States Aiming for a Crucial Target: Small Business Coverage

Matthew Gever

The list of states that are trying to help small businesses provide health coverage is growing.

A slew of health-care-related bills signed into law last month by Washington Governor Christine Gregoire includes one specifically aimed at helping small businesses obtain coverage. HB 1569 (http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1569&amp;year=2007) authorizes the creation of the Washington Health Insurance Partnership. Similar to the “Connector” mechanism created in Massachusetts, the Partnership will offer benefits administration to small employers that have at least one employee who earns less than 200 percent of the federal poverty level (FPL). The Partnership also will provide sliding-scale premium subsidies to individuals who earn less than 200 percent of the FPL.

The Partnership was one of 16 recommendations contained in a report (http://www.leg.wa.gov/documents/joint/HCCA/Final%20Report.pdf) issued last January by the state’s Blue Ribbon Commission on Health Care Costs and Access. “We decided that we had to step out, like some of our colleague states, and be a laboratory” for finding new health-care ideas, said Governor Gregoire at a news conference.

Many of those reforms were included in SB 5930 (http://www.leg.wa.gov/pub/billinfo/2007-08/Pdf/Bills/Session%20Law%202007/5930-S2.SL.pdf), which the Governor also signed. Among other provisions, the bill calls for establishment of a quality forum to promote evidence-based practices, improved transparency of cost and quality information for consumers, and the testing of a “health opportunity account” in Medicaid.
Paperwork Reduction

In Iowa, Governor Chet Culver signed two bills this session aimed at small businesses. HF 790 (http://coolice.legis.state.ia.us/CoolICE/default.asp?category=BillInfo&service=Billbook&ga=82&chbill=HF790&menu=text) is intended to help small firms pool their purchasing power by joining or setting up associations that buy coverage. “By banding together, they will qualify for lower insurance rates and will be able to provide coverage for their employees,” said Representative Ro Foege.

The law also allows insurance companies to provide discounts to small businesses that implement employee wellness programs, such as anti-smoking programs. Specifically, if a small business shows improved health outcomes and has fewer employee claims as a result of a wellness program, the insurance company is allowed, but not required, to transfer that small business into another insurance class with lower rates.

The other law, SF 346 (http://coolice.legis.state.ia.us/CoolICE/default.asp?category=BillInfo&service=Billbook&ga=82&chbill=SF346&menu=text), is designed to simplify the insurance application process for small businesses. Currently, employers who want to compare insurers’ products must fill out a separate form for each company.

“When I market health insurance and I go to an employer as it is today, if they want competitive bids I have to have them fill out applications for Principal, Wellmark, United, Coventry—in other words each employee would have to fill out four applications,” said Senator Tom Rielly, who works in the insurance industry. Under SF 346, an employer would only have to fill out one form, which all bidding companies would reference.

“What we’ve done is increase the bargaining power of small businesses in two ways,” said Senator Rielly. “One, they can choose to work with associations to get a better deal on insurance. Two, if they choose to work with insurers directly, the simplified application form means it will be easier for business owners to compare insurance offers on an apples to apples basis.”

Lone Stars No More

In Texas, the Senate has passed and a House committee is considering SB 922 (http://www.legis.state.tx.us/tldocs/80R/billtext/html/SB00922E.htm), which would encourage counties to test models for small business coverage. Intended to maximize flexibility and local control, the legislation would enable county commissions to establish local or regional health-care programs, which could offer insurance or health services.

The state Health and Human Services Commission would use general revenues to provide start-up grants to seven of these programs, which could include health savings accounts and high-deductible plans. The grants would average $150,000 each, for a total cost of $1.05 million in FY 2008. In addition, the local/regional programs could apply for additional funds from a “health opportunity pool,” created under an 1115 waiver from Medicaid.

It is expected that employers, employees and the state would jointly share the cost of premiums or health-care services. The programs would be required to allow any individual who receives state premium assistance to enroll.

“In many cases, owners care deeply about their employees and would love to provide insurance but they simply can’t afford it,” said Texas Senator Kirk Watson, who introduced the legislation.
STATE NEWS

CHILDREN’S HOSPICE PROGRAM PREMIERES

Matthew Gever

As part of its Health Reform Law of 2006, the Bay State has established a new program to provide hospice care for children. Unlike most states that offer children’s end-of-life care through Medicaid, Massachusetts will self-fund a program to bring palliative care to all children in the Bay State.

The program is designed to tailor hospice to children, whose needs are different from those of adults. "All the palliative care programs were for older people at the end of life and were focused on making them comfortable in their waning days," said Senator Richard Moore. "The program was needed because there was not a system in place to aid children and their families who face serious or terminal illness."

Children are often overlooked when it comes to hospice care. The National Hospice and Palliative Care Federation estimates that only one in ten children who need palliative care receive it. Some of the more common illnesses in children are cancer, AIDS, cystic fibrosis, renal failure and severe cerebral palsy.

Currently, 47 states and the District of Columbia provide the “optional” benefit of hospice under Medicaid. Federal rules require that individuals have a terminal illness, which generally means the patient has six months or less to live. Beneficiaries also must agree to forego curative treatment and accept only palliative care, which focuses on pain control and symptom management. Hospice care is also a mandated benefit for insurance companies operating in the Bay State.

Those rules can be problematic when it comes to dealing with children. Diagnosing a child with a life-threatening illness is less precise than diagnosing an adult. And parents are reluctant to give up curative treatment for their children.

“Disease in general expresses differently in children,” said Ann Armstrong-Dailey, founding director and CEO of Children’s Hospice International, in a previous State Health Notes article. “Physicians are getting better at treating many of these children and prolonging their lives, yet they live with the possibility of a recurrence hanging over their heads.”

“It's much harder for parents and adults to deal with the death of a child who hasn't really had a chance to live versus an older person who has lived their life,” said Sen. Moore.

**Tailored to Children**

A growing number of states—including Florida and Colorado—have retooled their hospice benefits for children by using Section 1915 federal waivers. States may now also create child-specific hospice programs by amending their state Medicaid plans in accordance with the 2005 Deficit Reduction Act.

Florida and Colorado based their 1915 waivers on the “CHI PACC” model (Children's Hospice International Program for All-inclusive Care for Children and Their Families) for children’s hospice. Developed by Children's Hospice International, this approach eliminates the six...
month end-of-life prognosis, allows curative treatment to be continued; and enables the family to use the services of other providers.

The Massachusetts pediatric hospice program is like CHI PACC in that it does not require a six-month end-of-life prognosis, and curative treatment may be continued. But it is different from existing CHI PACC programs in that it does not rely on Medicaid, making the benefits available to all Massachusetts children without regards to income eligibility.

To qualify, children must be younger than 19 and have life-limiting illnesses—but they are not eligible if they receive benefits similar to those of the program under another insurer. The program will provide appropriate curative treatment, pain and symptom management, sibling counseling, spiritual care emergency services and bereavement counseling. A primary-care provider will coordinate care.

Massachusetts decided not to use Medicaid waivers like the other states because “we had done our own research before we saw the CHI PACC model,” said D. Rigney Cunningham, executive director of the Hospice & Palliative Care Federation of Massachusetts (http://www.hospicefed.org/). Cunningham also noted that the idea already had many supporters in the Legislature, and that developing a state-only program would take much less time than going through the waiver process. "Money wasn't a huge consideration,” added Cunningham, referring to the state’s decision to self-fund the program.

The state is using an $800,000 grant from the state Department of Public Health to fund the program in FY 2007, and Governor Deval Patrick has requested another $800,000 for FY 2008.

At least six other states are considering establishing children’s hospice care programs. Maryland enacted a law (http://mlis.state.md.us/2007RS/bills/hb/hb0797t.pdf) in April requiring the state to conduct a study on services for terminally ill children and on the feasibility of implementing a CHI PACC waiver. Last session, California enacted AB 1745 (http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_1701-1750/ab_1745_bill_20060919_chaptered.html), establishing a pilot project for children’s palliative care within Medi-Cal, the state’s Medicaid program.

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STATE NEWS

TEEN TANNING DRAWS HEAT IN SOME STATES

Megan Foreman

As summer arrives, a growing number of lawmakers are turning their attention to the prevention of skin cancer. During 2007, 15 state legislatures considered bills that would have done everything from mandating that school curriculums include sun safety instruction to banning indoor tanning for minors.

Lawmakers have become increasingly concerned about rising skin cancer rates, especially because its victims are frequently younger than most other cancer patients. According to the American Cancer Society, one in every 15,000 boys ages 15-19, and one in every 30,000 girls will be diagnosed with melanoma this year. The Centers for Disease Control and Prevention (CDC) ranks skin cancer as the third most common cancer for people ages 20-24 and the most common cancer among people ages 25-29.
Some of the bills seek to restrict adolescents’ access to indoor tanning devices, which mimic sunlight in a much more concentrated dose by using intense ultraviolet (UV) rays. While indoor tanning is certainly not the only culprit to blame for skin cancer, some legislators are concerned that the damage incurred during adolescence can be deadly later in life.

The CDC reports that approximately 65-90 percent of melanomas are caused by UV radiation. More than one-half of a person's lifetime UV exposure occurs during childhood; by 18, most people have absorbed 80 percent of their lifetime UV exposure, says the American Academy of Dermatology.

The Beehive State took the prevention route to fighting rising skin cancer rates. In its 2007 session, the Utah Legislature passed, and the governor signed, Utah SB 52 (http://le.utah.gov/~2007/bills/sbillenr/sb0052.htm). The new law requires a parent or guardian of a child under 18 to appear in person to sign a waiver allowing a child to use a tanning facility. Parents must specify the number of tanning sessions the minor is allowed, and waivers expire after 12 months so parents must re-appear in person once a year.

Utah Senator Patricia Jones sponsored the legislation that addressed three things: skin cancer prevention, county-to-county equity within the regulations, and parental rights. "[The law] gives parents control and direction over what their kids are doing," she said. "It gave parents the time and opportunity to read about the dangers [of indoor tanning] and communicate with their kids about what they are doing."

Her initial motivation was that cancer prevention might lessen the human and financial burden of disease. "Health-care costs are spiraling out-of-control so fast, we [in the Legislature] ought to be looking at prevention, rather than trying to mitigate cost afterwards," she said. "The Legislature has to start the ball rolling and help people understand that many of these diseases are preventable."

Utah is not unique. Prior to the 2007 legislative session, 25 states had laws in place to restrict minors' access to indoor tanning devices. These laws vary in scope, but generally require tanning facilities to obtain a parent or legal guardian's written permission before allowing a teen to tan. (For more, go to www.ncsl.org/programs/health/tanningrestrictions.htm)

**Some Support in the Industry**

According to data from the Indoor Tanning Association (http://www.theita.com/) (ITA), the $5 billion dollar indoor tanning industry employs more than 160,000 Americans, mostly in small businesses. Over 30 million Americans patronize the salons each year, 2.3 million of whom are teens. On its Web site, the industry says that indoor tanning minimizes the risk of sunburn while maximizing the enjoyment of having a tan.

Nevertheless, ITA Executive Director John Overstreet supports parental consent laws. "Industry strongly supports parental consent for kids under 18 to use tanning devices," he said.

He wonders, however, about the need for additional laws. "In my estimate, 70 percent of the population is already covered by a state requirement for parental consent," Overstreet added. In the states that do not require parental consent, it is standard practice, Overstreet states, because many small business insurance policies require it when companies deal with minors. It is "simply a good idea for the business (to have a parent's permission)," he explained.

There is little independent data to support Overstreet’s claim that 70 percent of the population is already covered by state requirements; however, in states without tanning laws, the Health Departments often allow individual counties to implement their own regulations on teen tanning.
This county-to-county regulation was precisely the situation in Utah. Senator Jones said she expected resistance from some business groups and was surprised when her measure had no opponents. One small indoor tanning salon even testified in favor of the bill because, the owners said, it evened the playing field between counties. At least one Utah county had parental consent regulations in effect for years, which caused that county’s businesses to lose customers to other, less restrictive, counties.

But if the bill in Utah met little or no resistance, similar legislation in other parts of the country has engendered staunch opposition. California lawmakers are debating AB 105 (http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0101-0150/ab_105_bill_20070410_amended_asm_v97.html), which would ban people under the age of 18 from using tanning devices altogether. California leads the nation in the number of new melanoma cases, which will top out at an estimated 6,680 this year.

Assemblyman Ted Lieu, sponsor of AB 105, felt it was time to take on this issue because of the spike in skin cancer rates among increasingly younger women, said his chief of staff, David Ford. Originally, AB 105 sought to ban people under the age of 16 from indoor tanning, but the limit was upped to 18 in committee. According to Ford, committee members looked at the recommendations from the World Health Organization and the American Academy of Dermatology—both of which recommend that no one under 18 use tanning devices—and chose to heed those guidelines.

The ITA is fighting the bill. "California already has some of the most restrictive state regulations in the country," said Overstreet. "The proposed ban is an outrageous intrusion of government. If the Legislature honestly believes tanning is harmful for teens, are they willing to ban teens from state beaches and pools?"

"We don't let kids under age 18 vote, smoke or join the army," Ford responded, "because they aren't ready to make lasting, complicated decisions about these risky behaviors. Indoor tanning is one risk we shouldn't let them take."

JUST THE FACTS

There are two types of skin cancer: melanoma and nonmelanoma. Nonmelanoma cancer, which includes basal cell carcinoma and squamous cell carcinoma, is much more common than melanoma. More than 1 million people will be diagnosed with nonmelanoma skin cancer this year. This type of cancer rarely spreads to other parts of the body and, with early detection and treatment, persons who develop it have excellent survival rates.

Melanoma accounts for only 3 percent of skin cancer cases, but causes the majority of skin cancer deaths because it often spreads to other parts of the body. While melanoma is usually treatable if caught early, the number of new cases is on the rise. According to the American Cancer Society, an estimated 59,940 new melanoma cases will be diagnosed in 2007, and 8,110 people will die from the disease.

Risk factors for melanoma include sun exposure and sunburn, blistering sunburns during childhood or teenage years, fair skin, freckles, moles and a family history of melanoma. Fair-skinned people aren’t the only ones at risk, and cancer isn’t the only potential problem. UV exposure also can increase the risk of cataracts and immune suppression in people of all skin tones.

NCSL’s Megan Foreman covers teen tanning, as well as women’s, maternal and child health issues.
HIGHLIGHTS

MEDICAID

Growing Pains in Florida
A new report (http://ihcrp.georgetown.edu/floridamedicaid/index.html) indicates that Florida’s pioneering Medicaid waiver—now being tested in two counties—may be reducing the number of physicians willing to serve Medicaid patients. The survey of area physicians, conducted by the Georgetown Health Policy Institute (http://ihcrp.georgetown.edu/), found that 27 percent of physicians who had previously participated in Medicaid say they’ll cease to do so under the new plan. The doctors complained of cumbersome restrictions on providing care to children, as well as increases in paperwork. Researchers noted that only 8 percent of doctors (two-thirds of whom are specialists) responded to the survey and said the results should not be considered indicative of the entire population of doctors. Passed by the Legislature and enacted in 2005, Florida’s groundbreaking 1115 waiver entails moving from a “defined benefit” to a “defined contribution.” Qualifying beneficiaries receive a specific amount of “credit” with which to choose one of a variety of plans offering different benefit packages (benefits for children may not vary from the traditional Medicaid plan). The state pays each plan a premium adjusted for enrollees’ age, sex and health status. The reforms will be tested in Broward and Duval counties for two years, at the end of which lawmakers will vote on whether to make the reforms statewide. Florida’s Agency for Health Care Administration (http://www.floridahealthstat.com/) commented, “As with all studies based on focus groups and surveys, the information is a snapshot of a specific audience at a specific time. We do not agree with all the findings and have asked the university for their data so we can better understand their analysis and conclusions.”

PUBLIC HEALTH

Testing Convicted Panderers
The Tennessee Legislature is sending a bill (http://www.legislature.state.tn.us/bills/currentga/BILL/HB1775.pdf) to the Governor that would require those convicted of breaking the law by promoting prostitution—such as pimps and madams—to be tested for HIV. The bill was the brainchild of Representative Ulysses Jones, who got the idea from a local judge who suggested that “panderers” be tested. Two states—Nevada and Arizona—already require testing of those charged with pandering. “The ones promoting [prostitution] should also be tested,” Representative Jones told the Associated Press. Representative Brian Kelsey questioned the constitutionality of the bill, noting that those who will be tested generally are not “alleged to have engaged in any sexual activity.” The legislation is scheduled to take effect on July 1.

HIV/AIDS

South Carolina to Relieve Waiting List
A recent $26.8 million grant from the Department of Health and Human Services will help reduce South Carolina’s waiting list for its AIDS Drug Assistance Program (ADAP). ADAPs provide AIDS medications to low-income individuals. The Palmetto State currently has the longest waiting list in the country, at 473 people; the grant will help 93 of those individuals. The state Legislature also has approved increased funding for the state’s program. “We have in the past relied solely on federal dollars, and clearly, that has not worked,” Representative Joe Neal told the Columbia State. “We need to add dollars and they must come from the state. We have no other source.” Funding for ADAPs initially came from the federal government only under the Ryan White Care Act, but states have taken increasing roles in their own programs in recent years. To learn more about state ADAPs, see the April 30 SHN story, States Stepping up to the Plate to Help Those with HIV/AIDS (http://www.ncsl.org/programs/health/shn/2007/sn490c.htm).
GRAPHICALLY SPEAKING

DISPARITIES IN SUICIDE RATES IN ALASKA

The suicide rate for Alaska Natives is among the highest in the world and significantly higher than in the rest of the country, according to a new report from the Alaska Injury Prevention Center. Although Alaska Natives comprise 16 percent of the state’s population, they accounted for 39 percent of the suicides. Suicides were highest among younger Alaska Natives, ages 20-29.

The most common reasons given were depression and other mental illness, alcoholism and cultural and economic stress. “They’ve lost their culture, they don’t have a way to support their family, and then what we see is a lot of alcohol and drug use, particularly alcohol,” Diane Casto of the state’s division of behavioral health, told the New York Times.

Researchers interviewed the next of kin to obtain information about the departed. Some of the survivors said that mental health care was either rejected by victims or unattainable. Twenty-nine percent said the decedent did not believe in counseling or asking for help, 18 percent said they had difficulty finding mental health services and 11 percent reported problems with paying for treatment.

On the other hand, 80 percent of decedents had few impediments to obtaining needed medications. Slightly over half had an illness or disability that made it difficult to take care of normal daily activities, and about a third had problems with memory or thinking clearly.

One counter-intuitive finding indicated that the time of year had impact on the number of suicides, with the darker months of November and December having fewer suicides than the sunny months of June and July. The report recommends that substance abuse and mental health treatment be improved and more widely available, and that public health campaigns be launched to reduce the stigmas associated with mental illness.

The Alaska Department of Health and Social Services funded the study.