disclosure of charity care can make it difficult for hospitals to defend themselves from such challenges. Further, they alone likely cannot solve the bigger pricing transparency problem without a major overhaul of the system, which will involve the public and private sectors working together."

The PwC report outlines these charity care strategies for hospitals to consider:

- aligning patient charges to the uninsured with payer reimbursement rates;
- simplifying eligibility procedures for financial assistance and charity care;
- clearly communicating charity care policies and being sensitive to cultural barriers toward applying for charity care;
- providing complete and accurate information, with details about charity care and other community benefits on IRS Form 990;
- reporting to the community and local leaders through an annual community benefit report.

Download the report from www.pwc.com/pdfs/charitycare.pdf. ■

To get good info on race and ethnicity — ask

Researchers and policy-makers are finding that efforts to address racial and ethnic disparities in health care run into difficulty because of a very basic problem: it's hard to collect accurate data on patients' race, ethnicity, and preferred language, and those data are crucial in designing and implementing disparity-reduction programs.

A Commonwealth Fund study reported in the October 2005 *Journal of General Internal Medicine* found providers often are reluctant to risk alienating patients by asking for this potentially sensitive information. And some patients are concerned about why the information is needed.

Researchers from Northwestern University near Chicago found that there are right and wrong ways to ask for the information.

"While most patients interviewed agreed that hospitals and clinics should document the racial and ethnic makeup of their patient populations," the Commonwealth Fund study reported, "there were clear variations in participants' comfort. Levels were highest when patients were told that the information would be used to monitor and ensure equal quality care for all."

Also, the study found that when hospital patients were asked to describe their race and ethnicity in their own words, they were more receptive to answering the question and gave more accurate answers. When compared with the traditional method of asking patients to identify with one of the standard race and ethnicity categories provided by the federal Office of Management and Budget (OMB), researchers found that allowing patients to use their own words resulted in more complete and usable information. Patients were

less likely to choose the "unknown" or "other" categories to identify themselves because they had the ability to be specific.

"What's unique about this method is that it doesn't force a patient into an inappropriate category, or leave out the data altogether because there isn't a category that fits," said lead researcher David Baker. "Our research shows it's a method that works better for patients and researchers."

With other research indicating that U.S. racial and ethnic minorities often receive lower quality of care than whites, Mr. Baker said the first step toward addressing that problem "is for health care providers to routinely collect data on patients' race, ethnicity, and language and link these data to measures of quality, safety, and utilization."

The study was conducted in Northwestern University's General Internal Medicine clinic, which has not routinely collected information on patient race and ethnicity. A total of 220 white, black, Hispanic, Asian, multiracial, and other patients were interviewed about their attitudes and concerns around collection of race and ethnicity data as they left the clinic.

8 in 10 favor data collection

Fully 80% of those interviewed said it is important for health care providers to collect and track information on patients' race and ethnicity. And while 28% expressed significant discomfort disclosing their own information to a clerk or administrator, many said they would feel more comfortable giving information to a nurse or doctor.

The researchers reported that comfort levels were significantly lower for blacks than for whites, and blacks were more likely than whites

to express concern that the information would be used to discriminate against patients. Also, when compared with whites, blacks and Hispanics more often said they would be somewhat or much less likely to go to a hospital or clinic than routinely collected racial and ethnic information.

As part of the study, patients were read four different rationales for collecting the information: 1) to monitor and assure quality of care for all patients; 2) to abide by government regulations; 3) to ensure appropriate hiring and training of medical personnel; or 4) to monitor and assure quality of care for the individual patient.

The notion of monitoring and assuring quality of care for all patients had the most positive impact on patients' comfort levels, the researchers reported. For the 51% of study participants who expressed any level of discomfort reporting their race and ethnicity, this reason for collecting the data brought about the most significant improvement in comfort, with 25% saying it made them somewhat more comfortable and 26% saying it made them much more comfortable.

For nonwhite participants, the rationale of meeting government requirements actually reduced comfort levels. The researchers speculated the reason could be that the message implied the information is not useful to health care providers in improving quality of care. Respondents also were less comfortable with the rationale of ensuring appropriate hiring and training of medical personnel because, the authors speculated, of concerns that staff would be trained in racial stereotyping. And patients did not respond well to the notion that the data were needed to monitor and

assure quality of care for the individual patient, perhaps because it sounded like a promise the provider could not fulfill.

The study found that in addition to providing more accurate data, their recommended method proved to be efficient, making it possible to accurately capture patients' verbatim responses in an average of 37 seconds, only 17 seconds longer than the average time for completing the OMB questions.

According to the researchers, concerns about giving out race and ethnicity information can be

addressed by clearly explaining to patients and community leaders the reasons for gathering the data, and by seeking their input on how best to do it. Most important, the researchers said, providers who collect such information must use it to examine and address disparities, and then share the results with patients and communities.

"Good information about race and ethnicity is crucial to health care providers' efforts to ensure that all patients receive equal levels of high-quality health care," said Commonwealth Fund senior

program officer for programs on quality of care for underserved populations Anne Beal. "Adopting this new method can allow researchers and health care providers to more accurately determine the makeup of their patient population and to immediately identify new groups that are coming to health facilities."

Mr. Baker can be contacted at dwbaker@northwestern.edu. A journal abstract is available at www.blackwell-synergy.com/doi/abs/10.1111/j.1525-1497.2005.0195.x. ■

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Americans favor liability reform legislation

More than three-fifths of Americans surveyed by the Health Coalition on Liability and Access (HCLA) support passage of comprehensive medical liability reform legislation. And 76% of those surveyed said they favor legally imposed reasonable limits on noneconomic pain and suffering awards.

According to the poll, 74% of Americans believe their access to quality health care is threatened because medical liability costs are

driving doctors out of practice. And 64% said that medical lawsuit abuse is one of the primary causes of rising health care costs.

"It is clear that the medical liability crisis is an issue that deeply concerns Americans," said HCLA chairman Christian Shalgian.

Shalgian called on Congress to enact "common-sense medical liability reforms to preserve patients' access to care and to allow doctors to provide quality medical services." ■

Clip files / Local news from the states

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

Lawmakers reach an end-of-life bargain

CONCORD, NH — New Hampshire residents will likely have more tools to guide them in defining the type of medical care they receive at the end of their lives. A State House committee reached a last-minute compromise on a complex bill that reworked rules governing living wills and other end-of-life planning documents.

The legislation also would create guidelines for do-not-resuscitate orders, which allow patients to forgo CPR and are not currently addressed in state law.

It's been more than two years since a group of lawmakers, lawyers, health care providers and clerics began rewriting the rules that govern end-of-life planning in New Hampshire. While they worked, their already-emotional

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the procedures a person wants when they're near death or permanently unconscious. The other, called a durable power of attorney for health care, designates someone to make medical decisions when the patient cannot.

Current law does not cover do-not-resuscitate orders, which bar medical personnel from using CPR if a patient has a heart attack or stops breathing. Instead, most hospitals and nursing homes have their own forms patients can choose to fill out. In most cases, orders issued at one institution do not apply at another.

Under the compromise, doctors could opt out of providing treatment if they're morally opposed to carrying out the patient's wishes. Hospitals, too, could decline to honor do-not-resuscitate orders for moral or religious reasons as long as their policy is clearly posted in waiting rooms.

Still, not everyone was pleased with the committee draft. **Brad Cook**, a lobbyist for the Roman Catholic Bishop of Manchester, said the bill defined "near-death" and "permanently unconscious" too broadly, and that the changes would only confuse people. "We like the present law better," he said. "We think it's tighter, we think it's more precise, we think it's understood."

—Concord Monitor 5/20/06

Oregon acts to curtail suicides by older adults

PORTLAND, OR — Every year for at least the past decade, about 100 Oregonians ages 65 and older have committed suicide — enough to place the state well above the nation's elder suicide rate and fourth among states, all in the West, with the highest rates.

In Oregon and across the nation, suicide rates are highest among older adults — especially older men — and escalate sharply after age 65. But Oregon, for reasons that are not altogether clear, follows only Nevada, Wyoming, and Alaska in 2003 for having high concentrations of suicide among its most senior citizens.

The suicide in question is not the doctor-assisted variety. Oregon officials, anticipating the wave of baby boomers approaching their vulnerable years, are responding with an effort to hold down the suicide rate. Their plan, two years in the making, outlines ways groups can work together to promote awareness of suicide's danger to older citizens.

Dr. **Mel Kohn**, Oregon state epidemiologist, said a key element of the plan is to educate doctors and nurses to recognize symptoms of depression and explore patients' risk for suicide.

Right now, for example, less than half of doctors polled say they ask their depressed and suicidal elderly patients whether they have access to a gun, the dominant means of suicide in Oregon, according to **Mark Kaplan**, professor of community health at Portland State University and an expert in late-life suicide.

The state's report shows that more than a third of suicide victims had visited a physician in the past 30 days of life. Of the victims, 76% of men and 72% of women had some physical problem. Appointments for ailments give doctors an entree to discuss their patients' emotional health. The Oregon Department of Human Services has received \$100,000 in federal funding to help start the program.

—The Oregonian, 5/16/06

debate became more heated during the much-publicized battle over the fate of Terri Schiavo, a brain-damaged Florida woman who relied on a feeding tube for fluid and nutrition. Doctors were eventually allowed to remove the tube, as Schiavo's husband said she had wished, and she died last spring.

This winter, the House and Senate debated the bill at length before passing slightly different versions by wide margins. The concepts in the legislation are not new. Since 1991, the state has allowed adults to use two documents to indicate the type of care they'd like at the end of their lives. One, called a living will, outlines