October 2003

STATE COVERAGE INITIATIVES

stateside

Contents

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for SCI, an initiative of The Robert Wood Johnson Foundation.

Dual Eligibles the Focus of State and Federal Health Care Debates

States have long been concerned about "dual eligibles," or individuals who qualify for both Medicare, the federal health care program for adults aged 65 and older, and Medicaid, the federal-state partnership designed to cover low-income individuals. And states' recent struggles to contain costs in the wake of budget shortfalls and skyrocketing health care spending have brought the dual-eligible population to the forefront of policy discussions. Although this group constitutes merely 19 percent of all Medicaid beneficiaries, they account for nearly 39 percent of all Medicaid spending, and about half of all Medicaid prescription drug expenditures.

"The number one priority for states right now is dual eligibles," said Matt Salo, chief health lobbyist for the National Governors Association (NGA), at a workshop for state officials held by the State Coverage Initiatives program in July. President Bush's proposed Medicaid reform plan, as well as the Medicare prescription drug coverage bills in the House and Senate, have underscored the importance of dual eligibles in reform debates—and highlighted the tension that underlies the state/federal relationship, particularly in times of fiscal stress. "The real issue for states is figuring out the logical next steps for bringing low-income seniors and low-income people with disabilities back within Medicare," said Salo.

Indeed, at a time when state governors have not come to unanimous consensus about almost anything, they strongly agree that health care for dual eligibles should be financed by the federal government, said Salo, who recently led a Medicaid Reform Task Force of the nation's governors. "The single issue that the Task Force members came to consensus on very quickly, very strongly, and across party lines, was that the states had no business bailing out the Medicare program."

Altogether, there are 6.2 million individuals who are dually eligible for Medicare and Medicaid. An older and often disabled population, dual eligibles tend to be chronic disease sufferers and thus have disproportionately higher medical expenditures. Medicaid assistance pro-

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Letter from the Director

Vickie receives a token of SCI's appreciation from AcademyHealth President David Helms.

Despite continuing fiscal challenges, states have demonstrated their commitment to maintaining coverage to an extent that no one had envisioned in the first months of 2003. Admittedly, the federal government deserves part of the credit for providing last minute federal aid in the form of increased Medicaid match and general purpose relief. However, the states also deserve a great deal of recognition for struggling through fiscal challenges and working to maintain coverage for many of this nation's neediest citizens; some states have even made targeted gains in coverage during this trying time.

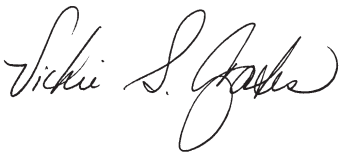
In this issue of *Stateside*, we discuss a group of individuals who sit squarely in the center of both the Medicaid reform and Medicare drug benefit debates: those who are dually eligible for Medicaid and Medicare. Although the nation's governors agree that coverage for dual eligibles should be fully funded by the federal government, the issue is far from settled.

We also highlight some of the challenges that states have faced as they try to implement premium assistance programs. Finally, we have asked former Vermont Medicaid Director Paul Wallace-Brodeur to reflect on his 40 years of public service dedicated to health care issues in Vermont.

This is the last issue of *Stateside* for which I will have the privilege of penning the director's letter. While I am excited about relocating to my home state (by adoption) of Oregon, I will truly miss my daily contact with SCI staff and our colleagues at AcademyHealth. I know they will continue to serve the states with creativity, responsiveness, and dedication.

I look forward to working with SCI and AcademyHealth from a new perspective, and remain committed to the goals and mission of the organization. David Helms, AcademyHealth's president and CEO—who led SCI for many years—will return to the team to serve as interim director while we search for a full-time replacement.

My years at SCI have been wonderful. There is no way that I could adequately acknowledge all of the talented and dedicated people with whom I have worked in this role. However, I would like to say a special thank you to The Robert Wood Johnson Foundation for their commitment to health care coverage, even during the toughest of times. It has made a difference.



Vickie S. Gates
SCI Program Director 2000 – 2003

SCI *Stateside*

This newsletter is prepared by AcademyHealth under a grant from The Robert Wood Johnson Foundation. AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health research and policy.

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grams, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs, pay for some or all of dual eligibles' Medicare cost-sharing depending on individuals' incomes and resources. Those with incomes too low to qualify for the QMB, SLMB, or QI programs qualify for full Medicaid benefits, which are paid by state Medicaid programs as well.

Much of the rising costs in Medicaid programs can be attributed to prescription drug spending by dual eligibles. Though not a mandatory part of Medicaid programs, prescription drug coverage is voluntarily included by all states in their Medicaid benefit packages. Thus, when dual eligibles are enrolled in Medicare, which does not pay for prescription drugs, Medicaid offers this benefit as part of its "wrap-around" coverage. This wrap-around coverage results in a total of $16 billion a year of pharmaceutical drug spending for dual eligibles.

The question of whether states or the federal government should assume responsibility for dual eligibles is a critical issue in the current Medicare prescription drug debate. The different approaches that the House and Senate bills take in terms of allocating financial responsibility for this group is a particularly contentious issue. "For the first time," said Julie James, a principal at Health Policy Alternatives, "Medicare would not be a universal benefit across the board."

The House version (H.R. 1) would institute a prescription drug benefit that would apply to all Medicare beneficiaries, including dual eligible individuals, with patient cost-sharing requirements based on income. In the Senate version (S. 1), on the other hand, some low-income seniors would not be eligible for Medicare drug coverage. Although the Senate bill is about $30 billion more generous than the House bill overall, it would not extend Medicare drug coverage to any dual eligible individuals who qualify for drug benefits under Medicaid. Also, like the House bill, the Senate bill varies enrollees' cost-sharing requirements based on income for those not eligible for Medicaid.

Not surprisingly, the governors have spoken out in unanimous support of the House bill, which gives the federal government some responsibility for the dual eligible population. In a letter dated August 1 to Representative Bill Thomas, the chairman of the House Ways and Means Committee, all 50 governors expressed their support for the House's package and rejection of the Senate's. "All of our nation's seniors deserve the peace of mind of knowing they will be included in the new prescription drug benefit," said the late Indiana Governor Frank O'Bannon.

According to John McManus, staff director for the House Ways and Means Subcommittee on Health, the primary intent of the House bill is not to develop a new model for the state/federal relationship. "The bill is not an attempt to provide fiscal relief to the states; that is incidental," he said at the Alliance for Health Care Reform's September 5 briefing on low-income Medicare beneficiaries. "We understand that the states are in dire straights, but the main goal of the bill is to create a strong prescription drug benefit for America's seniors."

With increasing health care expenditures and growing numbers of uninsured, it is easy to understand why both states and the federal government would like to absolve themselves of the financial responsibility for dual eligibles. The reality, however, is that the two groups will have to work together in order for any progress to be made in health care reform. Some analysts think that the $400 billion on the table for a new Medicare drug benefit is enough to make a compromise happen.

Others are not so optimistic. According to Marilyn Moon of the American Institutes for Research, a panelist at the September 5 Alliance event, the likelihood that a bill will pass seems to be decreasing as the debate about dual eligibles rages on. "Right now, I'd say there's a 50/50 chance that something will pass," she said. "I used to think it was much higher."

To view meeting materials from SCI's July workshop, which explored the issue of dual eligibles and other topics relevant to state officials, please visit: www.statecoverage.net/meetings.htm. The site includes slides and presenter biographical information from the workshop, which was titled, "Creative Strategies in Challenging Times: SCI Workshop for State Officials."

Save the Date — January 29 – 30, 2004

SCI's National Meeting for State Officials

Renaissance Washington, D.C. Hotel

Join your colleagues immediately following AcademyHealth's National Health Policy Conference (January 28 – 29) for in-depth discussions about health care coverage issues relevant to state policymakers. Please visit www.statecoverage.net/meetings.htm for details.

SCI Helps States Fine-Tune Premium-Assistance Programs

As states struggle with rising budget deficits, many are looking to leverage private funds to stretch limited—and sometimes shrinking—public dollars. One of the most promising strategies they are using is premium assistance (PA) programs, which subsidize employers' premiums for eligible low-income families and individuals. Unfortunately, however, many states have found it difficult to implement such programs.

"Implementing PA programs remains a challenge," says Kate Brewster, who runs RIteShare, Rhode Island's buy-in program. "Obtaining employer cooperation can be time-consuming and difficult, and federal laws such as ERISA present additional barriers to enrollment," she says.

In June 2003, the State Coverage Initiatives (SCI) program convened a small group consultation for 11 states that have been trying to make premium assistance work over the past few years. "The consultation helped me and my colleagues from Rhode Island to deal with some of the barriers we have faced," says Brewster.

The meeting was led by Rick Curtis and Ed Neuschler of the Institute for Health Policy Solutions (IHPS) and also attended by leaders at the National Academy for State Health Policy (NASHP), the National Governors Association (NGA), and The Robert Wood Johnson Foundation (RWJF).

"Premium assistance offers an important opportunity for many states facing severe fiscal difficulties," says Curtis. "By helping Medicaid and SCHIP eligibles to enroll in employer-sponsored health plans that they cannot afford on their own, premium assistance can reduce spending while covering people who might otherwise be uninsured," adds Neuschler. Perhaps more important, Curtis continues, PA can help states avoid unaffordable shifts from employer to state coverage.

"Although setting up a PA program requires an upfront investment of administrative resources, a growing number of states have shown that it can really pay off," says Neuschler.

At the meeting, attendees brainstormed and shared ideas about how to improve the PA programs, including:

- Following the example of Pennsylvania's Health Insurance Premium Payment (HIPP) program, which has adopted subrogation language to authorize officials from the state's Department of Public Welfare to

State Reports about Premium Assistance

SCI has added three recently published reports on states' experience with premium assistance to its State Reports database (www.statecoverage.net/reportsearch/index.cfm):

Premium Assistance: What Works? What Doesn't? (April 2003) by Ed Neuschler and Rick Curtis of the Institute for Health Policy Solutions. This piece explores how states can maximize private coverage and make operational decisions that would influence administrative structure, costs, and the reach of the program.

A Snapshot of State Experiences Implementing Premium Assistance Programs (April 2003) prepared by Claudia Williams for the National Association of State Health Policy and the Centers for Medicare and Medicaid Services. The report provides information on federal requirements and characteristics of state PA programs. It addresses how to identify potential participants, assess the cost-effectiveness of coverage, and avoid crowd-out.

Premium Assistance Programs Under SCHIP: Not for the Faint of Heart? (May 2003) by Amy Westpfahl Lutzky and Ian Hill of The Urban Institute. This report evaluates programs in three states that are part of the Assessing the New Federalism project: Massachusetts, Mississippi, and Wisconsin.

collect information directly from employers—rather than asking potential enrollees to obtain and submit the information themselves—in order to determine employees' eligibility for premium assistance.

- Adapting to PA programs a December 2000 regulation that amends ERISA to allow child support agencies to collect information from employers on the availability of coverage from absentee parents. Attendees discussed the possibility of modifying the National Medical Support Notice to make it easier for states to collect information directly from employers. Further information on the notice can be found in the Federal Register at www.gpoaccess.gov/fr/index.html (Federal Register: December 27, 2000, Vol. 65, No. 249).

SCI staff are committed to helping states develop efficient and cost-effective PA programs. Currently, they are working with officials in Pennsylvania to profile its successful HIPP program.

SCI has also recently partnered with the Centers for Medicare and Medicaid Services (CMS) and NASHP to develop a one-year "premium-assistance toolkit" project that will assist states that are interested in leveraging private funds. Run by NASHP and jointly funded by SCI and CMS, the toolkit will include practical information to help states assess whether to pursue a PA program. For more information, please contact SCI Senior Manager Jeremy Alberga at 202.292.6726 or jeremy.alberga@academyhealth.org.

Reports of Interest

Dirigo Health: Health Care Reform for Maine
Maine Office of the Governor, Summer 2003

www.statecoverage.net/statereports/me14.pdf

This summary looks at stakeholders' efforts to conceptualize and pass the Dirigo Health Plan, a universal health care coverage program in the state of Maine. It outlines the health insurance problems that the legislation aimed to address, such as access, cost, and quality, and the strategies that it has incorporated to deal with them.

Federalism and Health Policy
The Urban Institute Press, Summer 2003

To purchase a copy, visit www.urban.org/pubs/federalism/index.html.

This compilation of essays, edited by John Holahan and Alan Weil of the Urban Institute, and Joshua Weiner of RTI International, examines the joint responsibility of federal and state governments for the financing and delivery of health care, particularly for low-income populations. It also evaluates how well each has lived up to its responsibility, while offering ways that the relationship can be improved.

Health Care Purchasing Alliances: A Small Employer Alternative for Minnesota
Minnesota Department of Health, July 2003

www.statecoverage.net/statereports/mn56.pdf

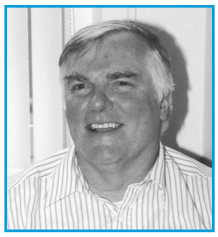
This report examines the progress that purchasing alliances have made as part of Minnesota's Community Purchasing Arrangements Act of 1997. The state's legislation was intended to address uninsurance and underinsurance among many state residents, particularly individuals in rural areas and those employed by small businesses. The report also examines the history and lessons of other purchasing alliances.

Hidden Costs, Lost Value: Uninsurance in America
Institute of Medicine, Committee on the Consequences of Uninsurance, 2003

http://stills.nap.edu/books/030908931X/html/

This report tallies some of the most clearly identifiable economic and social costs of uninsurance, as described in the previous four reports in this series. The Committee concludes that maintaining the current population of 41 million uninsured would result in a substantial loss of economic value due to the costs associated with worsening health, which is often a consequence of uninsurance.

Q & A with Paul Wallace-Brodeur



After serving for 40 years as a public servant in Vermont, Medicaid Director Paul Wallace-Brodeur retired in August 2003. His career in state government spanned many areas of health care including mental health, planning, and the development and implementation of coverage expansions such as Dr. Dynasaur, Vermont's coverage program for children. To say that Paul has seen a lot over the course of his career would be an understatement. We've asked him to comment on the breadth of his experience and share his perspective on the future of health care in Vermont and the nation.

Q. Looking back at your 40 years in public service for Vermont, what were your greatest challenges and accomplishments?

A. Every era had its challenges. When I was the director of Vermont's health planning agency in the 1970s, it was a challenge to establish a certificate of need process, because health care regulation was a new concept at that time. In addition, there was widespread concern about the rapid increase in health care costs. The public eye was always on our agency.

In the early 1980s, we succeeded in creating a business coalition to mobilize employers' support and interest in health care issues. With the elimination of federal funding for health planning, we were able to sustain Vermont's health planning program with state funds. In the late 1980s, we launched an initiative to address ethical issues in health care, conducted community forums on advance directives, and got legislation passed to authorize a durable power of attorney for health care.

Q. During the late 1980s, expanding access to health care took center stage in Vermont. What role did you have in those coverage initiatives?

A. I chaired a board created to design a program that would achieve universal coverage. Unfortunately, at the time our reports were released, the recession hit, so the plan had to be pared down. However, the legislature did pass a coverage expansion for kids called Dr. Dynasaur—a name that is still used for Vermont's Medicaid and SCHIP children's programs. In the early 1990s, I worked with the Vermont Health Care Authority—which was created by Governor Dean to spearhead a state initiative paralleling the Clinton universal access effort at the federal level.

Unfortunately, our plan met the same fate that Clinton's did. Governor Dean did not give up, however. He proposed that Vermont support an incremental expansion using federal 1115 waiver authority. I played a significant role in developing the waiver. After it was approved, I helped implement the expansion program in my position with Vermont Medicaid, which began in 1995.

The program was the first in the state to be based on a Medicaid managed care model. It was quite a roller coaster. After working hard to get plans to participate, they eventually pulled out for financial reasons. Ultimately we transferred everyone into the primary care case management (PCCM) program that exists today. The waiver has a pharmacy component, and the last few years have been consumed with pharmacy cost-containment efforts. We have implemented a preferred drug list and initiated a multi-state purchasing pool with Michigan and South Carolina.

Q. What are the major health care challenges now facing Vermont?

A. Vermont faces state-financed health expenditures that are growing faster than our revenues, and individual and small group insurance markets that are, at best, fragile. In addition, businesses are reeling from significant premium increases and looking for more affordable insurance products as a result. On the positive side, Vermont is doing well on measures of health care quality and access.

Q. Vermont received a grant for more than $1 million in FY 2000 from the Health Resources and Services Administration as part of their State Planning Grant program. How did this grant help Vermont develop plans to cover their uninsured?

A. Using our HRSA funds, we developed the most accurate picture of our uninsured that the state has ever had. We also developed a comprehensive assessment of Vermont's health system, designed a single payer financing model, and identified several initiatives to reduce the uninsured. Governor Dean championed an option that would allow employers to buy into our waiver program for uninsured adults. The proposal passed the Senate but unfortunately languished in the House. Several bills that would authorize a buy-in option were introduced into the legislature in 2003, and the budget bill requires a further analysis of such an arrangement this year. Health care is expected to be at the top of our 2004 legislative agenda.

Q. What do you think about the HRSA-funded single-payer research conducted in Vermont?

A. In our grant report to HRSA, we outlined a viable single-payer model for the state. But no matter how well you craft it, a single-payer plan is always a hard sell. It would generate a lot of change, and it was clear from the Clinton effort that people are wary of anything other than incremental changes to the health care system. They don't like the idea of the taxes that would be required to finance such a system, even if taxes would only substitute for payments they are already making. And typically businesses are unwilling to cede control of health benefits to government.

Q. How has Medicaid changed since you started?

A. When I started working for Medicaid, we had a very traditional program. Since then, the number of covered beneficiaries has increased significantly, commercial managed care came and went, and the program now operates using a PCCM model. Medicaid provides benefits to about 22 percent of Vermont's population and is the 2nd largest insurer in the state. Medicaid is no longer a single program. It now offers different benefit plans and beneficiary cost-sharing arrangements. Medicaid covers uninsured adults, provides pharmacy benefits to elderly and disabled Vermonters, and provides coverage to about one-third of all Vermont children.

Q. How likely do you think Medicaid reform is in the coming year or so?

A. I think it will be slow in coming. The current administration wants to shift more financial responsibility to the states in return for more program flexibility. But the states are in no position to assume that financial burden. Unless there is more widespread consensus about the role of Medicaid in the U.S. health care system, I believe we will mainly see incremental changes in the near term.

Q. Do you believe that states can emerge from the current budget crisis having made positive long-term changes in how they provide health care coverage?

A. Perhaps, but states don't have much to work with right now. Cutting benefits or provider payments and reducing eligibility don't in my view result in positive long-term change. However, I believe that states are out in front in the area of pharmacy cost-containment. Collective state action to negotiate with the pharmaceutical industry could be a long-term winner that represents a fundamental, positive change. But the process needs to be perfected. It requires the strong support of the Centers for Medicare and Medicaid Services, and states need to be committed to taking collective action.

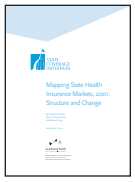
Q. You worked with Governor Dean for several years. What do you think he could bring to Washington?

A. He has a strong commitment to health care, particularly to universal coverage for children. His approach to improving access is practical rather than ideological, and I would expect him to develop a positive and coherent federal health policy agenda.

Q. Now that you have retired as Medicaid director, will you continue working in health care policy?

A. Yes. I will be doing some consulting with Vermont Medicaid, and expect to branch out in the future.

New from SCI



Mapping State Health Insurance Markets, 2001: Structure and Change. The monograph updates to 2001 SCI's previously released report on national trends in insurance markets through 1997. SCI Senior Consultant Deborah Chollet, Ph.D., who is a senior fellow at Mathematica Policy Research, is the report's lead author. For a copy, visit www.statecoverage.net/mapping2001.pdf.

SCI Needs Your Help

SCI is currently updating its Coverage Matrix at statecoverage.net/matrix.htm. The matrix illustrates how states are covering people through Medicaid, SCHIP, and state-only programs. Help us make sure it accurately reflects what is happening in your state by e-mailing corrections or additions to sci@academyhealth.org.

Coming Soon from SCI

Assessing ROI in State Disease Management Programs
Tom Wilson

This issue brief will focus on the methodological issues involved in assessing return on investment for disease management (DM) programs in Medicaid and state high-risk pools. With states seeking immediate savings from DM programs, assessing these outcomes has become a central issue. This brief will focus on the challenges involved in finding an adequate baseline measure and comparable outcomes metrics. The brief will be available in October at www.statecoverage.net/publications.htm.

SCI is pleased to announce the launch of **Program Perspectives** this fall. This series will be available exclusively online at www.statecoverage.net/publications.htm. It will feature questions and answers with the officials responsible for the administration of innovative state programs.

In the first issue of this series, Rod Betit will examine Utah's Primary Care Network (PCN). Betit is the executive director of the Utah Department of Health. He is responsible for conceptualizing and implementing the PCN. Future Program Perspectives will profile Pennsylvania's innovative Health Insurance Premium Payment (HIPP) program and Maine's new universal coverage plan, Dirigo Health.

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