

State Health Care Cost Containment Ideas

Prepared by NCSL's Standing Committee on Health

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Preamble: Following is a list of legislative ideas that states have either considered or passed into law. This list of ideas and descriptions was compiled as a project of NCSL's Standing Committee on Health for state legislators to consider as they try to address the problems of rising health care and health insurance costs. Some of these ideas have been enacted and shown to reduce costs; others have not. Some of these ideas conflict with other ideas, and some may actually cost the state money, but may meet other state needs. The committee attempted to include a range of ideas, even though individual members considered some of these actions to have negative social or other impacts, regardless of monetary savings. As such, NCSL's Standing Committee on Health stresses that readers please keep in mind the following:

- The menu of ideas is a project of the Health Committee; the ideas do not represent NCSL policy positions.
- In issuing this draft paper, the NCSL Health Committee does not necessarily endorse any of these ideas as recommendations for state action.
- For each action proposed in this paper, there are often compelling counter arguments about why these ideas may not reduce health care costs, or that implementation of these ideas may create other problems, such as a decline in the quality of services. For this reason, the paper presents the rationale for a particular perspective about how cost saving may be achieved, along with some of the counter arguments of each. However, constraint on length of this paper prohibits a detailed description of the possible benefits and negative impacts of each idea. Readers are encouraged to thoroughly research each idea before taking legislative action.

Executive Summary

Introduction

All states face the challenge of balancing health care needs with available resources. This paper intends to list a number of ideas tried in or proposed by states to contain costs while preserving coverage for various populations.

I. Direct Cost Containment Ideas

I-1. Repeal or modify "any willing provider" (AWP) laws

I-2. Enact a Certificate of Need law if your state doesn't have one.

I-3. If your state has a certificate of need law, apply it to only those circumstances where it is likely to be effective in controlling costs.

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I-5. Require public posting of prices for specified common procedures and tests

II. Prescription Drug Ideas

II-1. Institute a preferred drug list under Medicaid, similar to Oregon's.

II-2. Implement a preferred drug list with a supplemental rebate similar to Michigan's.

II-3. Join with other states in a drug purchasing pool to obtain volume discounts.

II-4. Hire pharmacists to provide patient education about how to reduce drug bills and avoid dangerous drug interactions.

II-5. Require pharmacies to publicly post the prices of drugs, grouped by class so people can see where substitutes may save money.

II-6. Implement a Medicaid "Pharmacy Plus" section 1115 waiver to cover Medicare recipients with incomes up to 200 percent of federal poverty guidelines.

II-7. Require state employees to use a mail-order pharmacy benefit manager for all maintenance drugs.

II-8. Encourage greater participation of safety net providers in the "340B Federal Drug Pricing Program."

II-9 Audit pharmacy benefit managers (PBMs) and administrators (PBAs).

III. Cost Shifting Ideas

III-1. Reduce Medicaid cost shifting by increasing Medicaid reimbursement to providers enough to pay actual costs.

III-2. When cutting Medicaid to balance the budget, do not cut provider reimbursement, especially to hospitals, which will shift costs to private payers and private insurance.

III-3. Improve enforcement of mandatory automobile insurance laws or add a mandatory medical payments provision to those laws.

III-4. Determine whether your state has a problem with cost shifting because large employers self-insure, and whether HMOs shift costs to the small employer and individual health insurance markets.

IV. Workforce Expansion/Scope of Practice Ideas

IV-1. Use loan forgiveness programs with specified work commitment payback mechanisms to expand the number of students in nursing programs.

IV-2. Expand the size of existing nursing education programs.

IV-3. Use loan forgiveness programs and cost of living stipends to train more faculty.

IV-4. Expand LPN (licensed practical nurse) programs.

IV-5. Reduce the paperwork burden on health care providers, particularly in the hospital and nursing home situations.

IV-6. Expand an existing dental school or start a new one.

IV-7. Expand the scope of practice or loosen supervision requirements for dental hygienists.

IV-8. Allow medication aides to administer medications in nursing homes and similar institutions (including schools).

IV-9. Allow physical therapists and occupational therapists to practice without referral from an MD.

IV-10. Allow psychologists to prescribe drugs related to their practice.

V. Health Insurance Reform Ideas

V-1. Restructure insurance products to increase personal responsibility for health care.

V-2. Repeal some or all coverage mandates.

V-3. Allow or expand pricing bands in the small group market.

V-4. Do not allow small groups of one with guaranteed issue.

V-5. Allow modest discounts (5 percent to 15 percent) for staying healthy in both individual and small group markets.

V-6. Prohibit medical underwriting on guaranteed renewal in the individual market (except for certain modest discounts).

V-7. Prohibit the practice of closing blocks of business.

V-8. Repeal any state prohibitions on forming groups for the purpose of obtaining insurance.

VI. Subsidy and Uninsured Care Ideas

VI-1. Change the financing of the "high-risk" or "uninsurable" pool to spread the costs over all employers.

VI-2. Expand the eligibility and practical usefulness for the "high-risk" or "uninsurable" pool.

VI-3. Implement disease management in high-risk pools.

VI-4. Expand the state's child health program.

VI-5. Expand Medicaid eligibility as much as practical for your state.

VI-6. Provide a subsidy for small employers to purchase insurance in the small group

market.

VII. Medical Errors and Medical Malpractice Ideas

VII-1. Cap non-economic damages.

VII-2. Establish a pre-trial screening panel to weed out frivolous lawsuits.

VII-3. Implement an "English rule" under which the loser pays the winner's attorney fees.

VII-4. Create a Medical Errors Commission to systematically identify medical errors, their causes, and how to prevent them.

VII-5. Limit contingency fees.

VII-6. Impose a collateral source rule to inform the jury what the victim has already received from other insurance or what other compensation is deducted from the jury award.

VII-7. Impose periodic payments on awards to reduce the up-front costs.

VIII. Preventive and Public Health Ideas

VIII-1. Transform some of the preventive mandates on health insurance to a free public health benefit.

VIII-2. Institute a public health nurse infant home visitation program.

VIII-3. Raise the state's tobacco and/or alcohol tax.

VIII-4. Institute a cooperative, multi-state effort to stop Internet tobacco sales.

VIII-5. Allow modest discounts (5 percent to 15 percent) for staying healthy in both individual and small group markets.

VIII-6. Invest in cancer screening and education.

VIII-7. Continue to Promote Childhood Immunizations.

VIII-8. Promote Adult Influenza Immunizations.

VIII-9. Require daily physical education for grades K-12 with a minimum of 30 minutes of moderate activity.

VIII-10. Require vending machines in schools to offer healthy foods and beverages or ban the sale of unhealthy foods.

VIII-11. Ban cigarette smoking in all public places.

VIII-12. Invest in good oral health.

VIII-13. Invest in prenatal care.

IX. Medicaid Ideas

- IX-1. Reduce the use of emergency room visits for non-emergency care.
- IX-2. Explore the use of waivers to increase state flexibility.
- IX-3. Allocate a small percentage of the Medicaid budget to cost control efforts.
- IX-4. Consider cost containment strategies for the Medicaid pharmacy benefit.
- IX-5. Maximize federal funding for services that are reimbursable through Medicaid.
- IX-6. Enhance the federal contribution to a state's Medicaid program.
- IX-7. Implement care management strategies.
- IX-8. Re-balance the state's long-term care system by developing and expanding home and community-based services.
- IX-9. Reduce reimbursement rates for acute-care providers.
- IX-10. Reduce income eligibility levels for optional populations such as CHIP, pregnant women, medically needy and nursing home recipients.
- IX-11. Reduce the length of time for continuous eligibility in SCHIP and Medicaid (or postpone scheduled increases in the length of time for continuous eligibility).
- IX-12. Require a waiting period (such as 90 days) between eligibility determination for SCHIP and coverage for services.
- IX-13. Reduce the scope of SCHIP benefits for optional services such as dental, behavioral health, chiropractic, allergy and tobacco cessation.
- IX-14. Increase cost sharing for SCHIP (and optional Medicaid) to federal limits
- IX-15. Raise eligibility standards (functional needs requirements) for community care services.
- IX-16. Reduce the personal needs allowance for nursing home residents.
- IX-17. Close state mental health and mental retardation facilities by consolidating the same bed capacity in a smaller number of sites.
- IX-18. Increase the size of small group facilities for people with mental retardation.
- IX-19. Freeze the number of Medicaid waiver slots (community care).

Introduction

Most states face serious budget problems. Funding for health care services accounts for nearly 30 percent of the states' average budget, and health care costs are rising at a much higher pace than state revenues. For example, in 2002, state Medicaid budgets grew an average 12.8 percent,

while state revenues grew a mere 1.2 percent. The costs for private sector health plans also are rising at a rapid rate, causing concern among employers and forcing some to reduce or drop coverage all together. As a result, state lawmakers are confronting the need to control health care costs.

As legislators deliberate and debate options, it may be wise to do so in the context of the state's health goals and the effect on the overall health care marketplace. Some decisions may be "penny wise, but pound foolish" and actually result in escalating costs. For example, shifting health care costs from the public to the private sector may result in increasing employer-sponsored insurance costs, resulting in more employers dropping coverage or increasing the employee share to the point that employees have to drop coverage. This would, in turn, increase the number of uninsured. Or, cutting one service may cost the state more in another service if a person's condition worsens. State legislators should ask themselves whether proposed options move them toward their goals, away from them, or would leave the state in a neutral position related to their goals.

I. Direct Cost Containment Ideas

Idea I-1. Repeal or modify "any willing provider" (AWP) laws.

Rationale: An "any willing provider" law requires a managed care organization (MCO) or preferred provider organization (PPO) to reimburse any non-member providers if they are willing to match the rates and terms offered MCO or PPO members. MCOs, PPOs and similar organizations are a means of fostering price competition among health care providers because they allow the third party that pays the providers' bills to comparison shop among providers before services are needed. An AWP law may remove the third party bargaining power in price negotiations with providers because there may be no incentive for a provider to submit a low bid when not having to compete for price. By limiting the number of providers, MCOs may be able to reduce overall administrative costs related to developing contracts and monitoring and interacting with providers, and to negotiate lower rates by offering a higher per-provider case load. AWP laws often also apply to pharmacy services where, for example, expanded use of direct mail-order options may reduce or eliminate the issues of geography or office hours.

Currently, only seven states have broad application AWP laws, affecting doctors, facilities and others. Another 14 states have laws covering only pharmacies. On April 2, 2003, the U.S. Supreme Court upheld Kentucky's Any Willing Provider law, thereby removing a potential legal barrier to such laws.

Counter Arguments: Health care providers will likely oppose this proposal. They may contend that by excluding some providers, MCOs are threatening providers' freedom to practice. Patient groups may also argue for more choice in selecting providers. In financial terms, savings may be limited because the insurers still set the actual prices and other service conditions in any willing provider states. For pharmacies the variable cost is mostly a dispensing fee.

Sources for further information:

- Blue Cross Blue Shield Association, <http://bcbshealthissues.com/issues/>
- National Association of Chain Drug Stores, <http://www.nacds.org>

Idea I-2. Enact a Certificate of Need (CON) law if your state doesn't have one.

Rationale: A Certificate of Need law requires permission to expand facilities or to buy expensive new equipment. The idea is to prevent health care facilities from over expanding or purchasing excessive amounts of expensive, high tech capacity. Health care institutions often compete against each other by obtaining the most recent up-to-date technologies. If capacity or equipment is underutilized, there may be a tendency to raise prices to cover fixed costs and to market the services to stimulate medically unnecessary demand. In other industries excessive capacity is likely to lead to price cutting competition, but this is unlikely in health care for two reasons:

- a. People making decisions about utilization and which provider to use (patients and doctors) are often separate from the third parties who pay the bills (insurers and governments); and,
- b. When people are really sick, or think they might be, they want the best^{3/4} and associate the best with the most expensive. They are not in a position to "shop" for the best price and service.

Since governmental programs sometimes reimburse institutions on some version of a "cost plus" basis that pays more for high operating overhead, a certificate of need process becomes particularly important because such reimbursement takes much of the financial risk out of over expansion by providers. In other words, if a facility has expensive equipment, it can bill at higher rates.

Counter Arguments: Administrative costs of running a CON program, with staff, expert panels and public hearings can use up some or all of the savings. The federal government and at least 16 states have tried CON laws and repealed them because it didn't seem to be making enough difference to pay for the cost and administrative burden.

Resources for further information:

- American Health Planning Association: National Directory, Virginia, (703) 673-3103; www.ahpanet.org
- "No pros in CONs" *Modern Healthcare* June 3, 2002; www.modernhealthcare.com/

Idea I-3. If your state has a certificate of need law, apply it only to those circumstances where it is likely to be effective in controlling costs.

Rationale: CON programs are expensive, both for the state government and especially for the applicant institutions and detailed justifications can be required for CON applications. Public hearings/public participation and due process requirements can be slow and costly for applicants, and there may be opportunities for competitors to impose expensive legal delays. The programs that operate CONs are subject to the normal bureaucracies and are likely to expand data requirements and into areas where they are not needed. Eliminating CONs may reduce the size of state government and reduce provider expenses. For example, some states cover 20 or more specified medical expansion functions, ranging from mobile high tech laboratories (16 states) to cardiac catheterization rooms (26 states) and air ambulances (nine states). In some cases, services may have been added primarily to protect an existing institution. Existing application

requirements can be streamlined to ensure results rather than delays and appeals.

Counter Arguments: In some states numerous bills to repeal or weaken CON laws are filed and backed by affected providers every year. It may be complex for legislators to determine which categories within an existing CON law are, in fact, saving money, and which are proven to be ineffective or harmful.

Resources for further information:

- American Health Planning Association: National Directory, Virginia, (703) 673-3103; www.ahpanet.org
- "No pros in CONs" *Modern Healthcare* June 3, 2002; www.modernhealthcare.com/

Idea I-4. Regulate prices for health care.

Rationale: Creation of an agency like the traditional public utilities commission to directly regulate prices, much like agencies that regulate electricity or telephone service, may help reduce health care prices. An academic study published in 2002 concluded that, "The published literature reflects broad-based agreement that rate setting was able to exercise considerable control over the cost/admission and over per capita hospital costs. For example the New Jersey DRG (diagnostic-related groups) rate setting system and the system in Maryland cut the average rate of increase per case by almost 5 percent. In contrast, most investigators have found that rate setting has not constrained the rate of growth in health care costs per capita. This is attributable to the fact that these programs have largely failed to control rates of admission."

Counter Arguments:

a) Where price regulation affects only part of the volume of providers' business (e.g., in the Medicaid program), it may shift costs and raise the prices in the private sector. This occurs when the prices paid are below the actual cost of providing the service. As long as care is taken to determine the desired effects, setting prices for limited parts of the market place (e.g., Medicaid, workers' comp, state employees) may result in savings for those sectors without problems elsewhere.

b) Comprehensive price regulation of mobile providers, who can move across state lines, is likely to be ineffective unless the state has a large surplus of that type of providers.

c) Price regulations with some health care industries will result in setting minimum prices that will result in prices above the levels a competitive market place would set. This approach requires a rational, price sensitive market place, which may be unusual, but might well apply to regulation of health insurance prices in a market place with enough insurers to result in meaningful price competition. Some would argue, however, that this may not apply to health insurance either. Only 1 percent of people who use medical services account for 27 percent of health care spending, and nearly 70 percent of spending is accounted for by just 10 percent of medical users. Insurance companies that ostensibly compete on price may actually be competing on the ability to not insure those who get sick, which creates problems for the rest of society because the government eventually pays one way or another.

d) Comprehensive price regulation carries a risk of becoming a "cost plus system" in which those with luxury or even excess facilities automatically are paid more.

e) Price regulation in a system as complicated as health care can be very expensive and might cost more than the savings involved.

f) A place where price regulation is likely to be most effective is when a certificate of need process has restricted the provider's ability to purchase excess capacity of high tech equipment and the objective of the regulation is to ensure that the resulting savings are passed on in lower prices, not given over to the owners of the equipment.

Resources for further information:

- In 2002 Hawaii enacted a law providing that the commissioner of insurance will approve or disapprove rate changes for health insurance.
- "Achievement, Access and Accountability: A Guide to Hospital Rate Regulation in Maryland," Maryland Hospital Association, January 2002.
- "Rising Health Care Costs" National Academy for State Health Policy, June 2002.

Idea I-5. Require public posting of prices for specified common procedures and tests.

Rationale: Price posting means putting up public notices of what various practitioners charge for common non-emergency tests and procedures. Price posting may include mammograms, well baby check-ups, routine office visits, school athletic physicals, or common lab tests—such as the glycol-hemoglobin alcohol test used for diabetics. Prices may be on a state Web site in order to assist consumers with comparison shopping. In addition to finding lower cost providers, price posting may enable consumers to increase their awareness of health care costs, which may discourage them from purchasing unnecessary services.

Counter Arguments: Price posting may not affect consumers who do not have cost-sharing provisions in their coverage, or those who belong to health maintenance organizations (HMOs) unless they are shopping for services not covered under the HMO plan. Policymakers need to determine who is responsible for posting the information, such as physicians, hospitals or the state, as well as the administrative costs associated with maintaining the system. Another complication is that there is often a difference between the "sticker price" and the price charged to large groups that can negotiate a reduced price.

II. Prescription Drug Ideas

Idea II-1. Institute a preferred drug list under Medicaid, similar to Oregon's.

Rationale: A preferred drug list or "PDL" generally is an official, state promulgated list that divides many of the commonly or popularly used prescription products into two categories: "preferred" and "non-preferred." A PDL usually lists preferred drug(s) within each "drug class." A drug class is a group of drugs that treat the same condition. For example, one class exists for drugs that treat high blood pressure, another class of drugs treat gastrointestinal disorders, etc. A preferred drug is normally one that is more effective than others in the same class. If several drugs are equally effective within a class, then the preferred drug is usually the least expensive

one. Oregon emphasizes scientific and medical evidence-based research or "best practices" to make decisions about which drugs are preferred for each class of medical condition. Once the findings are adopted and published, the resulting list is widely distributed and publicized, in part to educate physicians and patients. The goal is to change prescribing patterns voluntarily to what is often a less expensive alternative, or sometimes toward a generic instead of a brand name product. However, under this model, all drugs and brands remain available and covered, if the doctor or prescriber decides a "non-preferred" drug is medically necessary.

Counter Arguments: Oregon, for example, reports "encouraging" changes in prescribing within the early months of the program, but there is limited proof of how large or permanent the savings will be. For some disease treatments, the lengthy scientific studies concluded there was no critical difference among the medicines, but since prices are not attached to the PDL, some doctors and patients may not use the information. Pharmaceutical manufacturers caution that preferred drug lists, even voluntary ones, can limit patient access to a particular needed medicine. It may be necessary to initiate prior authorization to achieve cost savings.

Resources for further information:

- "State of Oregon: Evidence Based Information on Prescription Drugs," <http://www.oregonrx.org/>
- "[PhRMA, Physicians, Patients Call on States to Halt Plans to Deny Access to Medicines - Arguments, Filings and Letters of Support](http://www.phrma.org/publications/policy/02.07.2002.521.cfm)," PhRMA Web site, July 2002, <http://www.phrma.org/publications/policy/02.07.2002.521.cfm>

Idea II-2. Implement a preferred drug list with a supplemental rebate, similar to Michigan's.

Rationale: In December 2001, the Michigan Medicaid program combined three new strategies in a project to curb increasing pharmaceutical spending: 1) The state published a lengthy preferred drug list covering 40 major disease conditions (drug classes), each with "preferred" and "non-preferred" selections; 2) Prescribers were required to obtain "prior authorization" for each patient when a non-preferred drug was ordered; and 3) A supplemental rebate option was established, aimed at pharmaceutical manufacturers. Those manufacturers that agree to pay the state-based rebate, in addition to the federally established rebate, may obtain favorable consideration to have some or all of their brand name products included as "preferred." In its first phase of operation in 2002 the state reported cost savings of \$3.5 million per month for the supplemental rebate initiative.

Counter Arguments: The Michigan PDL program was subjected to a major court challenge from the Pharmaceutical Research and Manufacturers of America (PhRMA), which claimed that the process restricts access to medically necessary, FDA-approved drugs. On March 28, 2003, a federal court upheld all the key elements of the Michigan plan, but future court challenges are always possible. Critics of PDLs like the Michigan model say that using manufacturer payments to influence inclusion on a PDL is not medically sound, and may be construed as buying influence.

Resources for further information:

- Michigan Preferred Drug List, http://www.michigan.gov/documents/325druglist_14548_7.PDF
- Federal Court ruling on Michigan Rx program (Civil Action No 02-1306, decided 3/28/03), <http://www.dcd.uscourts.gov/02-1306.pdf>
- PhRMA Fact Sheet, June 2002, <http://www.phrma.org>
- Michigan agency report to NCSL, July 2002, <http://www.ncsl.org/programs/health/02am-rx-session.htm#MI>

Idea II-3. Join with other states in a drug purchasing pool to obtain volume discounts.

Rationale: To gain an economy of scale, several multi-state coalitions have formed to examine making bulk purchases of prescription drugs for Medicaid as well as other programs (such as state employee prescription drug coverage). Private sector health care companies often negotiate discount price agreements with manufacturers in return for using selected drugs in their formularies. A growing number of state policymakers believe that pooling pharmaceutical purchases for multiple states may yield new savings of 10 percent to 15 percent per year on pharmaceutical expenditures (or between 23 percent and 35 percent less than retail). Pooling pharmaceutical purchases for individuals without prescription coverage may make pharmaceuticals more affordable for individuals. Pooling for state employees, public agencies or Medicaid may reduce the cost to the state. The models developed by three regional groups rely on hiring a single management company to negotiate the best price, based on total quantity of products, along with preferred lists to persuade manufacturers to participate. Preferred drug lists and requiring prior authorization for non-preferred drugs are usually necessary elements to shift market share to particular manufacturers for a potentially larger discount.

Several states have joined together to seek better prices for pharmaceuticals for which they are already paying. A Northeast association that now includes nine states endorsed a Medicaid multi-state buying pool, and now is forming a non-profit pharmacy management company to avoid other middle-parties, and to seek deeper discounts through direct negotiations. A separate seven-state working group, including West Virginia, Louisiana and Mississippi, has selected a single company to get best prices for their public employee programs. Recently, Vermont, Michigan, South Carolina and Wisconsin, which already have single-state contracts with the same pharmaceutical benefit manager (PBM), announced a multi-state initiative based on latest preferred drug lists. The leaders of these projects all note the potential to add new categories of programs (such as senior Rx assistance) that could benefit from lower prices.

Counter Arguments: Pooling purchases is complicated and may not sufficiently shift market share to guarantee a discount from manufacturers. Simply "buying in bulk" may not necessarily create savings. Unless the state uses a pharmaceutical benefits manager or similar entity, it would need to have separate negotiations with each manufacturer to determine the discount, if any. If pools are created for various insured populations, costs to those who pay cash for their prescriptions may increase without a pool of their own. Some early supporters have voiced skepticism about the financial saving from bulk purchasing. The industry may not object to bulk purchasing pools as long as the state operates like a free market purchaser and not a regulator.

In addition, it is not clear whether purchasing pools will work because some of the regulations governing the Medicaid drug rebate program give the pharmaceutical companies grounds to turn down requests for volume discounts. As long as Medicaid drug purchases are kept separate, however, creating purchasing pools should not interfere with any federal rules or pricing schedules. Northern New England states have spent three years designing a contract structure, but as of early 2003 have yet to make any joint purchases. With rival for-profit and non-profit proposals under discussion, states should exercise special care before using an untested model that affects billions of dollars in transactions. States may need to use competitive bidding to determine which organization, if any, would provide the best service.

Resources for further information:

- "Multi-State and Bulk Purchasing Initiatives," NCSL report on projects from New England to Georgia, New Mexico and Hawaii, <http://www.ncsl.org/programs/health/bulkrx.htm>
- "[Multi-state Efforts Seek Better Rx Prices](http://www.ncsl.org/legis/pubs/Rx)," *State Legislatures*, NCSL, March 2002, <http://www.ncsl.org/legis/pubs/Rx>

Idea II-4. Hire pharmacists to provide patient education about how to reduce drug bills and avoid dangerous drug interactions.

Rationale: There are often big price differences among similar drugs in the same class. These differences go beyond the known generic vs. brand name differences and often include considerable differences among brand name drugs that treat the same conditions. Pharmacists may be able to recommend to patients that they consider another drug that is just as effective but less expensive (once a recommendation is approved by a patient's doctor). In some cases the physician will not approve the recommendation due to the patient's medical history or diagnosis, but in the majority of cases, physician reportedly concur with recommendations. Physicians do not always have current information about the cost of competing drugs, and may welcome an effort to save their patient money by switching to equally effective but cheaper drugs. Iowa instituted such a program, termed the "Brown Bag Pharmaceutical Assessment Program." The state initially issued \$25 vouchers to senior citizens, entitling them to a one-time evaluation by a professional pharmacist.

Counter Arguments: There will be a direct expenditure cost to the state to pay for these screenings. The results may be given directly to the patient, who may not be equipped to evaluate the new information.

Resources for further information:

- Iowa program information, http://www.iowapriority.org/brown_bag.asp
- MEDBANK of Maryland, <http://www.medbankmd.org>

Idea II-5. Require pharmacies to publicly post the prices of drugs, grouped by class so people can see where substitutes may save money.

Rationale: Several consumer surveys have shown there is a wide variation in the retail prices for

prescription drugs, especially purchased by those without insurance. States can require this information be forwarded to and posted on a state run Web site, or posted prominently at the pharmacy itself. This may be a low cost way to achieve part of the previous idea about hiring pharmacists to consult with citizens. It can assist consumers without limiting prices or altering the private market. In some ways it parallels most other consumer products that post prices on shelves and signs. A few states and the District of Columbia currently have laws requiring posting or disclosure of prices, including Florida, New York and Vermont. Use of the Web is new.

Counter Argument: Price posting cannot be done for Medicaid directly. Federal law prohibits states from disclosing the actual prices that they pay after rebate.

Resources for further information: Vermont Statutes 26 VSA §1897

Idea II-6. Implement a Medicaid "Pharmacy Plus" section 1115 waiver to cover Medicare recipients with incomes up to 200 percent of federal poverty guidelines.

Rationale: Pharmacy Plus is a new federal Medicaid waiver option, which allows states to provide pharmaceutical subsidies for seniors (or adults with disabilities) who have incomes between 100 percent and 200 percent of federal poverty guidelines. Approved states can obtain federal Medicaid matching funds (which range from 50 percent to 80 percent, depending on a state's Medicaid matching rate) to cover costs of purchasing pharmaceuticals for eligible people. Pharmacy Plus programs can provide substantial short-term fiscal relief for states already spending scarce state funds to assist low-income elders. The waiver requirements appear to work well for states hoping to expand some portion of pharmaceutical assistance, since expansion is a federal requirement under the waiver's terms. States without a subsidy program also can apply to create a program if they identify the state share of matching funds. The states that have done it say the requirements are easy to meet, especially since the federal Department of Health and Human Services (DHHS) is actively encouraging states to apply.

Counter Arguments: For states that do not already have a state-funded pharmaceutical assistance program, it may be difficult to come up with matching funds in tight budgetary times.. DHHS federal "terms and conditions" require cost neutrality (over a five-year period) affecting the entire Medicaid program. If costs or enrollment unexpectedly increase beyond what is budgeted the state could be obligated to cover additional costs. The waivers also require expansion beyond current operation, which has presented a fiscal challenge for the largest existing programs such as those in New Jersey, New York and Pennsylvania.

Resource for further information:

- "States and 'Pharmacy Plus' Medicaid Waiver Options,"
<http://www.ncsl.org/programs/health/pharmplus.htm> updated April 2003

Idea II-7. Require state employees to use a mail-order pharmacy benefit manager for all maintenance drugs.

Rationale: Mail order pharmacies often charge lower prices for many drugs. State employees could receive one original prescription and one refill to be filled locally, with any additional refills to be filled only by mail order. This would provide savings without reducing actual

pharmacy coverage. It would also save out-of-pocket costs for state employees.

Counter Arguments: Imposing such a requirement on state employees could be inconvenient and not always timely. Employees may not have a safe location for the delivery of medications without compromising their privacy. Retail pharmacies in some geographic areas (with high concentrations of state employees) may be more adversely affected than other pharmacies.

Idea II-8. Encourage greater participation of safety net providers in the "340B Federal Drug Pricing Program."

Rationale: The federal 340B Drug Pricing Program provides discounts on outpatient drugs to participating safety-net health providers, including federally qualified health centers (FQHCs); community, migrant, public housing and homeless clinics; and hospitals that serve low-income patients. The 340B program does not actually pay for pharmaceuticals. Minimum discounts are set through a formula in federal law, and the program is administered by the Office of Pharmacy Affairs within the U.S. Department of Health and Human Services. It combines federal buying power and works much like a bulk purchaser.

State participation in the program may be a cost-effective way for states to provide prescription drugs to low-income populations. A 2001 study concluded that 340B-funded safety net providers pay only 49 percent of the regular market price for prescription drugs, while Medicaid pays 60.5 percent. Federal law requires pharmaceutical manufacturers that participate in Medicaid also to participate in this drug pricing program.

Participating health centers and other providers set their own distribution policy: Prescriptions can be free, include modest co-payments or require actual cash payments by patients. Traditionally most centers serve low-income people, often those with income up to 200 percent of the federal poverty guidelines, but there is no income-based cutoff for the federal program itself.

Counter Arguments: Residents must be patients of an entity that participates in the 340B program to obtain the discounted prescriptions. States with a subsidy program for residents may save more by diverting patients to 340B and from Medicaid rolls as well. Some states or regions have more entities than others.

Resources for further information:

- NCSL's Web report on 340B use in the states: <http://www.ncsl.org/programs/health/drug340B.htm>
- Office of Pharmacy Affairs Web site: <http://bphc.hrsa.gov/opa/>

Idea II-9. Audit pharmacy benefit managers (PBMs) and administrators (PBAs).

Rationale: The past 15 years have witnessed the rapid rise of a new "PBM" industry^{3/4} managers and administrators that handle financial details of pharmaceutical transactions and approvals. PBMs normally negotiate discounted rates with drug manufacturers, which are then passed on to their clients. The methods in which PBMs are paid may vary, but many work on a percentage basis of the discounts they receive. They work both for managed care companies and

increasingly for state Medicaid and public employee benefit programs. Yet, most are neither licensed medical professionals nor health insurers, and therefore are largely unregulated and unmonitored by state or federal government. The PBM industry reports to manage more than 170 million patients in the United States, and also handles some denials of coverage to sick and elderly patients.

Audits should ensure PBM fees are fully disclosed and that any financial arrangements with drug companies are fully disclosed, including any incentives paid to the PBM. Audits could be done by the state or cooperatively with private PBM users (mostly employers).

Legislators in more than a dozen states have joined with retail pharmacists in urging new laws requiring registration, licensing and some financial accountability for PBMs, including certification and fees similar to those paid by pharmacies. In 2001, Georgia became the first state to enact such a law. Proponents argue that state regulation and oversight can save money for both consumers and the state, by preventing inadequately capitalized companies, by bringing in revenue from registration fees, and in some cases by redirecting rebate agreement funds back into state coffers. In 2003, Maine passed a law requiring financial disclosure by PBMs.

Counter Arguments: Some analysts point out that PBMs have dramatically reduced excess pharmaceutical spending, and kept health costs down. A half-dozen large national corporations dominate the market, so fears of companies failing to have adequate financing may be unfounded. Allocation of savings to public programs probably is a contract issue, not requiring changes in laws. There have also been reports that PBMs may seek more financial gain by negotiating with drug manufacturers to use certain brand name drugs, and not negotiate in the best interest of their clients to ensure both discounted prices and adequacy of different drugs.

Resources for further information:

- Georgia's 2002 law, [HB 585](#) requiring that PBMs be "licensed to practice as a pharmacy."
- "[PBMs Deliver Value to Patients and Payers](#)" (June 2002) by The Pharmaceutical Care Management Association (PCMA).
- "Bipartisan Bills Target PBM Practices" at http://www.ncpanet.org/leg_gov/targetpbms.shtml

III. Cost Shifting Ideas

Cost shifting is a common phenomenon in health care. The provider has costs (e.g., payroll) that must be met, but takes care of people who cannot or will not pay the full cost, so the charge to those who can pay is raised to make up the difference. This practice occurs in many economic activities (e.g., we all pay for shop lifting) but is more prominent in health care. Many providers are not in a moral or even legal position to refuse care to those who cannot pay so they have to shift costs to stay in business. The extent of cost shifting and the causes vary widely with local economic circumstances and reimbursements from Medicare and Medicaid. Medicare reimbursement in particular is not consistent from one state to another and from one hospital to another within a state. For example, officials in Wyoming indicate that the increase in private health insurance costs due to cost shifting is 30 percent, with 15 percent attributed to Medicare

underpayment, 5 percent to other government programs^{3/4} mostly Medicaid^{3/4} and 10 percent to private bad debt and charity care.

Idea III-1. Reduce Medicaid cost shifting by increasing Medicaid reimbursement to providers enough to pay actual costs.

Rationale: In many states, Medicaid provider payments may be significantly lower than Medicare, the state employee health plan and private insurance payments. Increasing Medicaid reimbursement rates may:

- Increase the likelihood that physicians will treat Medicaid beneficiaries or not limit the number of Medicaid patients that they treat. Physicians often refuse (cannot afford) services for Medicaid patients, which creates access problems for these individuals and increases the number of clients whose health needs worsen. This may lead to Medicaid patients needing extensive treatment and turning to more expensive sources of care, such as emergency rooms.
- Maximize the amount of federal payment for Medicaid services. States have a great deal of flexibility to determine and establish payment for providers and managed care plans. State rates determine how much federal money will be drawn down through the federal matching rate, which ranges from 50 percent to 80 percent. For example, for every dollar that Illinois Medicaid spends on medical services, it receives a dollar from the federal government. In Mississippi, the federal contribution is around \$3.35 for every dollar. These federal Medicaid dollars help support local businesses, including physician offices, hospitals, nursing homes and pharmacies. For example, Medicaid funds about 17 percent of all hospital costs in this country and nearly half of all nursing home costs.

Counter Arguments: With budget shortfalls, many states cannot afford to increase rates and expend general funds to secure matching federal funds. In fact, many states are freezing or cutting provider reimbursement rates to contain costs despite the negative consequences.

Resource for further information: Norton, Stephen, "Recent Trends in Medicaid Physician Fees, 1993-1998," the Urban Institute.

Idea III-2. When cutting Medicaid to balance the budget, do not cut provider reimbursement, especially to hospitals, which will shift costs to private payers and private insurance.

Rationale: Cutting reimbursement to providers who then shift the costs will put a hidden tax on private payers. This increases health insurance premiums even more, causes more employers and individuals to drop coverage, and increases the cost for governmental employees' insurance. In addition, these problems increase the financial burden on state programs that care for the uninsured. States may want to consider cutting optional services instead or reduce payments to providers where the marginal cost of seeing another patient is low.

Counter Arguments: The fiscal climate in the states will force policymakers to make tough choices about balancing their budgets. States may have to choose between cutting provider rates or eliminating certain people or services from their Medicaid programs.

Resource for further information: Institute of Medicine. (2000). *America's Health Care Safety Net: Intact but Endangered*. Washington, DC: National Academy Press.

Idea III-3. Improve enforcement of mandatory automobile insurance laws or add a mandatory medical payments provision to those laws.

Rationale: In some hospitals trauma care can be a major source of unreimbursed care. Motor vehicle accident rates are highest among the young, healthy and lower-income segment of the population who may not have health insurance due to costs or other reasons.

Counter Arguments: This same part of the population may also have difficulty affording car insurance and so may still evade mandatory insurance laws. Also, requiring additional coverage under auto insurance may raise premiums and cause additional people to go without coverage.

Resource for further information: NCSL's Insurance Program Web page:
<http://www.ncsl.org/programs/insur/insur.htm>

Idea III-4. Determine whether your state has a problem with cost shifting because large employers self-insure, and whether HMOs shift costs to the small employer and individual health insurance markets.

Rationale: Because many large employers are exempt from state regulation due to ERISA (the federal Employee Retirement Income Security Act), it is difficult for states to directly address this problem. Federal law offers some standards for continuity or renewability, and numerous state laws regulate small employers and individuals, some by setting "rate bands" aimed at reducing adverse affects on people who may be sicker. More than a dozen states have established health purchasing coops that seek to give smaller employers buying clout similar to much larger employers. State policymakers should engage all stakeholders, including the business community, in finding solutions to health insurance issues facing states.

Counter Arguments: Health insurance issues around cost-shift and insurance regulation are often very complex and involve factors that may extend outside of what states can influence (e.g., federal preemption). When discussions in this area arise, various stakeholder groups will often support one or another approach, which may create conflicts (e.g., some want more and some want fewer insurance mandates). Legislators, stakeholders and others often find it challenging to try to objectively weigh the benefits and pitfalls of different approaches to the problems around health insurance costs.

Resource for further information: "Pooled Purchasing: Who are the Players?" *Health Affairs*, July/August 1999.

IV. Workforce Expansion/Scope of Practice Ideas

Many health care occupations have shortages, most notably among nurses, dentists and front-line workers in long-term care. There are effective programs to train health care workers, but these are expensive. Trainees need clinical opportunities and lab courses in the basic sciences as well as in their specific areas. Faculty often must be paid more than other faculty to keep them from leaving to practice in their profession or from being recruited by states that need health profession faculty. This salary differential can cause friction within academic institutions in

terms of salary equity or department funding. For these reasons, academic institutions sometimes will cut back on health professions programs, particularly state-funded institutions during state fiscal problems.

Scope of practice changes can reduce costs by authorizing other health care professionals to conduct treatments normally restricted to a narrower set of practitioners. Widening the scope of authority for qualified practitioners who may charge less or are more abundant in numbers can eliminate requirements for costly referrals and provide greater access. Such changes are often contentious, however, with other professions opposing them for a mixture of economic and professional reasons.

Idea IV-1. Use loan forgiveness programs with specified work commitment payback mechanisms to expand the number of students in nursing programs.

Rationale: The nursing shortage is well documented. America's hospitals have approximately 126,000 unfilled nursing positions, and that number is on the rise. The average age of nurses is now 45.2 and there are insufficient nursing school graduates to replace those who will soon retire. Offering financial incentives is a tool to expand the pipeline of nurses and other health care professionals. In exchange, many states require these practitioners to work in medically underserved areas for a certain amount of time. In addition to encouraging individuals to enter the profession-including career changers or current health care professionals who may not have the resources to pay for additional education-these programs help distribute nurses and other needed practitioners to areas where they are needed most. Because of the high level of demand for direct entry baccalaureate and masters level RNs, such programs are effective in targeting the very individuals who are in demand.

In June 2002, the Department of Health and Human Services (DHHS) awarded a series of grants totaling more than \$30 million to increase the number of qualified nurses. More than \$22 million of those grants is designated for colleges, universities and other organizations to increase the number of nurses with advanced degrees and also help to improve the quality of care for elderly patients. Another \$8 million is designated to repay educational loans of clinical care nurses who work two to three years in designated public or nonprofit health facilities that are in the midst of a shortage.

Counter Arguments: These programs can be expensive, and in these tight times, states may not be able to consider such measures. Some nurses may pay off the loan and leave the state rather than work in the state to pay it back. Other problems also contribute to the nursing shortage, such as low salaries and working conditions, including mandatory overtime.

Resources for further information: State nursing associations and boards of nursing.

Idea IV-2. Expand the size of existing nursing education programs.

Rationale: The nursing shortage problem may not be a lack of qualified applicants in nursing programs, but a lack of slots in the state's nursing schools. According to the California Strategic Planning Committee for Nursing, in 2000-2001 there were approximately 40 percent more applicants for nursing education programs than could be enrolled due to lack of space. Grants to academic institutions to fund one additional faculty member for each eight additional slots can

help increase the number of students (this is a typical faculty/pupil ratio in an RN program). In addition, states can support two-year programs and distance learning opportunities with emphasis on rural areas.

Counter Arguments: Expanding educational programs will cost money, but may improve access and service quality. Additionally, other health care professions, such as radiology technicians and dental hygienists, are also in short supply in many areas and will want to compete for funding to increase their training capacity. Since nurse and health care professional training is typically more expensive than other vocations, states may be forced to curtail training for other important areas of the workforce in lieu of funding health care training.

Resource for further information: The Center for the Health Professions, <http://www.futurehealth.ucsf.edu/home.html>

Idea IV-3. Use loan forgiveness programs and cost-of-living stipends to train more faculty.

Rationale: Shortage of faculty can be a major problem for nursing programs. One good technique may be to allow bachelors level people to teach for a few years to determine if they like being an instructor and are effective in the role. Then give them a forgivable loan and a stipend to get the degree required to be a permanent faculty member at the institution.

Counter Argument: Providing additional support for nursing faculty may open the door for requests from other faculty areas where professionals are in short supply.

Resources for further information:

American Association of Colleges of Nursing:

- <http://www.aacn.nche.edu/Publications/issues/IB499WB.htm>
- <http://www.aacn.nche.edu/Media/Backgrounders/facultyshortage.htm>

Idea IV-4. Expand LPN (licensed practical nurse) programs.

Rationale: A substantial demand exists for LPNs, particularly in nursing homes, doctors' offices and similar settings. Some people who cannot afford the cost or the extra time required to earn a registered nurse (RN) degree may be able to achieve LPN status as an interim step to becoming a RN. Crafting a system that enables a broader array of people to advance and obtain an RN degree when their circumstances permit is possible.

Counter Argument: State budget shortfalls may make this unrealistic in the near future.

Resources for further information:

- The Center for the Health Professions: <http://www.futurehealth.ucsf.edu/home.html>
- American Nurses Association: <http://www.ana.org>

Idea IV-5. Reduce the paperwork burden on health care providers, particularly in the hospital and nursing home situations.

Rationale: Unnecessary or excessive paperwork may reduce the efficiency of the current workforce, which may be caused by: 1) government regulations; 2) billing requirements, which have become increasingly complex (state Medicaid programs may be partly responsible); and 3) documentation required due to liability issues. Careful study, perhaps with a task force or commission (including working nurses, management representatives of institutions, and other providers) could yield specific proposals for state action. Medicaid requirements in nursing home programs are often cited as requiring unnecessary or excessive paperwork, and so may be a good place for review. Making state regulations conform more closely to federal regulations may help, especially if state regulations are overly stringent, are tied to increased provider expenses and/or create barriers to increasing the pool of health providers. States may also want to explore newer technologies, such as electronic billing systems, which have helped reduce Medicaid and SCHIP paperwork, and have streamlined procedures.

Counter Arguments: Allowing less documentation of services or programs may affect the quality of programs, especially if regulatory agencies depend on this type of reporting to verify that programs are adhering to necessary policies and procedures. There could also be legal problems for the state or contracted providers if client problems occur and there is insufficient documentation regarding treatment. Hospital staff normally communicate through paperwork and patients' records. Many paperwork requirements relate to patient safety.

Idea IV-6. Expand an existing dental school or start a new one.

Rationale: The number of slots in dental schools has been decreasing while the need for dentists is increasing. The ratio of dentists to the population is dropping, and is expected to be about 52 dentists per 100,000 by 2020, down from 60 in 1990. Roughly 4,000 dentists graduate each year, down from a high of about 6,000 in 1975. A wave of retirements is expected that will make the shortage much worse because only 25 percent of dentists are under age 45. In addition, a geographic distribution problem exists, with too few who are willing to practice in rural areas or treat underserved patients, children, and people with disabilities. According to the Health Resources and Services Administration, 26.5 million people live in areas that are underserved for dental care, and 5,862 dentists are needed to remedy the shortage. There is also a shortage of women and minority dentists. Six dental schools closed between 1986 and 1993, although two new ones have been approved, in Arizona and Nevada.

Counter Arguments: This is an expensive undertaking and there are some obstacles to expanding dental schools or starting new ones. For example, a serious shortage exists of dental school faculty, since they make less than dentists in private practice. Nearly half of all faculty are over age 50, and 20 percent are over 60. Federal support for dental education was phased out in the early 1980s, so infrastructure and lab space in many dental schools is deteriorating. In addition, state and federal support for dental education has been dwindling. Additionally, states may have restrictions on which dentists can obtain a license to practice depending on where the person received his or her license. Also, most state dental associations formally or informally oppose any expansions in their state's supply of dentists through larger class sizes, new dental schools, loosening licensing requirements or other mechanisms.

Resources for further information:

- The American Dental Education Association, <http://www.adea.org>.

- The American Dental Association, <http://www.ada.org>
- The Center for the Health Professions: <http://www.futurehealth.ucsf.edu/home.html>

Idea IV-7. Expand the scope of practice or loosen supervision requirements for dental hygienists.

Rationale: Allowing dental hygienists to perform additional screening, education and prevention tasks can expand access to oral health services in a more cost effective manner, and while saving the limited supply of dentists to perform more complex procedures. For dental hygienists, state scope of practice and supervision laws vary widely across states, but their clinical training does not. Supervision and scope of practice laws may not be based on the clinical skills and abilities of certain health care professionals. It is in a state's interest to examine these issues to determine if economies can be achieved and more patients served, while maintaining quality services and patient safety, if scope of practice and supervision requirements are changed. For example, in Colorado, dental hygienists can establish independent practices and bill Medicaid themselves. In about 16 states, dental hygienists can practice at certain sites without a dentist present, although in some states a dentist must first see the patient and order the cleaning, education or screening. In Washington State, dental assistants can apply dental sealants under orders of a dental hygienist, while in 11 states dental hygienists cannot apply sealants unless a dentist is present. Modifying supervision requirements so that dental hygienists can practice to the extent of their training without direct supervision by dentists may allow them to expand access to care by conducting screening, education, routine cleaning and other services at clinics, schools, nursing homes and other sites not always readily served by dentists.

A few states are examining programs to train "expanded function dental assistants." Pennsylvania has used them extensively for many years. They are not hygienists, but assistants who are used as dental extenders to prepare and finish treatments for patients, which allows dentists more time to treat additional patients. This is one way to treat a larger number of Medicaid patients in a more profitable manner and perhaps help entice more dentists to treat Medicaid recipients.

Counter Arguments: State dental associations normally oppose expansions in scope of practice and loosening of supervision requirements. States will want to conduct a thorough review of the skills and licensing requirements of hygienists to ensure that they are qualified to expand their scope of practice.

Resources for more information:

- The American Dental Hygiene Association, 312/ 440-8900, <http://www.adha.org>.
- The American Dental Association, 312/440-2500, <http://www.ada.org>

Idea IV-8. Allow medication aides to administer medications in nursing homes and similar institutions (including schools).

Rationale: Medical aides would not be prescribing drugs, but could be authorized to distribute and help administer medications. This could free up other health professionals to concentrate on tasks that require more training.

Counter Arguments: Nurse groups or others may oppose this out of concern for patient safety and/or professional protections. When expanding scope of practice with any health care profession, policymakers should ensure that the authority is not inadvertently expanded beyond the training or skills of the targeted profession.

Resource for further information: American Society of Consultant Pharmacists, <http://www.ascp.com/public/pr/policy/unlicensed.shtml>

IV-9. Allow physical therapists and occupational therapists to practice without referral from a physician.

Rationale: Allowing physical therapists and occupational therapists to practice independently may save money by eliminating unnecessary patient visits to physicians.

Counter Arguments: Some critics fear that costs could actually escalate because there would be no "gatekeeper" function to prevent unnecessary physical or occupational therapy, except for health plan requirements. Also, this is a "scope of practice" issue, which may be opposed by physicians and chiropractors.

Resources for further information:

- American Physical Therapy Association, 800/999-2782, ext. 3162; <http://www.apta.org>
- American Occupational Therapy Association, 301/652-2682; <http://www.aota.org>
- American Medical Association, 800/262-1150; <http://www.ama.org>

Idea IV-10. Allow psychologists to prescribe drugs related to their practice.

Rationale: Allowing appropriately trained psychologists to prescribe certain drugs could save money by eliminating the need to be seen or reviewed by a psychiatrist. The U.S. military allowed some Ph.D. level psychologists this authority, under a pilot program, and New Mexico has enacted legislation that will allow psychologist to prescribe some medications after undergoing additional training..

Counter Arguments: Special training and other licensing requirements, such as passing certain examinations, should be required; currently, pharmacology courses are not usually part of psychologists' training. Psychologists with drug prescribing authority may also be restricted to using just certain medications from a formulary (e.g., drugs for psychological disorders). Some insurers caution that this will ultimately increase health care costs. Also, critics would argue that because psychiatrists are physicians, they are much better prepared to understand all of the complications related to drugs and their appropriate use, including interactions with other drugs with which psychologists would not be familiar.

Resources for further information:

- American Psychological Association: <http://www.apa.org>
- American Psychiatric Association: <http://www.psych.org>

V. Health Insurance Reform Ideas

Idea V-1. Restructure insurance products to increase personal responsibility for health care.

Rationale: Proposed restructuring for employer-based insurance would be a hybrid between the traditional defined benefit systems (such as an employer-sponsored managed care plan) and the defined contribution systems that are starting to appear. It is intended to be a voluntary program in which an employee has an account at an insurance company that he or she accesses by writing checks or using a credit card. The balance of the account comes from a monthly contribution by the employer and subsequent money directly deposited from the employee's paycheck if the employer's contributions are insufficient to pay medical bills. Traditional insurance with a copayment (e.g., 10 percent of bills up to a specified amount) would cover major expenses.

This design could save money in two ways: 1) insured people would have a financial incentive to keep costs down (e.g., avoid unnecessary doctor visits or tests, or comparison shop for drugs and other services); and 2) administrative costs for both the providers and the insurance company should be reduced by enabling the insured to pay on-the-spot for most services, especially smaller claims. In fact, the insurance company should be able to negotiate a prompt pay discount similar to the one credit card companies receive.

With proper design tailored to the individual employer, the existing balance between what the employer pays and what the employee pays could be maintained. Where collective bargaining is involved the balance between employer and employee contribution would be a natural topic for collective bargaining. But it would be important to maintain the principle that the employer's contribution was the first dollar and the employee's contribution the marginal second dollar to be used only if the employer's share was used up. The program could also include a clause that allows extra funds to be carried over to the next year for health-related items not covered (such as dental, vision, health club memberships or exercise equipment).

Many aspects of this system could be implemented by a private employer without additional legislation. However, state legislatures could facilitate such a system by:

1. Requiring carryover of employee account balances from one employer to another and access to account balances when unemployed.
2. Regulating the extent of payroll deductions (or wage reductions if that works better from a tax standpoint) for the employee's second dollar contribution.
3. Paying for the legal and accounting work necessary for a plan design that minimizes the federal tax consequences and stand ready to litigate test cases if the IRS disagrees with the interpretation used.
4. Modifying state income tax laws to accommodate this kind of benefit design.
5. Using state employees or other public employees as a large group to kick-start the system and get the necessary accounting systems and provider acceptance in place.
6. Legislating a recognizable credit card design and legislate penalties for misuse (e.g.,

spending for non-health care related activities). The penalties would fall on both vendors and insured people.

Counter Arguments: Certain aspects of the federal tax code could make the employers' contributions taxable unless they pay for insurance, not direct services. Also, the savings described may be somewhat reduced because where the insured person makes the decisions on payment he or she may buy some services^{3/4} particularly alternative medicine services or out-of-network services^{3/4} that would not ordinarily be covered. To keep the short-term financial incentives from reducing cost-effective preventive care, certain cost codes should be fully reimbursed and not charged against the employee's account. In addition, care should be taken so that people with greater needs for medical services are not priced out of the insurance market.

Opponents of this type of system or of state legislature involvement might say that it could be implemented by a private employer without additional legislation, or that this proposal overestimates the overuse and misuse of the health care system as a contributor to high health care costs.

Idea V-2. Repeal Some or All Coverage Mandates.

Rationale: Businesses and the insurance industry often point to mandated insurance coverage for certain conditions, treatments, and/or health practitioners as a source of increasing health insurance costs. The potential for reductions in employer-sponsored insurance costs may be significant, depending on the type of mandate. An April 2002 study by PriceWaterhouseCoopers prepared for the American Association of Health Plans calculated the size of the overall increase in health care costs to be 13.7 percent between 2001 and 2002. The study estimated that mandates (both state and federal) and government regulation accounted for about 2 percent of this increase (or 15 percent of the total increase). A federal General Accounting Office (GAO) study reported that mandates accounted for up to 22 percent of the overall insurance premium costs in Maryland.

The potential for savings from having few or no mandates will vary greatly among states, depending on how many and which mandates they require. For example, mandated chemical dependency coverage increased costs by 9 percent in those states that adopted it, according to a study published in a 1999 *Milbank Quarterly*. On the other hand, a study done in October 2001 by the Arizona Health Care Cost Containment System, found that mandating coverage of clinical trials contributed to a cost increase of only 0.2 percent.

Counter Arguments: Many clinical preventive services are known to be cost-effective because screening tests are often able to detect diseases early, and therefore avoid costly treatment needs. For example, screening for chlamydia infection among young women was found to be very cost effective in a 2001 *American Journal of Preventive Medicine* article, even in populations with low to moderate prevalence of the disease. Health experts and policymakers recognize that many effective preventive services reach only a small portion of the recommended population, and that mandating coverage for effective services may increase their use. Only four states now mandate coverage of chlamydia screening.

Moreover, if certain services are not covered, there could be a cost-shift to other payers or government programs when people who need such services cannot pay for them. This could be

an expensive cost shift for services such as mental health, if employers choose to drop coverage because of the expense to themselves. Even if certain mandates are repealed, they will remain due to market demand, thus limiting the cost savings. And finally, political support for particular mandates may make repeal difficult. There also may be a time-based disconnect between the cost of mandated preventive care and the cost savings. For example, if insured people switch insurance carriers, the first carrier bears the cost of the prevention and the second one gets the savings. Wyoming lacks most of the common state mandates, but insurance costs there have risen as fast or faster than in other states for other reasons (including low Medicare rates and lack of managed care), so repealing mandates is like all the other solutions^{3/4} at best a partial answer.

Resources for further information:

- "The Factors Fueling Rising Healthcare Costs," PriceWaterhouseCoopers, Washington DC, April 2002.
- "Priorities Among Recommended Clinical Preventive Services," *American Journal of Preventive Medicine*, 21, no. 1, (July 2001).

Idea V-3. Allow or expand pricing bands in the small group market.

Rationale: During the 1990s, state legislatures enacted a series of measures intended to increase small group access to health insurance. Compression of premiums through rating bands was one approach used to make insurance more affordable to these groups, particularly for people at high risk. Rating bands limit variations in allowable premium rates based on factors such as age, gender, claims experience and health status. As of 2001, rate bands were in use in 19 states.

Rather than a series of rating bands, some states allow only a single rate for guaranteed issue small group insurance. According to some observers, this may cause individuals to leave the small group market for individual plans. For example, in 2002, Colorado's insurance commissioner reported at NCSL's Annual Meeting that the state's single rate charged for guaranteed issue small group insurance was causing insured people to move from small group to individual plans. However, in neighboring Wyoming, where medical underwriting determines the position within the fairly large rate band, which allows up to a 67 percent difference, policyholders have not fled to individuals plans.

Counter Arguments: Expanding the rate band likely means immediate higher premiums for those who may be older, sicker, or in an unfavorable geographic area. Are higher costs to employers and workers really consistent with cost containment? Some might lose coverage entirely because of the increases.

Resources for More Information:

- *Major Health Care Policies: 50 State Profiles*, NCSL (2000).
- State Reforms of Small Group Health Insurance, Kaiser Family Foundation, website accessed 4/1/03, www.kff.org/content/archive/1315/state.html

Idea V-4. Do not allow small groups of one with guaranteed issue.

Rationale: In an effort to encourage affordable, accessible private health insurance, states and the federal HIPAA law focused on small employers, often defined as groups of 2 to 50 employees. However, about 14 states have defined "small" to include "one," in practice covering individuals who are self-employed or sole proprietors. Even with the preexisting condition periods that are still allowed, when groups of one are allowed guaranteed small group issue, there is too much potential for adverse selection with people waiting until they develop significant health risks before they buy insurance.

Counter Arguments: The states with coverage for "groups of one" intended this special protection for individuals who otherwise would pay higher premiums, and perhaps not be eligible for any regular insurance. Repeal of existing laws would meet with opposition from those who could lose coverage; generally it would be a challenge to tie the change to actual cost savings, such as an assurance that premium rates would be reduced.

Resources for further information:

- "Health Insurance Reform in the Small-Group Market," *Health Affairs*, 1999. Web: www.healthaffairs.org/1120_search.php .
- "Small Group Market Reform: States' Experiences," Commonwealth Fund, http://www.cmwf.org/programs/health_care/smgrpbrf.asp

Idea V-5. Allow modest discounts (5 percent to 15 percent) for staying healthy in both individual and small group markets.

Rationale: Evidence presented at the 2002 NCSL Annual Meeting indicated that this mild form of medical underwriting reduces costs enough to save everybody, including those who do not get the discount, some money. People may achieve the "staying healthy" criteria (no claims except for specified preventive codes) by paying for a few small items directly, but that reduces insurance costs, especially administrative ones. Existing "rate band" laws that may restrict the range of higher charges based on demographics were written to protect those who might have a chronic illness or be a high end user of health care. With clearer evidence of the multiple benefits of prevention and healthy behavior, it may be possible to reward such behavior without "punishing" those who may have to use health insurance more often.

Counter Arguments: Allowing too much discount could erode the ability of the insurance pool to subsidize members with chronic illness or are higher end health care users. Consumer-directed health plans are speculative because there is little experience with them yet.

Idea V-6. Prohibit medical underwriting on guaranteed renewal in the individual market (except for certain modest discounts).

Rationale: The *Wall Street Journal* recently reported on a carrier that had been re-underwriting policies, raising rates when buyers made claims. The reaction to this report led the carrier and some professional associations to repudiate this practice. Nonetheless, it continues to surface from time to time, particularly among carriers that market through unregulated means, such as association health plans. It is in the interest of public policy to encourage people to buy health insurance when healthy so they will have insurance if they get sick or develop a major risk. Medical underwriting on renewal and re-underwriting at the insurer's discretion defeat this

purpose because they raise the prices for people who get sick to the point they cannot afford coverage. Rules against underwriting and re-underwriting may be viewed as complementary to rules that prevent individuals from waiting until they are sick to purchase coverage, since the insurance market only works if neither the buyer nor the seller may benefit by changing what they do when health care is needed. Modest discounts could be offered for staying healthy and modest increases could be allowed for certain traditional characteristics including tobacco use, obesity and age.

Counter Arguments: Rate increases on renewal are limited to 15 percent under the National Association of Insurance Commissioners (NAIC) model. These rules do not limit increases that affect everyone, only disproportionate increases based on health conditions that appear after a person is covered.

Resources for further information:

- http://www.healthaffairs.org/WebExclusives/Web_Exclusive_Letters_Pauly_090502.htm
- http://www.nahu.org/news/releases/Reunderwriting_statement.doc
- <http://www.benefitnews.com/nwarc.cfm?ID=1212>

Idea V-7. Prohibit the practice of closing blocks of business.

Rationale: When a company closes a block of business, it markets a particular policy (known as a block of business) for a period of time and, subsequently, ceases to market the policy to new customers. In the event that a policy is closed, an insurer might permit healthy individuals to transfer to a new policy, while the unhealthy policyholders are left in the old block. As a result, the ill policyholders in the old block will likely have higher expenses and pay higher rates. Ultimately, the cost of participation in the old block may become so high that policyholders are forced to drop out of the plan. This is a slightly cruder form of underwriting. State legislators may want to require that companies use the experience from all their blocks of business for underwriting purposes in order to avoid this potential problem.

Counter Arguments: This type of detailed regulation is more commonly handled by insurance commissions and departments, which can evaluate the entire range of each company's products and offerings. A "closed" or "open" block of business alone does not define the actual make-up of the group, nor the premiums they may or may not be charged in the future.

Resource for further information: "Small Employer Model Act" National Association of Insurance Commissioners, http://www.naic.org/models_papers/papers/insurance/semml206.doc (pp. 59-61).

Idea V-8. Repeal any state prohibitions on forming groups for the purpose of obtaining insurance.

Rationale: Allowing small businesses to band together to leverage the purchasing power of larger numbers to get better insurance rates may reduce insurance costs. Currently at least 23 states allow or even coordinate voluntary purchasing cooperatives or alliances. A 2000 report by

the General Accounting Office (GAO) concluded, "Cooperatives can provide small employers' employees with a better choice of health plans offering standardized benefits and can offer employers fewer administrative hurdles to obtaining health insurance." It is believed that the regulatory burdens/protections of the federal HIPAA (federal Health Insurance Portability and Accountability Act) would continue to apply to the small businesses in such a group.

Counter Arguments: Some of the purchasing alliances formed in the past decade have had "disappointing" results in achieving substantial savings. As a result, some programs were underused, or have seen drop-offs in business participation. Savings may be only a one-time factor, with rates increasing in future years at the same high rates all purchasers witnessed in 2002 and 2003 (averaging 14.4 percent). Finally, a similar-sounding policy idea, "Association Health Plans," has become controversial because it is connected with total exemption, or preemption from state insurance regulation.

Resources for further information:

- "Cooperatives Offer Small Employers Plan Choice and Market Prices," U.S. General Accounting Office, March 2000; <http://www.gao.gov/archive/2000/he00149.pdf>
- "Unregulated AHPs: Sky High Premiums and Loss of Consumer Protections," February 5, 2003; <http://bcbshealthissues.com/proactive/newsroom/release.vtml?id=37904>
- *Health Insurance Purchasing Cooperatives: Analysis of Data on Prototypes*, Robert Wood Johnson Foundation, http://www.rwjf.org/reports/grr/023270.htm#int_top.

VI. Subsidy Program Ideas

Idea VI-1. Change the financing of the "high-risk" or "uninsurable" pool to spread the costs over all employers.

Rationale: Thirty states have a subsidized pool where people who are "medically uninsurable" may purchase coverage. These are often financed by some kind of an assessment on insurance companies. This approach falls most heavily on small businesses and individuals who purchase insurance. Employers who do not cover their workers and self-insuring employers do not contribute because ERISA (the federal Employee Retirement Income Security Act) preempts these assessments, even though their employees may seek coverage in this pool in the future under another federal law, HIPAA (the Health Insurance Portability and Accountability Act). Changing the financing to a broader base, such as an employment tax or hospital revenue tax, would be fairer and reduce the burden on small businesses and individuals. Several states level the playing field between self-insured plans and commercial carriers by assessing re-insurers on a "per covered life" basis.

Counter Arguments: The biggest challenge states face is finding a fair and steady source of funds to subsidize enrollment for people who cannot afford the high premiums. General fund appropriations, lotteries and special taxes, used in a few states, have often proven unreliable, since they do not rise and fall with overall changes in health costs, and enrollment in pools in some states have been capped as a result. Hospital revenue taxes have been criticized as "sick taxes." Payroll taxes may be attacked as creating an unfavorable business climate. Keeping the assessment tied to insurance, by looking at reinsurance and third-party administration, can

maintain the tie between the assessment and the use of the public service.

Resources for further information:

- "Frequently Asked Questions: Access and the Uninsured," <http://www.ncsl.org/programs/health/forum/faqaccess.htm> (the seventh question deals with pools).
- "Medical High Risk Pools," *State Health Notes*, 24, no. 388 (January 27, 2003), NCSL.
- Communicating for Agriculture, www.selfemployedcountry.org
- National Association of State Comprehensive Health Insurance Plans, <http://www.naschip.org>

Idea VI-2. Expand the eligibility and practical usefulness for the "high-risk" or "uninsurable" pool.

Rationale: The two most successful and long lasting pools, in Minnesota and Connecticut, market to self-insured individuals and very small businesses as well as people with medical risks. Expanding the pool to healthier individuals and even groups may build political support for continued operation and subsidy while keeping average rates somewhat lower. State subsidies to low-income workers and individuals are provided in several states, including Montana and Wisconsin, to lower barriers to entry, thus keeping a healthier mix of people in the pool. While this requires continued state subsidies to operate the pool, bringing higher-end health care users into coverage can keep them healthier by obtaining needed care, gives them an opportunity to contribute part of the cost through premiums, and can reduce overall health costs for the entire system.

Counter Arguments: The cost of coverage for the medically uninsurable will continue to be very high and require subsidies in addition to premiums paid by people insured in these programs. Even though increasing pool membership lowers average costs and subsidies, it will raise total costs for the state since people will not join the pool unless they are unable to find competitive prices outside the pool. Pool prices should remain above the regular market's insurance premiums to prevent unfair competition with the private market.

Resources for further information:

- "Frequently Asked Questions: Access and the Uninsured," <http://www.ncsl.org/programs/health/forum/faqaccess.htm> (the seventh question deals with pools).
- "Medical High Risk Pools," *State Health Notes*, 24, no. 388 (January 27, 2003), NCSL.
- Communicating for Agriculture, www.selfemployedcountry.org
- National Association of State Comprehensive Health Insurance Plans, <http://www.naschip.org>

Idea VI-3. Implement disease management in high-risk pools.

Rationale: There is not conclusive evidence that case management and disease management saves money when offered to everyone in a health plan. But these services appear to be worth providing for people with chronic or complicated medical conditions. This patient-friendly approach to managing care is a natural for the small groups in medical high-risk pools since they enter the pools based on having such conditions.

Counter Arguments: Clear performance contracting is needed to be sure that the group providing the disease management can deliver cost-effective care. Other performance indicators, such as increasing access to better quality care for disease management recipients may be more difficult to measure.

Resource for further information: Barbara Brett, Colorado high risk pool, has pioneered this approach; <http://www.covercolorado.org>

Idea VI-4. Expand the state's child health program.

Rationale: The State Children's Health Insurance Program (SCHIP) provides health care for low-income children in working families. The federal share of costs is greater under SCHIP than Medicaid-between 65 percent and 85 percent of expenses, depending on the state. According to the Centers for Medicare and Medicaid Services (CMS), in fiscal year 2002, state SCHIP expenditures were about \$1.6 billion, while the federal share of SCHIP expenditures was \$3.8 billion. States can leverage this federal money to expand coverage and reduce uncompensated care and the cost shifts to the private sector. In light of the current state of the economy, the need for SCHIP will increase as costs rise, and cause more people to lose private health insurance. According to a recent Urban Institute survey, SCHIP is widely viewed as successful in addressing a vital need of bringing health coverage to uninsured children. It is not seen as overly costly, especially compared with Medicaid.

Counter Arguments: Although SCHIP has an enhanced federal matching rate, it is probably not likely that expansions will occur in states with financial crises. Although small in scale relative to Medicaid, growth in SCHIP puts increasing pressure on state budgets. An additional concern is "crowd-out"-as a SCHIP program expands, it may cover people who might otherwise be able to obtain private insurance or can afford to pay part of their health care bills.

Resources for further information:

- NCSL, <http://www.ncsl.org/programs/health/chiphome.htm>
- Centers for Medicare and Medicaid Services, <http://www.cms.gov>
- Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org>
- National Governors Association, <http://www.nga.org>
- Urban Institute, <http://www.urban.org>

Idea VI-5. Expand Medicaid eligibility as much as practical for your state.

Rationale: The federal and state governments share Medicaid costs. The federal government contributes 50 percent of a state's administrative expenses, but the federal matching rate for

eligible medical services varies among states with a low of 50 percent to a high of 80 percent. Federal-state financing allows states to provide health insurance to the uninsured and support health care safety net providers (public hospitals; community, migrant and school health centers; and mental health clinics) while paying only half or less of the cost. Providing coverage for more of the uninsured reduces state spending on uncompensated care and aids in creating a healthier population with access to primary and preventive services, which can decrease the number of emergency room visits and costly hospitalizations. This ultimately will reduce the cost-shifting that occurs when the uninsured need care but cannot pay for it.

The federal government identifies 28 mandatory coverage groups and 21 optional groups. States must cover certain poor citizens who qualify based on their income and eligibility for a certain "category" of people (such as welfare-related status, disability, low-income Medicare recipient, and status as a low-income child or pregnant woman). People in any of these "categories" are eligible for Medicaid if they meet both income and resource tests and reside in the state. However, illegal immigrants are not eligible and certain legal immigrants are barred from coverage for five years after they enter the country and are then eligible at state option.

States may choose to cover a number of optional groups, most notably people in the same categories as the mandatory groups, but with higher income. However, if people do not meet the specified criteria, no matter how poor they are, they do not qualify for Medicaid. For example, Medicaid serves as a safety net for catastrophic coverage in many states. Thirty-six states operate a medically needy program allowing certain people with high medical bills to qualify for Medicaid after they incur a specified amount of medical expenses.

With increased flexibility under federal options, states may now cover many more people than originally allowed under federal guidelines. While great variation exists among states in the number and scope of eligibility categories, every state has extended coverage beyond the mandatory groups. For example, 38 states extend Medicaid eligibility to pregnant women at higher income levels than required, and 49 states do so for infants. As a result of states' commitment to coverage for pregnant women and children, Medicaid now pays for about one-third of all births and covers about 20 percent of all children. A few states have used federal section 1115 waivers to extend coverage to virtually all low-income populations (e.g., Minnesota, Oregon and Tennessee).

Several states are experimenting with expanding Medicaid eligibility through public-private partnerships called "employer premium assistance programs." With a premium assistance program expansion, a state can extend eligibility to the working uninsured in a program that is financed by the employer, the employee and the state Medicaid program. The state may require a waiver to implement a premium assistance program. The Health Insurance Flexibility and Accountability (HIFA) 1115 waiver initiative invites states to propose innovative ways of expanding Medicaid with public-private partnerships.

Arkansas' Health Insurance Flexibility and Accountability 1115 waiver, still pending as of July 1, 2003, would create an employer premium assistance program that is financed in part by a tax on the participating employers. This proposed arrangement, if approved by the Centers for Medicare and Medicaid Services (CMS), will create new alternatives for states struggling with the ominous task of financing Medicaid expansions in tough times. To date, CMS has not allowed states to use employer contributions as a portion of their "state match" money.

For states with difficult budget problems, an expansion could be financed without adding to the general fund burden. For example, states could implement an employment tax calculated to be approximately equal to the state matching requirement. The tax would fall only on the wages for eligible employees who did not have health insurance. As a result, employers who do not provide health insurance benefits to their low-wage employees would have an additional expense, but one less than the cost of providing insurance. Employers who do provide insurance would have their expenses cut if their eligible low-wage workers switched to Medicaid. This may be possible because Medicaid usually offers a richer benefit package than plans in the private sector. States could propose a waiver to restrict their expansion to employed people, which would be consistent with the work requirements of welfare reform and the general philosophy of helping people who are trying to help themselves by working.

Counter Arguments: Many states have already expanded the size and scope of Medicaid to meet the health care needs of their most vulnerable citizens. There currently is little discussion of expanding to new populations. In addition, some policymakers would prefer that insurance coverage problems be solved in the private sector and not by expanding government programs.

Resources for further information:

- "The Health Insurance Flexibility and Accountability Waiver Initiative," NCSL, <http://www.ncsl.org/programs/health/hifa.htm>
- Centers for Medicare and Medicaid Services, <http://cms.hhs.gov/hifa/default.asp>
- *Medicaid Survival Kit*, NCSL, <http://www.ncsl.org/programs/health/medkit.htm>

Idea VI-6. Provide a subsidy for small employers to purchase insurance in the small group market.

Rationale: Employer-based insurance is the cornerstone of health coverage in this country. Most non-elderly Americans obtain health insurance through their employment (although this number is dropping). But not all employers offer coverage and many low-wage earners are unable to afford their portion of the premiums for employer-sponsored health insurance. The working uninsured and their dependents make up the vast majority of the 41 million people without health insurance in this country. Small businesses are the least likely to offer coverage for several reasons:

1. Many small businesses operate on a thin profit margin and cannot afford to purchase coverage for their workers.
2. Insuring a small group entails higher administrative and marketing costs.
3. Premiums are volatile because they are based on medical underwriting.
4. Small business owners are hesitant to make a commitment to employees that they may not be able to sustain over time or to offer coverage to employees who may leave after a few months.
5. Insurers often do not market to small businesses because they view them as too risky.

A number of states are experimenting with ways to make health insurance more affordable and accessible to employers and workers. Some states use tax incentives (a credit or deduction) to offset the cost of health insurance for small employers. Presently, about 13 states have tax incentive packages for those in the individual health insurance market, and three states have incentives specifically for small employers.

Some counties and localities also are involved in initiatives to expand health coverage to uninsured working people by subsidizing employer-sponsored health insurance. State lawmakers can assess their state's local initiatives and determine if there is a role for the state in enabling other communities to replicate successful local programs.

States can also use the flexibility under the federally matched Medicaid and State Children's Health Insurance Programs to create employer premium assistance programs. These programs allow states to subsidize employer-sponsored coverage for low-income workers and their family members. The federal government, employers and employees each pay a portion of the costs.

Counter Arguments: Research indicates that to be effective, the tax incentive must equal a large percentage (at least 70 percent) of the cost of health insurance. A significant tax incentive or expanding an existing public program to subsidize employer-sponsored insurance may be difficult in tight budget times. Implementing a program to subsidize employer-sponsored insurance with Medicaid or SCHIP money requires a waiver, will result in initial increases in administrative costs, and may be administratively burdensome.

Resources for further information:

- State Coverage Initiatives, <http://www.statecoverage.net>
- "The Health Insurance Flexibility and Accountability Waiver Initiative," NCSL, <http://www.ncsl.org/programs/health/hifa.htm>
- The Commonwealth Fund, <http://www.cmwf.org>

VII. Medical Errors and Medical Malpractice Ideas

Idea VII-1. Cap non-economic damages.

Rationale: Awards for non-economic damages (e.g., punitive damages, pain and suffering, etc.) are dependent on a number of factors including the views of individual juries, the persuasiveness of competing lawyers, and the degree to which a state's judiciary can control these awards. Insurance companies cannot reliably predict such awards and usually charge larger premiums to cover liability insurance. Capping non-economic damages has been a key element of tort reform in a number of states including California and Colorado. In contrast, economic damages can be reasonably well measured and are statistically predicable with large enough insured populations. Insurance companies can deal with statistically predictable risks.

Counter Arguments: The American Trial Lawyers Association notes that placing caps on non-economic damages is ineffective in holding down premiums and unfairly penalizes malpractice victims. A study released in 2002 and commissioned by the Center for Justice and Democracy and the California-based Foundation for Taxpayer and Consumer Rights compared national

malpractice premiums with those in California. The study found that the average 2000 premium per doctor in California was only 8.2 percent below that of the nation. Additionally, other factors, such as the insurance industry's losses after the September 11 terrorist attacks, may also be part of the reason why liability insurance rates are increasing.

Resources for further information:

- American Medical Association: Medical Liability Reform page, <http://www.ama-assn.org/ama/pub/category/7861.html>
- Association of Trial Lawyers of America: <http://www.atla.org>

Idea VII-2. Establish a pre-trial screening panel to weed out frivolous lawsuits.

Rationale: A pre-trial screening panel may reduce the number of cases where the claim is not well founded, but the lawsuit is begun in the hope of settling it for less than the cost of fighting the suit. Pre-trial hearings or similar approaches are elements of solutions in those states that have been successful in their tort reform efforts, including California. About half the states have some version of pre-trial screenings.

Counter Argument: Such a panel's constitutionality is usually challenged, but it has been routinely upheld, except in Wyoming.

Resources for further information:

- NCSL's medical malpractice Web page: <http://www.ncsl.org/programs/insur/medmal.htm>
- American Medical Association: Medical Liability Reform page, <http://www.ama-assn.org/ama/pub/category/7861.html>
- Association of Trial Lawyers of America: <http://www.atla.org>

Idea VII-3. Implement an "English rule" under which the loser pays the winner's attorney fees.

Rationale: Imposing attorney fee payments would pose a financial risk for bringing a suit that is not well founded, and pose a financial risk to a defendant for not settling a well-founded case.. Most if not all courts in this country have a rule that allows the judge to impose legal fees and costs on a losing party, but it is rarely used.

Counter Argument: This would likely be opposed by most lawyers because it would greatly reduce litigation. Additionally, individuals may be reluctant to press forward with a case out of concern that they may be held liable for sizeable attorney fees.

Resources for further information:

- NCSL's medical malpractice Web page: <http://www.ncsl.org/programs/insur/medmal.htm>

- American Medical Association: Medical Liability Reform page, <http://www.ama-assn.org/ama/pub/category/7861.html>
- Association of Trial Lawyers of America: <http://www.atla.org>

Idea VII-4. Create a Medical Errors Commission to systematically identify medical errors, their causes, and how to prevent them.

Rationale: Fear of the tort liability system is a barrier to health care providers being forthcoming about errors. Also, a large portion of awards often goes toward attorney fees and not to compensate the plaintiff. The state may be able to replace the tort liability system with a medical errors commission that investigates errors in the same way the National Transportation Safety Board investigates airplane accidents. The commission would compensate people injured by negligence (or gross negligence) on a compensation schedule similar to the one used in workers' compensation. The system would allow appeals to the courts, but would not allow trials de novo. The state would compensate the attorneys on a fee schedule rather than using a contingency fee system.

Nevada passed legislation in 2003 to require that all hospitals report "sentinel events" to an institutional safety officer within 24 hours of an occurrence. A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, including any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function. The patient officer is responsible for reporting the incident to the state health division. The division retains the data within a repository for health care quality assurance. Each hospital is responsible for having an institutional patient safety plan.

Counter Argument: According to a July 2002 report by the Department of Health and Human Services, the principal obstacle in taking steps to improve health care practices and prevent errors is fear by doctors, hospitals and nurses. They fear that reports on adverse events and efforts to improve care will be subject to discovery in lawsuits. This fear is the reason that, to be fully effective, compensation from the medical errors commission must be an exclusive remedy, prohibiting lawsuits. A medical errors commission may also be dependent on self-reporting by hospitals and physicians. Regardless of certain protections against lawsuits, hospitals, doctors and other providers may not want to be subjected to "bad press" they could receive if they report numerous medical errors.

Resource for further information: [Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System](http://www.hcla.org/html/newslist.htm), Department of Health and Human Services, July, 2002; <http://www.hcla.org/html/newslist.htm>

Idea VII-5. Limit contingency fees.

Rationale: Limiting contingency fees should result in more of the money spent on malpractice liability insurance going to the injured victim. It should also make lawyers less willing to take questionable cases because they will receive less from the final award or settlement. According to a Health and Human Services report released in July 2002, a plaintiff who wins a judgment must pay the lawyer 30 percent to 40 percent of the award and sometimes even more. Lawyers, therefore, have an interest in finding the most attractive case. According to the report, 72 percent

of paid insurance premiums is spent on legal, administrative and related costs, and only 28 percent actually goes to patients.

Counter Argument: Lawyers note that malpractice cases can be expensive to conduct and that the outcomes will not always favor the plaintiff, so restricting fees to a set amount could cause some attorneys to avoid taking these types of cases. The trial lawyers will likely oppose such restrictions.

Resources for further information:

- [Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System](http://www.hcla.org/html/newslist.htm), Department of Health and Human Services, July, 2002; <http://www.hcla.org/html/newslist.htm>
- American Medical Association: Medical Liability Reform page, <http://www.ama-assn.org/ama/pub/category/7861.html>
- Association of Trial Lawyers of America: <http://www.atla.org>

Idea VII-6. Impose a collateral source rule to inform the jury what the victim has already received from other insurance or what other compensation is deducted from the jury award.

Rationale: The collateral source rule prevents a plaintiff from obtaining a double recovery in excess of the actual loss. Double recovery may create incentives for incurring more medical and other dual covered expenses as necessary in order to increase the amount of an eventual award.

Counter Argument: The rule may be viewed as helping those who have harmed another person escape full responsibility for their acts.

Idea VII-7. Impose periodic payments on awards to reduce the up-front costs.

Rationale: Excessive verdicts mean huge insurance payments, which sometimes exceed premium limits. Insurers may not be able to plan and invest accordingly for large lump sum payments. According to the American Medical Association (AMA), periodic payment is important for many reasons. It contributes greatly to market stability by giving insurers a road map to plan for future expenditures over time. Periodic payment also ensures that plaintiffs will have the funds necessary to cover future expenses, which could benefit people who are not able to manage a one-time large sum of money.

Counter Argument: There should be assurances that an insurer or other entity making periodic payments over a period of time do not become insolvent or cannot continue making payments for other reasons.

Resources for further information:

- American Medical Association: Medical Liability Reform page, <http://www.ama-assn.org/ama/pub/category/7861.html>
- Association of Trial Lawyers of America: <http://www.atla.org>

VIII. Preventive and Public Health Ideas

One important, but often overlooked, cost containment strategy is to focus on the preventable causes of illness, disability and premature death. After all, if people don't get sick, there is no need to worry about the cost of their care. Many of the factors contributing to fatal conditions are behavior-related and preventable. One-third of all deaths in the U.S. are related to tobacco use or poor diet (over-eating) and lack of exercise. Most of the leading causes of death result from expensive chronic conditions such as heart disease, stroke, chronic lower respiratory diseases and diabetes.

Several health promotion activities offer substantial promise for reducing morbidity, premature mortality rates and overall health care system cost. These activities include discouraging tobacco use and dealing with obesity by encouraging good eating habits and regular physical activity. Smoking is a leading risk factor for heart disease, stroke, respiratory diseases and certain cancers (e.g., lung and mouth cancer), while obesity is directly associated with an increased risk of heart disease and diabetes.

Public health actions successfully made good health available to everyone, regardless of social status, race or income. The public health system benefits everyone; it prioritizes the health of communities over individual or business interests. Legislators play an important role in protecting the public's health by virtue of the laws, regulations and ordinances they create and the funds they appropriate.

Idea VIII-1. Transform some of the preventive mandates on health insurance to a free public health benefit.

Rationale: If the government would fund some of the key preventive screening and health services for the general population, health insurance plans would not have to cover them, thus saving costs for private insurance. A 2001 study in the *Journal of Preventive Medicine* ranked clinical preventive services such as childhood vaccinations, cervical cancer screening and screening for hypertension as holding the highest scores for being cost effective. These steps should reduce health insurance costs by the amount the mandates cost and should reach the unemployed and people who get health coverage through ERISA-exempt plans (under the federal Employee Retirement and Income Security Act). If proper administrative mechanisms are in place, the total administrative costs in the system should be reduced.

Counter Argument: No current funding mechanism exists to pay for this sort of program. Policymakers have suggested paying for public health by increasing tobacco taxes, requiring an employer contribution equal to the amount already contributed to pay for the preventive services portion of employee health plans, and by tax credits. This will also cost the state money, however, limiting the ability of states with deficits to undertake it.

Resource for further information: *American Journal of Preventive Medicine*, 21, no.1, July 2001.

Idea VIII-2. Institute a Public Health Nurse infant home visitation program.

Rationale: Nurse home visitation programs sponsor nurses to visit new parents and their babies to provide services such as infant care education, health services, linkages to community

resources, and emotional support. Programs also serve pregnant women and families with young children-usually from birth up to age 2 or 3. These programs are often focused on first-time, low-income mothers. As many as 550,000 children nationwide currently participate in nurse home visitation programs.

The programs work to improve the health status of newborns, child health and development, and family self-sufficiency. Nurse home visiting programs reduce incidences of child abuse, delinquency and maternal substance abuse. The children served by these programs are less likely to smoke, use illegal drugs and exhibit anti-social behavior during adolescence.

Programs are usually funded by public and private sources, including Medicaid, the Maternal and Child Health Services block grant, and Temporary Assistance to Needy Families (TANF). Nurse home visiting programs range in cost from \$300 per family to more than \$3,000, depending on nurses' salaries and the level and frequency of services. However, several studies show that the cost is recuperated through reduction in welfare payments and food stamps, unintended subsequent pregnancies, the need to involve child protective services and other cost savings. The programs that are most successful are comprehensive and intensive, have clear target populations, and are tailored to meet families' specific needs.

Counter Arguments: Research and evaluation are critical to ensuring cost-effectiveness and quality of the programs. Reduction in rates of smoking and substance abuse has been proven to occur only with young, poor and unmarried mothers-not with the larger population. For married, middle class mothers there was no significant improvement. The cost of nurse home visitation programs is also significant, with some estimates exceeding \$3,000 per family per year. It may be difficult to obtain sustained funding to support such programs in light of limited resources to meet competing and increasing health needs.

Resources for further information:

- American Academy of Pediatrics Policy Statement, "The role of home-visitation programs in improving health outcomes for children and families," <http://www.aap.org/policy/re9734.html>.
- Eckenrode, J., Ganzel, B., Henderson, C.R., Smith, E., Olds, D., et al. "Preventing child abuse and neglect with a program of nurse home visitation: the limiting effects of domestic violence." *Journal of the American Medical Association*, 2000, 284:1385-1391.
- Olds D., Henderson, C.R. Jr., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., Pettitt, L., Sidora, K., Morris, P., & Powers, J. "Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized trial." *Journal of the American Medical Association*, 1998; 280(14);1238-1244.
- Wilkins, Andrea, & Dwight, Lucy. "Programs That Serve Children in Low-Income Families," NCSL. November 2002; <http://www.ncsl.org/statefed/WELFARE/programsforchildren.pdf>

Idea VIII-3. Raise the state's tobacco and/or alcohol tax.

Rationale: According to the Centers for Disease Control and Prevention, about 48 million

American adults smoke cigarettes. Each day, approximately 5,000 young people try a cigarette for the first time. Annually, tobacco use costs more than \$75 billion in medical expenditures and \$80 billion in lost productivity. Raising the tax reduces smoking, especially among the young. Cigarette consumption drops when prices go up, which is good for the health of a state's population. Adolescents and young adults are more responsive than adults to cigarette price changes. Increasing cigarette excise taxes can prevent adolescents from starting to smoke and encourages cessation for all smokers. People who receive their health insurance coverage through Medicaid have approximately 50 percent greater smoking prevalence than the overall U.S. population.

Counter Argument: A cigarette tax singles out one group to pay for programs that may not benefit them. Increasing cigarette excise taxes is seen as an unfair tax policy that targets particular segments of the population. If people quit smoking due to higher cigarette prices, there may be more demand for cessation services. In addition, higher prices in one state may result in smuggling from nearby states. The large disparities in price resulting from differences in tobacco taxation create incentives to smuggle small quantities for personal use, to an organized level involving large quantities, generally for resale.

Resource for further information:

- *Reducing Tobacco Use: A Report of the Surgeon General*, page 341, 2000, http://www.cdc.gov/tobacco/sgr_tobacco_use.htm

Idea VIII-4. Institute a cooperative, multi-state effort to stop Internet tobacco sales.

Rationale: Both federal and state governments are addressing this issue. Congressman Martin Meehan (D-MA) and James Hansen (R-UT) have introduced legislation to crack down on both Internet tobacco sales to kids and tax evasion. H.R. 5724 would protect and require Internet retailers to verify the age of their customers using government issued identification checked against related databases. It also would require signature and age verification upon delivery. The bill would fight tax evasion by requiring Internet retailers to register with the states where they sell their products and comply with all related state laws regarding state tobacco tax collection and reporting. It would give state officials the right in federal courts to seek enforcement of Internet retailer's compliance with both the tax collection and youth access provisions of the bill and to obtain unpaid state taxes.

While states have been unable to address the problem as comprehensively as federal legislation could, some states are taking action on their own to make Internet sellers of tobacco products act more responsibly. New York has [prohibited all Internet and mail order cigarette sales](#) into the state, and the U.S. Court of Appeals has [rejected legal challenges by cigarette companies](#) to the state's Internet sales ban. For example, there are laws addressing youth access in [Rhode Island](#) and [California](#), a new law to [collect taxes on Internet tobacco product sales](#) in California, and new legislation to address both youth access and taxation problems on the Internet in [New Jersey](#).

Counter Argument: It is difficult and may be costly to police these sales to avoid sales to minors and the sales often evade state tobacco taxes.

Resources for further information:

- U.S. General Accounting Office, [*Internet Cigarette Sales: Giving ATF Investigative Authority May Improve Reporting and Enforcement*](#), GAO-02-743, August 9, 2002.
- Tobacco Law Center, Minnesota Department of Health, "[Smoke on the Web: Can Children Buy Cigarettes Online?](#) Enforcement Options, Challenges and Recommendations," March 2002.
- Rubin, R. et al., [Online Tobacco Sales Grow, States Lose](#), Forrester Research, Inc., April 27, 2001.

Idea VIII-5. Allow modest discounts (5 percent to 15 percent) for staying healthy in both individual and small group markets.

Rationale: An unregulated market sets much higher discounts than this for people in good health and for healthy behavior. Smokers and obese individuals may find insurance premiums unaffordable or unavailable. In the individual market, people who actually use their policies to cover health care may face sudden rate hikes as a result of insurance company underwriting practices. States may seek to strike a balance between making insurance more affordable by limiting most underwriting (varying premiums based on health) and allowing some variation for healthy behavior. Many states that prohibit medical underwriting do permit 15 percent discounts for non-smokers. Similar discounts for other healthy behavior, such as healthy weight maintenance, are also possible.

Another insurance design that may encourage healthy behavior without penalizing people with chronic illnesses or others is a lower priced plan with a high deductible that also pays first dollar for a set amount, such as \$200, for preventive and early primary care services. This is designed to attract younger, healthier people into the insurance pool without creating incentives to skimp on appropriate prevention and early interventions. Some consumer-directed health plans have similar structures.

Counter Argument: Allowing too much of a discount could erode the ability of the insurance pool to subsidize high-end users. Consumer-directed health plans are speculative because there is little experience with them yet.

Resources for further information:

- <http://www.healthinsurecoverage.com> includes estimates of annual costs for smoking and obesity
- <http://www.bera.com/papers/insure.doc> Bibliography on "Cigarette Smoking and the Insurance Industry."

Idea VIII-6. Invest in cancer screening and education.

Rationale: Cancer is one of the leading causes of death in America, claiming the lives of more than half a million people every year. Many cancer deaths could be avoided if more people were screened for cancer. Screening for colorectal, breast and cervical cancers can reduce illness and death through early detection. Yet many adults are not getting regular lifesaving screenings as recommended. In 2002, these three cancers accounted for nearly one fifth of all U.S. cancer

deaths and more than \$60 billion for direct medical costs. Early detection could substantially reduce the billions of dollars spent on cancer treatment each year. Not only does cancer screening save lives by detecting breast, cervical and colorectal cancers early; it also is the first step in preventing many cases of colorectal and cervical cancers from ever developing.

Policymakers may address cancer prevention by supporting public education about cancer prevention and by promoting screening. States can support education and screening programs for uninsured or underinsured people, monitor their Medicaid and other public programs to ensure that proper education and screenings are done, and require health insurance plans to cover screening services. In addition, policymakers should support cancer registries to track and identify cancer patterns among various populations and determine whether prevention measures and screening make a difference.

Counter Arguments: Health insurance mandates may drive up the cost of health insurance premiums, making it more difficult for small businesses to afford health insurance for their employees. Mandates will be only partially effective because of the portion of the population covered by ERISA-exempt plans, which may not be regulated by states. Such screenings may be more effective if the state makes them available for free, or at reduced cost, as a public benefit. In addition, many cancers can be caused by personal behaviors, such as smoking or obesity, and people should take more responsibility for their own health.

Resources for further information:

- NCSL's cancer prevention Web page:
<http://www.ncsl.org/programs/health/cancerweb.htm>
- Centers for Disease Control and Prevention. *The Promise of Prevention. Reducing the Health and Economic Burden of Chronic Disease*. Atlanta: Department of Health and Human Services, Centers for Disease Control and Prevention, February 2003.
- Health Insurance Association of America. *Issue Brief: Why Do Health Insurance Premiums Rise*. Washington, D.C.: September 2002.

Idea VIII-7. Continue to Promote Childhood Immunizations.

Rationale: Vaccinations rank among the top 10 public health achievements of the 20th century, and are a cost-saving investment. Vaccine-preventable diseases are at an all-time low due to the success of state immunization programs, including their use and enforcement of immunization requirements to ensure high coverage. Immunization laws have been very successful and it is critical to maintain high immunization coverage in school, childcare, college and institutional settings. Requiring insurance coverage of childhood immunizations remains cost effective and is good preventive medicine. Insurance mandates can help lighten the financial burden on parents and ensure satisfactory immunization rates. They also help public health clinics that sometimes provide immunizations for the underinsured. At least 28 states and the District of Columbia now have legislation mandating insurer coverage of immunization. Some states have made free or reduced cost immunizations available as a public health measure.

Counter Arguments: A vocal minority of people oppose laws that require immunization, pointing to individual rights and fear of vaccine-caused complications. In addition, mandates can

be seen as a source of health care cost inflation. Rather than passing the costs to parents, costs shift to private insurance companies that later cover them by increasing premiums and limiting other benefits. Mandates will be only partially effective because of the portion of the population covered by ERISA-exempt plans, which may not be regulated by states.

Resource for further information: NCSL's immunization Web page:
<http://www.ncsl.org/programs/health/immuni2.htm>

Idea VIII-8. Promote Adult Influenza Immunizations.

Rationale: Influenza, otherwise referred to as "the flu," accounts for more than 20,000 deaths and 114,000 hospitalizations each year in the United States. More than 90 percent of these deaths and approximately 48,000 of the hospitalizations occur among people age 65 or older. The Centers for Disease Control and Prevention (CDC) recommends influenza vaccine for anyone age 50 or older, people in nursing homes or chronic care facilities, anyone with certain chronic health conditions, pregnant women in their second or third trimester, health care workers, individuals with HIV/AIDS, people who are taking medicine that weakens the immune system, children receiving long-term aspirin therapy, and any household contacts with people at risk of developing infection.

Vaccinations can reduce both health-care costs and productivity losses associated with illness. Studies of influenza vaccination have reported overall societal cost savings, substantial reductions in hospitalization and death, a reduction in both direct medical costs and indirect costs from work absenteeism, reductions in physician visits, lost workdays, and antibiotic use for influenza-associated illnesses.

Resources for further information:

- NCSL's immunization Web page: www.ncsl.org/programs/health/immuni2
- National Immunization Program, (CDC): www.cdc.gov/nip/

Idea VIII-9. Require daily physical education for grades K-12 with a minimum of 30 minutes of moderate activity.

Rationale: Regular physical activity in childhood and adolescence improves strength and endurance, helps build healthy bones and muscles, helps control weight, reduces anxiety and stress, increases self-esteem, and may improve blood pressure and cholesterol levels. Recent research indicates that daily physical activity, whether in the form of physical education or recess, can improve academic performance. However, only 8 percent of elementary schools, 6.4 percent of middle/junior high schools, and 5.8 percent of senior high schools provide daily physical education (150 minutes per week for elementary schools; 225 minutes per week for middle/junior and senior high schools). A new genre of physical education has been developing over the last decade that promotes activities and sports that students enjoy and can pursue throughout their lives, such as walking, rock climbing, aerobics, bicycling and cross country skiing.

Counter Arguments: Budget cuts are challenging mandated physical education and turning it into an optional class in many school districts. State academic tests are also causing states to

reduce the availability of physical education since physical education skills are not included on these exams. There is no federal standard or education mandate for physical education; therefore, state and local boards of education are free to decide on the extent and intensity of the physical education curriculum and standards in schools. Great variation exists among state physical education requirements and allowable exemptions. Some states leave this kind of requirement to the discretion of the local school boards.

Resource for further information: "Physical Education among Children and Adolescents," Health Policy Tracking Service, NCSL, forthcoming in Summer 2003.

Idea VIII-10. Require vending machines in schools to offer healthy foods and beverages or ban the sale of unhealthy foods.

Rationale: Schools across the country are supplementing their budgets by selling foods and beverages to students from vending machines. Profits help fund extracurricular activities, computers, software, and academic and sports programs. A majority of the foods and beverages offered in vending machines are high in fat, sugar and sodium. Many public health groups believe that school vending machines are contributing to the epidemic of childhood obesity. The U.S. Department of Agriculture requires schools that receive funding from the National School Lunch Program to make vending machines located in school cafeterias inaccessible during food service hours. This restriction does not apply to machines and snack bars located outside of the cafeteria. Therefore, some students have access to unhealthy foods and beverages throughout the school day. States are looking at three options to reduce the amount unhealthy foods that students consume during the school day: 1) banning vending machines from schools altogether; 2) developing nutrition standards for foods served in school vending machines that result in banning the sale of soft drinks, candy and high-fat baked goods; and 3) requiring an equal number of healthy snacks to be served in vending machines, with prices competitive with or cheaper than the unhealthy snacks.

Counter Argument: Vending machines and snack bars are not the sole source of unhealthy foods in schools and the removal of such machines will not solve the obesity epidemic alone. Many schools also have contracts with fast food vendors and offer those foods in addition to those under the National School Lunch Program. Additionally, student sales and teacher rewards for good academic performance also present the opportunity for students to eat unhealthy foods at schools. If vending machines are banned in schools, states may be called upon to make up for the lost revenue. The food industry believes that the key to reducing obesity is to encourage school kids to be more physically active, indicating that all foods in moderation have a place in a healthy diet. In addition, stronger nutrition education rather than banning vending machines may help students make healthier food choices at school.

Resource for further information: "Nutrition and Obesity," Health Policy Tracking Service, NCSL, April 2003.

Idea VIII-11. Ban cigarette smoking in all public places.

Rationale: Public health organizations world-wide have published research indicating the hazards of second hand smoke, including cancer, heart disease, emphysema and asthma. An estimated \$157 billion a year, including direct and indirect costs, is attributed to smoking. As

states struggle to curb Medicaid costs, it is important to note that about 14 percent of all Medicaid expenditures are related to smoking. Using research on secondhand smoke, California, Connecticut, Delaware, Florida and New York have successfully banned smoking in public places including restaurants.

Counter Argument: Legislators who oppose smoking bans believe that they are an infringement upon both smoker and restaurant owner rights. Restaurant owners should have a choice in deciding whether or not to ban smoking or to have an establishment that caters to the smoking public. Many restaurant owners have spent money to install ventilation systems due to city or state legislation requiring non-smoking sections.

Resource for further information: "Public Place Smoking," Health Policy Tracking Service, NCSL, April 2003.

Idea VIII-12. Invest in oral health.

Rationale: Tooth decay is the leading chronic disease in children ages 5 to 17. It is largely preventable through fluoridation of water, fluoride treatments, dental sealants and regular preventive screenings. About half of all cavities go untreated among low-income children. Untreated cavities cause pain, weight loss, school absenteeism and can result in costly complications. State policymakers can support fluoride programs, ensure that children in their state Medicaid and SCHIP programs obtain regular dental care, and support preventive oral health services for other low-income residents. States can work with their state dental associations to encourage more dentists to participate in publicly funded programs. They also can expand the scope of practice for dental hygienists to allow them to conduct more oral health education and screening activities.

Counter Arguments: Legislators may hear from groups who oppose fluoridation of public water supplies because they claim that water fluoridation may cause health problems. Also, attracting more dentists to public programs may cost states additional money. Expanding the scope of practice for dental hygienists may meet resistance from the dentists.

Resources for further information:

- NCSL's oral health Web page: <http://www.ncsl.org/programs/health/oralhea.htm>
- CDC's oral health Web page: <http://www.cdc.gov/oralhealth>
- American Dental Association, 312/440-2500, <http://www.ada.org>
- American Dental Hygiene Association, 312/440-8900, <http://www.adha.org>

Idea VIII-13. Invest in prenatal care.

Rationale: Preventing premature babies is a proven cost-savings investment. Certain women are at greater risk of having premature babies, which raises costs substantially. According to the Institute for Medicine, every dollar spent on prenatal care for high-risk women saves \$3 in medical costs for sick newborns. Every low birthweight delivery that is prevented saves between \$14,000 and \$30,000 per child in long-term health care costs. A 1999 study published in *Obstetrics and Gynecology* by Nicholson, et al. found that nationwide, pre-term deliveries cost

an estimated \$460 million more than term deliveries annually. Costs associated with uninsured babies who need intensive care are picked up by taxpayers, charity or the insured population through higher insurance premiums. In 2001, 7.7 percent of infants were born low birthweight, an increase from 7.6 percent in 2000. The low birthweight rate has increased slowly but steadily since 1984, and the 2001 rate is the highest in 30 years.

The number of women receiving early prenatal care has risen over the past few decades, exceeding 83 percent in 2000. Prenatal care as a preventive measure has many benefits, such as access to early screening, monitoring for potential complications, and education to reduce unhealthy behaviors. These benefits can reduce the risk of pregnancy complications, premature delivery, low birthweight babies, and infant mortality, all of which can improve maternal and infant health and help to lower costs.

Counter Arguments: Conducting outreach and educating families about the importance of prenatal care requires a financial investment, which may be difficult to secure in tough budget times. Although providing prenatal care is cost-efficient, it still requires funding for services, providers and education.

Resources for further information:

- NCSL's *Medicaid Survival Kit* chapter on Mothers and Children: <http://www.ncsl.org/programs/health/medkit.htm>
- March of Dimes: <http://www.marchofdimes.com>
- Healthy People 2010: http://www.healthypeople.gov/Document/HTML/Volume2/16MICH.htm#_Toc494699663
- American Academy of Pediatrics: www.aap.org
- American College of Obstetricians and Gynecologists: www.acog.org

IX. Medicaid Ideas

(Note: see also items under Prescription Drugs and Cost Shifting in previous sections.)

Medicaid serves about 40 million low-income Americans, including welfare-related families, children, pregnant women, and certain low-income elderly and people with significant disabilities. Medicaid accounts for 20 percent of the average state's budget, funds almost half of nursing home services and about 17 percent of all prescription drugs and hospital services throughout the nation.

Idea IX-1. Reduce the use of emergency room visits for non-emergency care.

Rationale: Health care delivered in an emergency room (ER) setting is more expensive than primary care clinic or doctor's office. State Medicaid programs strapped for funds are exploring avenues to reduce the number of unnecessary ER visits for Medicaid beneficiaries. Contributing to this problem is the inadequate number of primary care clinics and doctors willing to treat additional Medicaid clients. A beneficiary without a primary care doctor may go to the ER for

primary and preventive services or may delay needed care until it becomes urgent. This compounds the national problem of overflowing emergency rooms.

Arkansas' Medicaid program reduced the number of non-emergency care visits by Medicaid clients to the ER by increasing the number of providers participating in Medicaid and instituting a primary care case management program. The state recruited and retained more providers by installing an electronic eligibility and claims processing system, which reduced paperwork and guaranteed speedy reimbursement. This system transformed the way Arkansas's physicians view the Medicaid program. It helped beneficiaries to become valued customers of the medical community. The case management program helped prevent costly emergency room visits through management of the patient at the time of the emergency and improved access and communication between patients and their primary care physicians.

The Medicaid program in Washington allows hospitals to levy a small co-payment (\$3) for certain clients who visit hospital ERs for routine, non-emergency treatment in an effort to change the behavior of clients.

Counter Arguments: Creating an electronic payment system would require administrative start-up costs. However, the federal government will provide 90 percent of the initial costs for converting to an electronic billing and eligibility determination system.

Resource for further information: Arkansas Medicaid Web site
<http://www.medicaid.state.ar.us/>

Idea IX-2. Explore the use of waivers to increase state flexibility.

Rationale: The Bush administration is receptive to waivers allowing state experimentation provided they are cost neutral for the federal government. "Section 1115" waivers allow states to customize and redesign their Medicaid programs to meet state specific goals for health insurance coverage. With a waiver, a state can expand coverage to uninsured adults financed in part by a sliding scale premium. Waivers also allow states to implement cost-sharing programs, customize benefits or change the service delivery mechanism. For example, an 1115 waiver allows Utah to cover some uninsured adults (who were previously not covered by Medicaid) with a limited benefit package (primary and preventive care only) financed in part by reducing benefits to other Medicaid-covered populations and by requiring significant cost sharing.

Counter Arguments: 1115 waivers are not necessarily considered a cost-containment strategy and they generally cost the state money because they usually involve expanding coverage to new populations. Also, expansion and modification of programs that rely on matching state general funds are prone to cutbacks as states experience economic problems. This, in turn, can create instability for people covered by the state's Medicaid health care system when eligibility, benefit packages and other components change.

Resource for further information: NCSL's Medicaid Web page,
<http://www.ncsl.org/programs/health/medicaid.htm>

Idea IX-3. Allocate a small percentage of the Medicaid budget to cost control efforts.

Rationale: Requiring a state Medicaid agency to submit a plan with specific, quantifiable

milestones and cost saving efforts, including some that should show prompt results, can help constrain Medicaid spending. A legislative committee can review and approve the plan and monitor results. For example, Wyoming did this with a subcommittee that included the House and Senate chairs of the health committees and one of the two chairs of the joint appropriations committee to demonstrate that the Legislature took the effort seriously. The committee rejected the first attempt at a plan due to lack of quantifiable milestones showing measurable progress in the first year, but accepted the next one after the agency corrected its plan.

Counter Arguments: Some states have hired consulting groups to conduct studies on cost-containment measures, such as Washington's recent series of Lewin reports. However, contracting with outside sources may be expensive. In addition, almost any proposed cost containment measures will be opposed by special interest groups that represent providers or industries that receive Medicaid funding.

Idea IX-4. Consider cost containment strategies for the Medicaid pharmacy benefit.

Rationale: Although prescription drugs account for only about 10 percent of Medicaid spending, costs are growing at a fast clip. Prescription drug costs rose at an annual rate of 19.7 percent between 1998 and 2000, compared with 8 percent for other services. States are considering or have enacted a variety of changes in their Medicaid programs to respond to the challenges arising from increased demand for and higher costs of prescription drugs. Recent state legislation related to Medicaid prescription drugs generally is designed around new or expanded applications of management tools already available to states through federal law. Among the strategies receiving legislative attention are use of:

- Preferred drug lists or formularies
- Generic substitution
- Cost-sharing or copayments
- Multi-state purchasing
- Prior authorization
- Drug utilization review
- Dispensing fees
- Ingredient fees
- Supplemental rebates from manufacturer

Many legislative initiatives address several Medicaid policy areas simultaneously. Several laws focus on altering the mix of drugs prescribed, either through broadened generic substitution or through creation of preferred drug lists and the use of prior authorization.

Counter Arguments: Overly restrictive limits that curtail access to necessary drugs can backfire if a patient's condition worsens and requires more expensive care. Additionally, patients' advocates, medical providers and pharmaceutical manufacturers may oppose programs and

actions that restrict access to certain drugs or that significantly reduce spending.

Resource for further information: NCSL, <http://www.ncsl.org/programs/health/medicaidrx.htm>

Idea IX-5. Maximize federal funding for services that are reimbursable through Medicaid.

Rationale: Some states may be providing services with state funds that could be reimbursable through Medicaid. By identifying those services and shifting them to Medicaid the state can draw down at least 50 percent federal funding for these services. Services that states may already provide that could be billed to Medicaid include certain services for foster care children, case management, maternal and child health clinic services, home visitation, family planning clinics, services for children with developmental disabilities, school-based health services, mental health services and substance abuse services.

Counter Arguments: This strategy will involve administrative time and resource commitments to identify services and realign them with Medicaid. The result will also expand the size and scope of the Medicaid program. Additionally, Medicaid normally requires adherence to regulations and reporting that would be required of new programs and services funded by Medicaid.

Resource for further information: *Managing Medicaid Costs: A Legislator's Tool Kit*, NCSL, <http://www.ncsl.org/programs/health/forum/cost/containment.htm>

Idea IX-6. Enhance the federal contribution to a state's Medicaid program.

Rationale: A state can maximize federal funding with intergovernmental transfers, disproportionate share hospital payments and provider taxes, assessments and voluntary contributions.

Counter Arguments: Although these financing arrangements are permitted by law, the federal government has placed some restrictions on how states can use them to maximize federal matching payments, and are starting to phase-out some of these programs. The cost of administering intergovernmental transfers may be more than the additional revenue.

Resource for further information: *Managing Medicaid Costs: A Legislator's Tool Kit*, NCSL, <http://www.ncsl.org/programs/health/forum/cost/containment.htm>

IX-7. Implement care management strategies.

Rationale: Health costs for the relatively small number of very ill patients account for a major share of Medicaid spending. In an effort to reduce the costs for these clients and avert medical complications or an escalation of symptoms for those with chronic diseases, states are experimenting with care management strategies. States are using case management, care coordination and disease management to improve services and health results for clients as well as to achieve cost savings. These strategies involve targeting certain high-risk populations with complex needs (such as children with special needs) or with specific diseases (such as diabetes) for interventions such as coordinating treatment and communication among specialists or basing treatment for individuals with chronic, treatable illnesses on focused, proven interventions. States are beginning to contract with private companies for these services.

Counter Argument: Although such strategies make sense for improving patient care, the jury is still out on whether they actually save money for Medicaid programs, especially in the short term.

Resource for further information: *Managing Medicaid Costs: A Legislator's Tool Kit*, NCSL, <http://www.ncsl.org/programs/health/forum/cost/containment.htm>

Idea IX-8. Re-balance the state's long-term care system by developing and expanding home and community-based services.

Rationale: States spend at least one-third of their Medicaid budgets on long-term care for the elderly and people with disabilities, with the lion's share going to institutional settings. States are increasing their home and community-based services (mainly through waiver programs), in an effort to respond to consumer demand, meet legal obligations under the Americans with Disabilities Act (ADA) and the U.S. Supreme Court *Olmstead vs. L.C.* decision, and possibly save money in the process. The new "Independence Plus" Medicaid waivers and other opportunities for federal grant assistance have encouraged states to transfer more people out of nursing homes or Intermediate Care Facilities for People with Mental Retardation (ICF/MR). States with highly developed community-based systems claim to have achieved cost savings and improved quality of life. While services to many individuals may cost less in the community, the aggregate costs of community-based waiver services cannot exceed the costs of institutional services.

Counter Arguments: In the early 1990s, the research clearly stated that community-based services cost less than institutional care. In many individual cases, that is the case, but researchers are now looking more broadly and the fiscal comparisons are not as clear cut. Some policymakers claim that expanding home and community-based services will result in the "woodwork effect," attracting many individuals who have refused to go to an institution, but who will seek services in the community if they are offered under a waiver program. The final verdict is still out. States should look at their long-term care systems to evaluate opportunities for cost savings. If a state has very limited community-based services, re-balancing the system may be an appropriate, necessary and possibly a cost saving measure.

Resources for further information:

- NCSL's Web site about home and community-based services and the *Olmstead* decision: <http://www.ncsl.org/programs/health/olmstead-home.htm>
- "Frequently Asked Questions On Long-Term Care," NCSL, <http://www.ncsl.org/programs/health/forum/faqltc.htm>

Idea IX-9. Reduce reimbursement rates for acute-care providers.

Rationale: Small cuts may not threaten the integrity of the provider system. Both providers and clients should be considered for reductions to ensure the program remains financially viable. Other relief (medical liability reform) may reduce providers' costs.

Counter Arguments: Even small cuts may increase the numbers of providers leaving the system, jeopardizing access and the health status of clients. Clients may put off seeing a doctor and

become sicker before receiving care, including emergency care, if they cannot see primary providers on a timely basis. Cuts could adversely affect providers with high Medicaid client populations, and could provide geographic gaps in services. As mentioned previously, provider cuts may also shift costs to the private sector, causing additional increases in insurance premiums.

Idea IX-10. Reduce income eligibility levels for optional populations such as SCHIP, pregnant women, medically needy and nursing home recipients.

Rationale: Reducing eligibility under Medicaid and the State Children's Health Insurance Program would focus limited resources on people with the least financial resources, while helping the state in tough financial times.

Counter Arguments: Eliminating eligibility for existing clients at risk of health care and financial instability would hurt people and shift the costs elsewhere, either to providers, other state or local programs, or the private sector. Displaced clients may not be eligible at any price for other coverage.

Idea IX-11. Reduce the length of time for continuous eligibility in SCHIP and Medicaid (or postpone scheduled increases in the length of time for continuous eligibility).

Rationale: Reducing continuous eligibility would avoid a cost increase at a time of financial scarcity. It would not remove currently eligible individuals, but prevent an increase in enrollment from children who would otherwise be leaving the program due to ineligibility.

Counter Arguments: Reducing continuous eligibility would increase the "hassle factor," keeping truly eligible people from maintaining enrollment because of administrative burdens. It would reduce the "medical home" benefits of prevention and consistency in care. Often an eligible individual may let eligibility lapse while they are "well" only to require more expensive services when they re-enroll during an illness. It would also increase administrative costs without medical benefits, and discourage provider participation.

Idea IX-12. Require a waiting period (such as 90 days) between eligibility determination for SCHIP and coverage for services.

Rationale: A waiting period would implement cost control procedures similar to those used in the private sector and provide budget savings without eliminating individual children from enrollment.

Counter Argument: Such waiting periods could discourage enrollment. They could also result in delayed or no treatment, resulting in more expensive needs later on.

Idea IX-13. Reduce the scope of SCHIP benefits for optional services such as dental, behavioral health, chiropractic, allergy and tobacco cessation.

Rationale: Scaling back services would provide savings by restricting services to the federal minimum benefit levels. Some people believe that the less acute services can be more easily abused than acute care and hospitalization.

Counter Arguments: Short-term savings may result in long-term costs, perhaps in more

expensive settings. Others believe there is potential for abuse for hospital reimbursement maximization strategies, and that the less acute services should not be singled out for "abuse."

Idea IX-14. Increase cost sharing for SCHIP (and optional Medicaid) to federal limits.

Rationale: Some states have adopted cost sharing below the permissible federal level. Increasing cost sharing would free up resources while staying within acceptable limits, and would mirror recent cost-sharing increases experienced in the private sector.

Counter Argument: Increasing cost sharing could discourage some patients from seeking treatment, perhaps resulting in more expensive costs later.

Idea IX-15. Raise eligibility standards (functional needs requirements) for community care services.

Rationale: Imposing more restrictions on eligibility standards would ensure that the neediest clients receive services. It would allow savings by removing clients with lesser functional needs while retaining clients of higher income with greater functional needs. Due to Medicaid law, the only other choice is to change the income requirement, which could force some higher need clients into institutional care. The current functional assessment system is subject to abuse because people want to obtain desirable services such as housekeeping, cooking and transportation.

Counter Arguments: Removing higher function clients who have lower incomes may still result in institutional care since these clients have fewer financial resources for their overall care (heating, cooling, safe and clean domicile, etc.). If fraud is a problem with functional assessments, more targeted tools (investigation, worker training, etc.) should be used to identify clients without a medical need for care. Clients for whom care provides stabilization could deteriorate if care is removed.

Idea IX-16. Reduce the personal needs allowance for nursing home residents.

Rationale: Nursing home residents are permitted to retain a portion of income, including Supplemental Security Income (SSI), for personal needs such as toiletries and clothing. Reducing this monthly allotment applies a greater portion of the resident's income to the cost of care before the state and federal government pay the balance. SSI is a 100 percent federal payment. If it was not earned, and it is not retirement income, so it should be used for the cost of nursing home care.

Counter Arguments: Nursing home residents have many personal and social needs not provided by their institution, and families may not be present or may be unable to afford such items. Charitable entities should not be the defacto source for basic items such as clothing. Other residents (e.g., armed forces veterans) are allowed to retain a larger portion of their income.

Idea IX-17. Close state mental health and mental retardation facilities by consolidating the same bed capacity in a smaller number of sites.

Rationale: The total number of beds available statewide would not change, but the per bed cost would decline due to lower fixed costs. The facilities are generally used for stabilization services,

which could be provided despite the longer distances. Closing institutions would reduce long-term investment in institutional settings, ultimately shifting resources to additional community care.

Counter Arguments: There would be longer drives for law enforcement officials who transport mental health patients and for families who visit both mental health and mental retardation patients. Some family members still advocate that a mental retardation facility provides a more appropriate setting with greater freedom and less risk for people with mental retardation than community settings. The economic impact on the community of the closed facilities can be severe in tough economic times.

Idea IX-18. Increase the size of small group facilities for people with mental retardation.

Rationale: If states with three to four-bed facilities increased the number to five or six beds, they could achieve per client savings in fixed costs, without the need for significant additional staffing. It would also provide additional beds for population growth and de-institutionalization.

Counter Arguments: Consumer advocates point out that a home-like setting is the most desirable, and increasing the size of facilities would reverse an important consumer victory. Transitional payments are insufficient and may not be able to bridge the cost of increasing a facility's size when it was designed for three to four-bed capacity. Such a shift may also upset the compromises negotiated with residential neighbors opposed to institutions due to traffic, parking and other concerns.

Idea IX-19. Freeze the number of Medicaid waiver slots (community care).

Rationale: States could freeze the number of clients in community waiver programs by allowing those enrolled in the program to retain their slot, but not filling new slots as they become available. This would provide savings, but retain services to enrolled clients. It would allow those with greatest need (in institutions) to continue to receive services, including housing. Waiver placements are less integral to the safety net provided by the state.

Counter Arguments: Reducing community placements does not comply with the intent of the *Olmstead* Supreme Court decision. It would retain an institutional bias, in lieu of greater emphasis on community care. Waiver slots are by definition "cost neutral" so no real savings should occur. Waivers can result in savings to both state and federal governments, which can be lost if clients move to institutional settings.

Health Committee Menu Page: <http://www.ncsl.org/standcomm/schealth/schealth.htm>

Health Cost Containment Menu Page: <http://www.ncsl.org/programs/health/healthcost.htm>