STATE NEWS

OHIO TO COVER CHILDREN WITH SERIOUS HEALTH CONDITIONS

Anna Wolke

While proposed expansions of its Medicaid program and SCHIP remain in holding patterns, Ohio is taking an incremental step forward toward covering all uninsured children in the state. The state has created a unique health insurance buy-in program, targeting children from middle-class families with serious health conditions that make private coverage unaffordable or unavailable.

Enacted as part of the 2007 budget bill (HB 119), the Children’s Buy-in Program is aimed at children under the age of 19, who are eligible if they meet one of the following criteria:

- they were unable to purchase health insurance due to a preexisting condition;
- they have lost coverage by exceeding their policy’s life-time benefit costs;
- premiums for any available insurance policies are more than twice the cost of the state buy-in program; or
- the child participates in Ohio’s Program for Medically Handicapped Children, which links families with handicapped children to comprehensive care and services.

To be eligible, the families of participating children must earn above 300 percent of the federal poverty level. Premiums will be based on a sliding income scale, and each family will pay from $250 to $500 per month in premiums. Once enrolled, the children’s coverage will be provided by CareSource, a managed-care plan.

Because the program subsidizes premiums for children with income levels well above those for Medicaid or SCHIP, Ohio will use state-only funds to help pay for the program. "We are not aware
of any similar state-funded programs that target a group of children at this income level," said John Corlett, deputy director of Ohio Medicaid.

Many states have sought to expand coverage to uninsured children but have approached this goal in different ways. Pennsylvania, Illinois, Tennessee, Wisconsin, and Washington all have implemented buy-in programs with similarities to Ohio’s program.

"About 5.4 percent of children in Ohio were uninsured in 2004, and of all the uninsured kids, approximately 1 in 5 had special health care needs," said Maureen Corcoran, Medicaid assistant deputy, citing a 2004 Ohio Family Health Survey.

Ohio officials estimate that a total of 5,000 children will enroll, costing the state an estimated $10 million over the next 15 years.

**SCHIP Controversy**

The decision to create a buy-in program targeting this specific subset of children was made after lawmakers held several hearings on the issue of children’s health coverage. Legislators noticed a pattern in the testimony of parents with uninsured children. "The testimony revealed that many children who were uninsured had faced serious medical conditions and found available coverage to be unaffordable," said Corlett. "The legislature then made the decision to focus a coverage program more narrowly to include children with extraordinary health problems."

He also noted, "So far, we have had to deny most of the applications we have received for the buy-in program, because the families' incomes were too low. Right now, there is a gap in (coverage) eligibility for these kids."

This gap might be filled if Ohio succeeds in solving its difficulty with expanding its SCHIP. A year ago, Governor Strickland unveiled his comprehensive Healthcare Coverage Reform Initiative, announcing his intention to give every child access to health coverage. However, as the state moved forward plans to meet this objective, it met with considerable push-back from the federal government.

Last December, the Centers for Medicare & Medicaid Services (CMS) rejected Ohio’s attempt to carry out legislation that would have expanded its Medicaid program to all children in families earning up to 300 percent of the federal poverty level. CMS cited new guidelines, issued in an August 2007 letter, that say before expanding SCHIP or Medicaid eligibility to children in families with incomes greater than 250 percent of poverty, states must demonstrate that they have enrolled in Medicaid or SCHIP at least 95 percent of children in the state below 200 percent of the poverty. The state continues to negotiate with CMS over a proposed expansion.
A tried-and-true method for treating opiate addiction is coming under increasing scrutiny from lawmakers as they confront an increase in methadone-related deaths and respond to long-standing community concerns about methadone clinics in their neighborhoods.

Methadone has historically been the safest and most effective means for treating people with an addiction to heroin and other opiates. The drug relieves cravings and reduces the symptoms of withdrawal, so that those who are committed to recovery can resume work, raise families and conduct their daily lives free from the constant hunger for heroin.

However, the synthetic opiate has been the subject of negative press recently, as it has been linked to a rising number of overdose deaths. The number of methadone-related poisoning deaths has increased 468 percent since 1999, compared to a 66 percent increase in overall poisoning deaths, according to a recent report from the National Center for Health Statistics (NCHS).

While some of the deaths are linked to diversion—using drugs for non-medical purposes—many are not. Instead, methadone has become increasingly popular as a pain killer for non-substance abusing patients. Methadone has less potential for abuse—and is far cheaper because it is not patented—than many other painkillers.

Many of the problems occur, experts say, because few doctors—especially physicians who practice in non-methadone settings—are trained in how to dispense methadone as a pain killer. “With the drug’s half-life significantly longer than its effect on pain, the initial proper dosing of methadone is difficult and not all physicians are aware of its varying equivalence to other opioid medications,” said the NCHS report. In other words, some doctors over-prescribe the medication and a large dose can be deadly for those who have not developed a tolerance to opiates.

**Moratoriums and Regs**

Nevertheless, the increase in deaths has intensified some communities’ opposition to methadone clinics, and some lawmakers are responding by renewing moratoriums on new clinic construction and publishing regulations that deter patients from receiving treatment.

For example, in 1999, Indiana enacted a moratorium that forbade any new clinics in counties that had fewer than 40,000 residents, already had a clinic or was contiguous with a county that already had a clinic. The moratorium was extended every year but was temporarily lifted in 2006. In 2007, the Legislature passed another moratorium (SB 450) that will expire at the end of 2008. “This moratorium will give us the time we need to [review the issue] while responding to immediate community concerns about new clinics being considered now,” said Senator Connie Sipes.

With the moratorium expiring at the end of this year, the Legislature recently passed SB 157, which increases the amount of regulations for methadone clinics.
Part of the justification given is to keep out-of-staters away. “Opioid clinics in southern Indiana are flooded with patients from Kentucky and other neighboring states because we have very few regulations governing their behavior,” said Indiana Representative Steven Stemler. Often, clinics will set up in border areas to encourage out-of-state clients to come in, if the neighboring state is more restrictive or has a lack of clinics.

"Because of the number of patients traveling to Indiana to receive care, Indiana residents and legislators believed—inaccurately—that Indiana’s methadone regulations were particularly lax," said Kathleen Kane-Willis, interim director for the Institute for Metropolitan Affairs at Roosevelt University.

One of the key new provisions enacted was drug testing of new patients, specifically looking for non-opioid drug use such as cocaine and marijuana. New patients who fail a test will not be eligible for take-home doses and would instead have to ingest while at the clinic. The bill also restricts overall access to take-home methadone doses, reducing that amount from 14 days from 30. The take-home restriction had historically been one the key differences between Indiana and the rules in Ohio and Kentucky—the latter two states having significantly more restrictive policies, according to Mark Parrino of the American Association for the Treatment of Opioid Dependence. The bill also increases the number of on-site visits of clinics and sets up a central registry of patients. “Enacting these restrictions will discourage opioid patients from crossing state lines,” said Stemler.

These restrictions, however, may adversely affect Indiana’s patients, said Chris Kelly, director of the Washington, D.C. chapter of Advocates for Recovery Through Medicine, a methadone advocacy group. Specifically, he said that the lack of new clinics is swelling patient count at existing clinics to unsustainable levels. “It’s a classic supply/demand imbalance,” he said.

In 2007, West Virginia enacted a hold on new clinics, mostly because clinics were opening at an incredibly fast rate—faster than the state could keep up with from a regulatory and patient safety standpoint. “We put a moratorium on the development of new clinics until rules are provided that are acceptable to the legislature,” said Delegate Don Perdue in a recent NCSL interview. Additionally, state officials were concerned about the increases in methadone-related deaths and were hoping to develop an educational component on proper use. "Because the number of methadone clinics was growing so rapidly, it became difficult to educate the public about the problems," said Delegate Perdue.

Louisiana instituted a moratorium in 2003 which is scheduled to last until July of this year. That would change if the Legislature passes HB 1062, which would extend the ban until July, 2010. However, the bill does provide the Department of Health and Hospitals the discretion to license a new facility if it determines a need exists.

In addition to moratoriums, states restrict new clinics through the “Certificate of Need” process, which limits construction of new health-care facilities based on community need. Currently, 22 states have CON provisions for substance abuse facilities, according to NCSL’s website on the topic. The CON process can have the same effect as a moratorium. “Here in DC, up until a few months ago we had a certificate of need process that almost prohibited any new providers, so there are only 4 right now—we could easily support 10,” said Kelly.
For more information on methadone and other treatments for opiate addiction, please visit http://www.ncsl.org/programs/health/forum/mat.htm or contact one of NCSL’s substance abuse experts:

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**STATE NEWS**

**ADAPS: WAITING LISTS NEARLY ELIMINATED IN 2007, BUT WHAT’S AHEAD?**

*Matthew Gever*

There’s some good news regarding the long-beleaguered AIDS Drug Assistance Programs (ADAPs). The latest yearly survey of the 58 state-run programs found that ADAPS—which provide prescription medications to mostly very low-income, uninsured clients with HIV/AIDS—were so well-funded in 2007 that, at least during the one month of September, all waiting lists for the program were eliminated. Those lists were eradicated even though the ADAP client caseload grew to its highest level in 2007 since the program began—with 102,000 people served in the month of June 2007 alone.

But the picture isn’t all bright. Since September, Montana has built a new list of six people. And experts worry that the current economic downturn could again force people to wait for life-saving drugs.

All 50 states and 8 territories run ADAPs, supplementing federal funds with their own to provide medications or purchase health insurance for the patients. About 146,000 individuals are enrolled in ADAPs, which help approximately 3 out of every 10 people with the virus, according to the report, produced by the National Association of State and Territorial AIDS Directors and the Henry J. Kaiser Family Foundation.

Authors of the report attribute the elimination of waiting lists to the fact that some states, whose economies were recovering from an earlier downturn, provided additional funds to the ADAPs from their general revenues. Other factors include the President’s ADAP initiative (which provided additional one-time funding to 10 states with waiting lists); the one-time impact of switching patients to Medicare Part D; increasing sophistication on the part of ADAPs in obtaining pharmaceutical rebates; and reauthorization of the Ryan White Act, which provided supplemental grants to states with significant needs.

States institute waiting lists as one of a series of cost-control measures. In March of 2007, 571 people in four states were on such lists. The majority of them were in South Carolina, which at times had
wait lists numbering up to 600 people. Two actions helped the state eliminate this list. "The first and in some ways most important thing that happened was that a group of community-based organizations in the state that serve people living with HIV and AIDS came together to form a grassroots advocacy organization, and they advocated the ADAP with our state legislature," said Noreen O'Donnell, the state’s ADAP director. In response to this, the state appropriated an additional $3 million in recurring funds to the program, allowing it to serve all eligible comers.

Nevertheless, the experts are watchful. “We’re hearing things about the state economic downturn and we don’t know what that’s going to mean for ADAP’s,” said Jennifer KaTes, vice president and director of HIV policy at the Kaiser Foundation…And so from a planning perspective it’s a little bit of a challenge for states, I think.”

HIGHLIGHTS

ORGAN DONATIONS

Tax Deductions for Live Donors
Oklahoma is now providing tax deductions to live organ donors as part of a 130-page omnibus bill recently signed into law. The law provides for a one-time $10,000 state income tax deduction for unreimbursed costs associated with the donation of all or part of a liver, pancreas, kidney, intestine, lung or bone marrow. The bill also directs the Oklahoma Tax Commission to develop rules as to what expenses will qualify for the deduction. This makes Oklahoma the 13th state to adopt a form of tax deduction for organ donations, according to the United Network for Organ Sharing. Federal law still prohibits actual payment for organs.

Opt-In to Opt-Out
Meanwhile, the Delaware General Assembly is considering a controversial bill (H.B. 302) that would radically overhaul the state’s organ donation policies. Currently, people who want to become organ donors can opt into the system by indicating so on their drivers’ licenses. The bill would automatically designate people as donors unless they sign an opt-out statement. Studies show that about 90 percent of people agree with organ donation, but only about 40 percent of Delaware drivers have opted-in on their licenses, said bill sponsor Representative Peter Schwartzkopf, who donated a kidney to a friend. Many European nations have opt-out systems, and Spain, whose donation law closely resembles H.B. 302, has the world’s highest organ donation rate with only 2 percent of the population opting out. Currently, 74,488 Americans are waiting for a donated kidney.

QUALITY

State Ratings
The Agency for Health Research and Quality has just released the 2007 "State Snapshot," which provides state-by-state information on states’ performance in health-care quality,
progress in meeting many of the Healthy People 2010 goals, and states’ performance on service recommendations by the U.S. Preventive Services Task Force and the CDC’s Advisory Committee on Immunization Practice. To view this year’s State Snapshot, go to http://statesnapshots.s-3.com/snaps07/index.jsp.

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**GRAPHICALLY SPEAKING**

**HIGH-DEDUCTIBLE HEALTH PLANS STILL MAKE UP SMALL SHARE OF MARKET, BUT ACCEPTANCE COULD GROW**

*Anna C. Spencer*

While consumer-directed health plans (CDHPs) are being offered by a growing number of employers, enrollment in these products constituted just 5 percent of total enrollment in employer-sponsored health plans in 2007 (see below), according to a recent report from the Center for Studying Health System Change.

An annual employee benefits survey reports by the consultant group Cowden Associates, found that more than half of enrollees in a high-deductible plan were unhappy with the out-of-pocket costs. “The dissatisfaction level was the real eye-opener,” Vince Wolf, executive vice president of Cowden Associates, told the *Post-Gazette*.

Similarly, a new study from the Kaiser Family Foundation found that only a fairly small number of families have sufficient assets to cover cost-sharing in consumer-directed health plans. Most uninsured households do not have overall financial assets large enough to cover the HSA deductible if they get sick. For example, about one-third (33 percent) of households with at least two uninsured members had gross financial assets of at least $2,000, the minimum deductible for an HSA-qualified family plan in 2004, and only 9 percent had enough of these assets to cover the out-of-pocket maximum ($10,000). These families may have other financial obligations to meet as well, the study noted.

Still, health plans and benefits consultants predict more employers will offer these products in the future as momentum strengthens for greater consumer engagement in health care. According to the Health System Change report, many large employers are engaged in “watchful waiting,” and the report authors predict that as employees become more comfortable with the CDHPs, eventually more traditional health plans will be dropped or restructured to favor the choice of an CDHP. They also are hoping to learn from the experiences of the few large employers that have replaced all benefit options with CDHPs.
**Employer-Sponsored Health Plan Enrollment by Plan Type, 2007**

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<th>Enrollment (%)</th>
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<td>CDHP*</td>
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* CDHPs include high-deductible health plans with a spending account.

Source: 2007 Kaiser Family Foundation and Health Research and Educational Trust Employer Health Benefits Annual Survey