STATE NEWS

MASSACHUSETTS SETS OUT TO BEND THE COST CURVE

Dick Cauchi

Massachusetts has taken another giant leap. Legislation (S 2863) signed into law August 10 goes beyond the well-publicized, near-universal health reform passed in 2006 by seeking to reduce the rising costs of health care, increasing transparency of cost and quality for consumers, and promoting electronic health records systems.

"This bill takes the next critical step by improving the quality and affordability of health care. It launches several initiatives essential to creating a transparent system of quality improvement and cost containment," said Senator Richard T. Moore, one of the chief architects of the 2006 health reform law and also of the new cost containment plan.

The universal coverage law, which began to be implemented in 2007, has helped to 439,000 formerly uninsured Massachusetts residents attain coverage. Cost overruns have been a sticking point in recent months, with some employers balking at the price of the program. At the same time, a recent survey by the Harvard School of Public Health and the Blue Cross/Blue Shield Foundation found that public support for the program, including the individual mandate, remains high.

Restructuring Payment Systems
The practical goal of the new law is to "bend the curve" on the graph of rapid cost growth for treatment and coverage. Many of the law’s programs will be evaluated, and the outcomes reported to legislators.

The law calls for creating a Health Payment Reform Commission, aimed at restructuring the current payment system with incentives for "efficient and effective care." The state will provide consumer
information and annual cost containment and quality goals and require providers and insurers to report on progress toward the goals.

To reduce administrative costs, the state will develop standards for uniform billing and coding. All providers and insurers are required to abide by these standards by 2012. For example, computerized order entries for tests and medicines alone are projected to save $170 million per year in hospitals statewide.

The law authorizes a formal list of "never-events" (such as operating on the wrong organ) and prohibits health providers from billing for costs related to these errors. Providers also must inform the state of "serious reportable events," adverse drug events and hospital-acquired infections.

In addition, both providers and insurers will be required to publicly explain each year the reason for any cost or premium increases. The Attorney General is authorized to represent consumers to question the basis of the increased charges.

Using $25 million for deployment, a new state e-Health Institute will oversee the mandated statewide adoption of electronic medical records. All physicians must demonstrate competency in the use of health information technology by 2015.

To educate providers on the use of therapeutic alternatives to high-cost, brand-name drugs, a Pharmacy Academic Detailing Program will be established. Pharmaceutical and medical device companies must report to the state Department of Public Health any payment or gift of more than $50 made to a health-care professional. Those gifts would be publicly reported on the state’s web site. "Biased marketing and financial inducements are destructive to the sacred doctor-patient relationship," said Senator Mark Montigny, author of the gift ban legislation. "Evidence-based academic detailing enhances this relationship."

To increase the number of primary care providers, the law recognizes nurse practitioners as primary-care providers and expands the use of physician assistants. A "medical home" demonstration project will be created to promote coordinated and comprehensive care for low-income residents.

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**STATE NEWS**

**SCHIP CONTROVERSY CONTINUES UNABATED**

Matthew Gever and Christina Kent

As time passes, the questions surrounding SCHIP only seem to grow.

Perhaps the biggest is the question of reauthorization. Created in 1997, SCHIP was scheduled to be reauthorized in 2007. But Congress and the Bush administration failed to reach agreement on such issues as the amount of federal funds that would be available, and the president vetoed two bills. Ultimately, Congress passed and the president signed a bill that extends SCHIP unchanged through March 2009.
Some congressional leaders have been hoping to move the latest version of the SCHIP bill (H.R.3963) this September. But few expect Congress to take the bill up until next year. In part, that’s because the Congressional Budget Office (CBO) recently estimated that H.R.3963 would increase the federal budget deficit by $1.6 billion over five years. That’s a violation of congressional pay-as-you-go (PAYGO) rules, so the bill would have to be altered to either serve fewer children or raise more revenue. Both alternatives are polarizing.

Then there is the continuing question of what effect the Aug. 17, 2007 letter from the Centers for Medicare & Medicaid Services (CMS) will have on states. The letter set out specific conditions for states that want to enroll in SCHIP children whose family incomes are above 250 percent of the federal poverty level. "We expect affected states to amend their SCHIP state plan (or 1115 demonstration) in accordance with this review strategy within 12 months, or CMS may pursue corrective action," the letter said. However, CMS officials have repeatedly stated that they do not expect current enrollees to be affected by the directive.

In 2008, seven states set the SCHIP income eligibility limit at less than 200 percent of poverty, 23 states allow a maximum income equal to 200 percent of poverty, and 20 states set the limit above 200 percent of the poverty level.

As the one-year deadline for meeting the new conditions approached, many wondered whether CMS would pursue "corrective action" against states that enroll higher-income children.

California—whose SCHIP is open to children with incomes above 250 percent of poverty— informed CMS in a letter that it would not change its SCHIP rules because the CMS directive contradicts state law, and California is "constitutionally obligated to follow state law." (A report commissioned by the state on its options is at: www.chcf.org/documents/policy/SCHIPAtTheCrossroads.pdf)

CMS declined to take any action. Instead, CMS spokesman Jeff Nelligan said CMS will “continue to work with states that are already providing coverage under the SCHIP program to children in families with effective family income levels above 250 percent of the federal poverty level. At this time, we are not taking compliance action."

Nevertheless, if it is not thrown out by a lawsuit brought by a handful of states, nor overturned by a new federal administration, the directive could have an enormous effect on state SCHIPs. According to the National Health Policy Forum, as of May 2008, eight states—Hawaii, Illinois, Maine, Massachusetts, New Jersey, Pennsylvania, Vermont, Washington and Wisconsin—have passed universal state universal coverage for children.

"Ultimately, the factor that could most affect the number of children in SCHIP could be decided by the amount of funding that Congress allots, when it reauthorizes the SCHIP program," Peter Orszag, director of the CBO, told Congress in April.

"The directive could have much greater impact on enrollment in SCHIP if the Congress expanded the program significantly. Under its baseline projections for SCHIP, which assume continued allotments of about $5 billion per year, CBO estimates that enrollment of children in SCHIP will fall from 6.8 million in 2009 to 3.3 million in 2018, as the growth in health care costs per person diminishes the number of children states can cover with a fixed sum of money. However, if the Congress substantially increased SCHIP funding, additional states would probably wish to
expand their programs to children in families with income above 250 percent of the poverty level. In that case, the August 17th directive would be a more significant constraint on enrollment,” Orszag added.

**Different Strokes**

Another enormous question is the effect that the current economic slowdown will have on SCHIPs. Some of the states that have sought to expand their SCHIP programs to higher income levels have started running into difficulties not only from CMS but from budget deficits.

**New York** turned in a state plan amendment to CMS to expand SCHIP eligibility up to 400 percent of poverty. CMS rejected the proposal on the grounds that the state "has not demonstrated that its program operates in an effective and efficient manner with respect to the core population of targeted low-income children."

The state then planned to cover the additional children using state-only funds. But that prospect was torpedoed by the state’s current $5.4 billion budget deficit. The shortfall led the governor and the Legislature to suspend the planned expansion, as well as cut many agency budgets.

In 2007, the **Louisiana** Legislature enacted a law that expanded SCHIP eligibility from 200 percent of poverty, to 300 percent. That proposal was rejected by CMS, but after discussion, the agency decided to allow and accordingly fund expansion of the program up to 250 percent of poverty.

The program will give eligible children access to the state’s Group Benefits insurance program, which covers state employees. A spokesperson for Louisiana’s Department of Health and Hospitals said the expansion will save the state the hassle of a "request for proposal" process for a provider, and give families access to an already existing provider network. Parents pay a $50 monthly premium—regardless of the number of children being enrolled—and are responsible for co-payments and deductibles on an income-based sliding scale. The state expects about 6,500 children to qualify under the new income guidelines. Governor Bobby Jindal has also expressed the desire to pursue the 300 percent expansion in the near future.

The **Ohio** legislature in 2007 approved an expansion of SCHIP from 200 percent to 300 percent of poverty. The state had planned to achieve the expansion through a Medicaid state plan amendment, to which the August 17 letter would not apply. CMS ultimately rejected this plan, saying the state needed to use its remaining SCHIP funds before dipping into its Medicaid budget.

In response, Ohio decided to use state-only funds to cover the expansion in the short term. “We don’t know what impact all of this will have in the future, but for now, Ohio’s program is in place and secure,” said Senator Joy Padgett in an op-ed piece. However, the long-term forecast is bleaker, with the governor predicting budget shortfalls in SCHIP of close to $100 million in FY 2009 unless the federal government approves a new match. Some say the legislature acted rashly by expanding SCHIP without federal approval in place. “This is the type of fiscal irresponsibility the president opposed,” said Marc Kilmer of the Buckeye Institute, an Ohio-based think tank.
STATE NEWS

WITH SOARING PRISON COSTS, STATES TURN TO EARLY RELEASE OF AGED, INFIRM INMATES

Bren Gorman

In an effort to slow ballooning incarceration costs, a growing number of states are releasing older, chronically ill offenders into the community. Studies show that geriatric inmates (who develop an average of three chronic illnesses while imprisoned) cost the states an average $70,000 per year—two to three times the cost of imprisoning a younger inmate. Research also documents that older inmates are unlikely to re-offend.

In June, North Carolina Governor Mike Easley signed SB 1480, creating an early release program for "no-risk" inmates who are over 65 years of age and completely incapacitated by a chronic illness or disease. Because these inmates could not care for themselves upon release, the law requires that they have a comprehensive "medical release plan" detailing who will provide what type of medical treatment, where it will be provided and how it will be funded.

"We looked at the numbers and from 2005 to 2006, the state spent $60 million for outside medical services for the 100 costliest prisoners, many of whom pose no threat to public safety because of advanced illness," said North Carolina Senate Majority Leader Tony Rand, the bill’s primary sponsor. Prisoners incarcerated for violent or sexual offenses are not eligible for the program.

At least 37 states have set up early release programs for geriatric, ill inmates. None of them allow inmates who have been convicted of violent or sexual offenses to participate. Because state definitions of the age at which prisoners are categorized as "geriatric" varies from 50 in Ohio to 65 in New York, the exact number of older prisoners is not known.

In California, the question may no longer be whether to release prisoners, but rather which ones to release. In 2007, the Golden State spent $2.1 billion dollars on health care for its roughly 172,000 inmates. "California is in the middle of a crisis in its state prisons," said California Assemblyman Sandré Swanson. "In addition to issues of overcrowding, the state spends the most money on prisoners who pose the least threat to public safety… housing aged prisoners with chronic illness does nothing but waste precious resources."

Assemblyman Swanson has introduced a bill (AB 1965) that would establish one of the nation’s broadest early release program for chronically ill geriatric prisoners. Like the North Carolina bill, inmates would not qualify if they are serving time for a violent or sexual offense. Unlike the North Carolina program, however, California inmates could qualify at age 55 and would not need to be incapacitated by their chronic illness. Before release, inmates would have to show proof that they qualify for Medicare, Medi-Cal or private health insurance coverage. Shifting the cost burden to Medi-cal or Medicare would allow California to use federal matching funds to ensure that the health-care needs of program participants are met.

Controversy Continues
Opponents of early release programs cite public safety issues. "Having a medical condition that requires ongoing medical attention should not give a person the green light to commit crimes and
then go free,” said San Bernardino County Sheriff Gary Penrod. ”This is not a positive deterrent to crime prevention."

But proponents point to research that shows prisoners over 55 have recidivism rates of 2 percent to 8 percent, compared to 70 percent for the general population. Early release is not a ”get out of jail free card,” they add—in California, inmates must have completed at least 50 percent of their sentence before they are eligible to be considered for early release.

In fiscal year 2007, state spending on corrections increased at a higher rate than spending on education and Medicaid and accounted for an average of 6.8 percent of state general funds. Oregon spent the highest percentage of general revenue funds on corrections—10.9 percent—while Florida and Vermont, the next highest, spent 9.3 percent. Minnesota and Alabama spent the least—less than 3 percent of general revenues.

The California Legislative Analysts Office estimates that the costs for health care for prisoners over the age of 55 range up to $138,000 a year per inmate, nearly triple the cost for average prisoners. The state Department of Corrections and Rehabilitation estimates that in 2007, approximately 10,500 prisoners over age 55 were incarcerated; that number is expected to climb to over 30,000 by 2020. It is not clear how many of these older prisoners would be eligible for the early-release program proposed in AB 1965 but if just 500 eligible prisoners were freed, Assemblyman Swanson estimates that at least $6.8 million would be saved per year, and says the net savings would accrue to a much higher number over time.

Assemblyman Swanson concluded, "My bill is designed to inject some compassionate relief into our overcrowded system. If we’re able to effect the compassionate release of prisoners to their family and to outside medical care, then it will ease overcrowding and bring greater economic relief to the financially overburdened prison system in the state of California."

**HIGHLIGHTS**

**COVERAGE**

**Uninsured Rate Drops**

The number of uninsured Americans decreased by 1.3 million from 2006 to 2007, a change largely attributable to an increase in government-sponsored coverage, says a report from the U.S. Census Bureau. The Bureau's annual report on income, poverty and health insurance found that the number of uninsured people decreased from 47 million in 2006 to 45.7 million in 2007. During the year, however, the percentage of people with private insurance decreased, while the percentage of those covered by government programs increased, a shift some health policy analysts say is problematic. "That's not a sustainable way to maintain our health-care system over time," Len Nichols of the New America Foundation told BNA. The percentage of people covered by private insurance dropped from 67.9 percent to 67.5 percent from 2006 to 2007, and the number of people with employer-based coverage decreased from 59.7 percent to 59.3 percent. During that same period, enrollment in government health plans—Medicare, Medicaid, SCHIP, military health care and individual state programs—grew from 80.3 million to 83 million. The report also examined regional and state insurance rates and found that 11.4 percent of residents in the Northeast and Midwest were uninsured, lower than rates in the West and South, at 16.9 percent and 18.4 percent,
respectively. An average of data from 2005 to 2008 showed Texas 24.4 percent of Texans were uninsured, the highest level among the states. Hawaii, Iowa, Massachusetts, Minnesota, and Wisconsin had uninsured rates of around 8.3 percent.

**PUBLIC HEALTH**

**Measles Cases Up**
Seven measles outbreaks occurred in the United States during the first seven months of 2008, affecting at least 131 residents—the highest number of cases reported in more than 10 years—and resulting in 15 hospitalizations, according to a report released by the Centers for Disease Control and Prevention. In 1997, the CDC received reports of 138 measles cases, compared with 42 in 2007. Among the 131 measles cases reported in 2008, 122 involved residents who were not vaccinated or who had an undetermined vaccination status. Sixty-three of the measles cases involved children whose parents decided not to have them vaccinated, and 16 measles cases involved children younger than age one who could not receive vaccinations because of their age. Most measles cases could be traced back to individuals who had traveled to countries where vaccination against the disease does not occur, including Israel, Switzerland and Great Britain. "Every year, the U.S. experiences importation of measles. What is different this year is once it is imported, we are seeing it spread to more people, and most of that spread is to people under 20," Anne Schuchat of the CDC told the Baltimore Sun. Concern about the link between the measles inoculation and autism decreased the number of parents who chose to get their children vaccinated. Parents also decide not to vaccinated their children against the disease because of a false sense of the low risk associated with catching measles, says the Sun.

**SUBSTANCE ABUSE**

**Rethinking 21**
A group of 128 college and university presidents have formed a coalition to address problem drinking on the nation’s campuses. Called the Amethyst Initiative, the coalition is designed to start a national debate on the age at which young adults can legally starting drinking. Critics say that setting the age at 21 allows colleges to shirk responsibility for dealing with binge drinking. Others contend that the 21-year-old limit has reduced drunk driving fatalities. More on both sides of the argument can be found here.

**ACCESS**

**Covering Uninsured is Costly**
As expensive as it is to be without insurance, covering the uninsured could prove to cost even more, according to a new report in Health Affairs. According to the study, the uninsured receive about $86 billion in care while they go without insurance, of which $30 billion is out-of-pocket while the other $56 billion is in uncompensated care. If this group were to be given full-year coverage, their spending would increase by another $123 billion. And savings for private insurance holders would be minimal. Despite a steady increase in the overall number of uninsured, uncompensated care has remained steady as 6 percent of hospital costs.
GRAPHICALLY SPEAKING

RURAL AND LOW-INCOME COMMUNITIES HAVE FEWER PRIMARY CARE PHYSICIANS

As more medical residents choose specialty placements, the need for primary care practitioners will grow, especially in rural and low-income areas, according to a new report from the National Association of Community Health Centers. According to NACHC, 56 million Americans currently lack adequate access to primary health care. To fill this need, up to 60,140 more primary care providers (including up to 44,500 nurses) will be required. The report recommends that states recruit students who are willing to work in underserved communities or who come from these backgrounds. States also may reconsider the scope of practice for professionals, such as nurse practitioners and physician assistants, as well as increasing reimbursement to primary care practitioners. Alaska, Wisconsin and Washington, D.C. have the most providers per patient, while Nevada, Alabama and Oklahoma have the fewest.

Percent change in U.S. medical school graduates filling select ED residency position, 1998-2006