



STATES IN ACTION

A Quarterly Look at Innovations in Health Policy

May 2005

Introduction

The past few years have been difficult for states, given rising insurance premiums, weak labor markets, budget shortfalls, and other problems. Despite these pressures, many states have come up with innovative strategies for stretching health care dollars and improving the quality of care.

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In addition to expanding coverage through Medicaid, the State Children's Health Insurance Program, and other programs, states have found ways—particularly through public-private partnerships—to more effectively purchase care, better manage diseases, and promote cost-effective primary and preventive health services.

These strategies are outlined in a recent series of reports prepared by the Economic and Social Research Institute for The Commonwealth Fund, *Stretching State Dollars in Difficult Economic Times* (http://www.cmwf.org/publications/publications_show.htm?doc_id=243623). To keep track of these and other interesting efforts, the Fund is inaugurating a newsletter, *States in Action: A Quarterly Look at Innovations in Health Policy*, to identify and describe innovative state programs across the country.

Our first issue highlights strategies for purchasing care, building on employer-based coverage, and expanding county-based coverage. Future issues will examine efforts to improve the quality and efficiency of care and continue to spotlight strategies to expand coverage. We will be highlighting existing programs as well as new initiatives.

To tell us how we can improve upon this newsletter, please take a short online survey (<http://64.73.28.22/s.asp?u=952831079598>)

We welcome those involved in state efforts to expand coverage and improve care and efficiency to let us know about their efforts at stateinnovations@cmwf.org.

We hope policymakers, administrators, and researchers across the country will find these newsletters useful resources as they work to stretch health care dollars and meet the needs of their residents.

This *States in Action* quarterly newsletter is part of a new Commonwealth Fund initiative on State Innovations. The initiative aims to increase understanding about state health system performance, identify and measure the effects of policies intended to improve performance, and spread information about promising practices. For more information about the program, contact Jennifer Edwards, State Innovations program director, at je@cmwf.org.

Featured State Profile . . .

Minnesota's Smart-Buy Alliance: A Coalition of Public and Private Purchasers Demands Quality and Efficiency in Health Care

Summary: The state of Minnesota has joined with private business and labor groups in a "Smart-Buy Alliance" to drive quality improvements and efficiencies in the health care delivery system. While Alliance members continue to purchase health care individually, they have agreed to set uniform performance standards, cost/quality reporting requirements, and technology demands on health plans and providers and to favor providers and health plans that are certified for highest quality. Together, the Alliance members buy health insurance on behalf of about 70% of state residents.

Issue: Minnesota, like the entire U.S., has experienced years of double-digit growth in health care premiums and persistent reports of poor quality care. In response, the state of Minnesota has joined with private business and labor groups to change the way they purchase care. The coalition hopes to reduce an estimated 30% of direct health care outlays resulting from inappropriate and poor quality care and to achieve an estimated 10% of savings from health information technologies.¹

Objective: The Smart-Buy Alliance members pool their purchasing power to drive value in the health care delivery system. Their goals are to improve quality and lower costs by reducing inappropriate and unnecessary care, encouraging evidence-based medicine and use of highest-performing providers, and reducing providers' administrative costs through common reporting requirements. That

is, the Alliance hopes to achieve savings in the long run through coordinating their members' expectations on quality and value.

"Members are shifting from simply paying for health care insurance to reforming the system by the way we purchase services," said Brian Osberg, assistant commissioner of health care for Minnesota's Department of Human Services (DHS).

Background: The formation of the Alliance, announced in November 2004, resulted from months of study by a "Health Cabinet" comprised of members of Minnesota Governor Tim Pawlenty's Administration and representatives from business and labor groups, some of whom had been involved in other quality purchasing initiatives. The participating organizations agree to common

For More Information: State of Minnesota Governor's Health Cabinet site, <http://www.maximumstrengthhealthcare.com>

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¹ 30% poor quality estimate based on literature review summarized in *Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership*, Midwest Business Group on Health (2003); 10% potential savings from information technology based on 7/21/04 press release by the U.S. Department of Health and Human Services. (State of Minnesota, Governor's Health Care Cabinet, Presentation: *Minnesota's Smart Buy Health Care Purchaser Alliance*, State Coverage Initiatives National Meeting, February 5, 2005).

principles in their purchasing decisions, which translate into similar demands in health plan contracts, shared use of tools and technologies, and greater empowerment of members.

Participants: Alliance members purchase health insurance for 3.5 million people, or 70% of the state's residents. DHS represents about 660,000 members of Medicaid, the State Children's Health Insurance Program (CHIP), and state health care programs. Minnesota's Department of Employee Relations purchases care for more than 100,000 state employees and their dependents.

Private sector participants include:

- Buyer's Health Care Action Group, a coalition of employers in the forefront of developing new purchasing strategies;
- Minnesota Business Partnership, representing Minnesota's largest employers;
- Minnesota Chamber of Commerce, representing employers of all sizes across the state;
- Labor/Management Health Care Coalition of the Upper Midwest;
- Minnesota Association of Professional Employees;
- Employers Association; and
- Advocates for Market Place Options for Mainstreet.

Process of Change: While Alliance members continue to purchase health care individually, they are encouraging higher quality and efficiency by collectively pursuing four key strategies:

1. Reward or require "best in class" certification. Alliance members will build on existing "best in class" certification programs in development that identify health care providers achieving certain levels of expertise, experience, proficiency, and results. Currently, the Health Value Partnership for Heart Care identifies and rewards the top-performing cardiac care centers in Minnesota. Cancer care will be certified next. Alliance members will consider certification when selecting providers and will encourage patients to do the same.

2. Adopt and utilize uniform measures of quality and results. The Alliance will adopt uniform methods of measuring quality of care and results and use them in purchasing. To facilitate comparison of health plans, Alliance members will use a common purchase order that delineates specific kinds of information the plans must provide about performance and outcomes. This is based on the "eValue8" value-based purchasing tool (described in the box below). Medicaid, for example, will incorporate features of eValue8 into their contracts with health plans. Some of the private purchasers will use the eValue8 tool to request proposals from various health plans. The state already has notified the managed care plans that cover two-thirds of public health program enrollees that they will incorporate new benchmark indicators into the 2006 contracts.

EValue8

EValue8, an initiative sponsored by the National Business Coalition on Health and Watson Wyatt Worldwide, is a Web-based tool that allows health care purchasers to assess and compare health plans on a local, regional, or national basis.

EValue8 uses standardized requests for information to collect vendor-specific data from health plans and then analyzes the data using automated scoring based on best practice standards.

EValue8 prepares comparative reports that cover several key areas of health plan performance, including:

- Adoption of health information technology
- Member and provider communication
- Disease management
- Program administration
- Provider performance
- Patient safety
- Pharmacy benefit management
- Behavioral health
- Financial stability

For more information, visit: <http://www.evalue8.org/eValue8/about/overview.cfm>

3. Empower consumers with easy access to information. In addition to collecting information from providers, the Alliance will provide consumers with standardized, user-friendly information about health care costs and quality. Consumers will have access to:

- The Community Measurement Project—This provides information on how well MinnesotaCare (state-subsidized coverage for eligible populations) systems meet certain proven standards, for example the extent to which physicians adhere to clinical guidelines and evidence-based medicine. It currently provides comparative measures for asthma, children's health, depression, diabetes, high blood pressure, and women's health. Also provides information on how to work with your doctor to stay healthy (<http://www.mnhealthcare.org>).
- Compare Your Care—Consumers take an online survey about care they have received. Surveys exist for child, adolescent, and adult general and preventive health; pediatric and adult asthma; diabetes; heart disease; and depression. Consumers are provided with information and advice for self-care. The accumulated responses enable comparisons among clinics, networks, and care systems (<http://www.healthfront-info.org/>).
- Minnesota Health Information Web Site—A clearinghouse that connects consumers with a wide range of information about the cost and quality of health care in Minnesota. The site includes links to

numerous health-related sites that compare provider performance and costs, help consumers manage their health conditions, give tips on purchasing care, and offer strategies for staying healthy. The site was created by the Governor's Health Cabinet and is administered by the Minnesota Department of Health (<http://www.minnesotahealthinfo.org>).

- The Adverse Health Events Reporting Law—Passed during the 2003 legislative session and modified again in 2004, this state law provides health care consumers with information on how successfully hospitals and outpatient surgical centers prevent adverse events. Twenty-seven types of incidents will be tracked and publicly reported, including wrong-site surgery, retention of a foreign object in a patient after surgery, and death or serious disability associated with medication error. Under the legislation, hospitals must notify the Minnesota Department of Health (DOH) when any of these 27 errors occur. The DOH will then publish annual reports of the events by facility along with an analysis of the events, corrections implemented by facilities, and recommendations for improvement.

4. Require use of information technology. The Alliance will encourage efficiencies and quality improvements by supporting development and/or requiring adoption of new technologies. It is pursuing the following:

- providing patients with “Smart Card” electronic insurance cards for instant information about their eligibility and benefits;²
- supporting the development and widespread use of electronic prescription technology, intended to reduce medication errors and administrative costs;
- requiring that health plans use the standardized, electronic insurance claim forms employed by Medicare (forms CMC-92 and CMC-1500); and
- developing automated systems that track patient satisfaction and clinical outcomes and speed up payments to providers.

Next Steps: Members of the Smart-Buy Alliance can choose which initiatives to pursue. For example, the Labor/Management Health Care Coalition of the Upper Midwest is leading the best in class certification initiative, while DHS is working with other health plans on SmartCard technology. The members will share the results of their initiatives and are building the requirements—whether for quality standards, SmartCards, automated systems, or other measures—into this year's negotiations with health plans and providers. For most purchasers, the new contracts will take effect in calendar year 2006.

Challenges and Lessons for State Purchasers: State administrators emphasize that an effective purchasing coalition requires broad-based consensus, some compromises, and a bottom-up approach. According to Osberg, “this is a voluntary and market-based initiative, with no mandate. The

² Alliance members are currently pursuing a request for proposal process to develop the Smart Card technology.

Alliance will only work if we all have the resolve to implement the provisions we've agreed on."

So far there have been many questions but not a great deal of "push back" from health plans and providers. Cal Ludeman, Minnesota's commissioner of employee relations and chair of the Governor's Health Cabinet, said "some suppliers have been anxious, wondering how the world will change, but they're being as collaborative as possible."

Ludeman stressed the need for constant communication among stakeholders, as well as education and outreach. "Part of the job is training our own members—going to small towns and talking to employees and employers about how to contract, what questions to ask, and how to shop for health care."

Snapshots

California's Children's Health Initiatives: County-Based Programs to Guarantee Coverage

California counties are taking creative approaches to guarantee that all low- to mid-income children have access to health coverage. As of April 2005, 10 counties have implemented and another 18 are planning Children's Health Initiatives (CHIs). With funding from private philanthropies, local and state contributions, and tobacco tax revenues, these counties have extensive outreach campaigns to enroll eligible children in Medi-Cal and Healthy

Families (California's Medicaid and CHIP programs) or the new "Healthy Kids" programs (implemented and funded in each county) for children who are not eligible for public programs.³ Together, these counties have enrolled more than 70,000 children in their Healthy Kids plans and tens of thousands more under Medi-Cal and Healthy Families.

Results from the first CHI, begun in Santa Clara County in 2001, are promising. A new evaluation of the impact

of the program found a 50 percent reduction in unmet need for medical and dental care (to be featured in a future newsletter).⁴ An earlier evaluation found that for every child enrolled in Santa Clara's Healthy Kids plan, CHI added

For More Information: Institute for Health Policy Solutions Web site, <http://ihps-ca.org/>
Santa Clara program: <http://www.chikids.org/>
Statewide campaign:

<http://www.100percentcampaign.org/>

Contacts: Institute for Health Policy Solutions California, (650) 287-4210, Liane Wong, California Director, Lwong@ihps-ca.org, or Hilary Frazer, Senior Program Researcher, Hfrazier@ihps-ca.org

³ California Endowment, the David and Lucile Packard Foundation, Blue Shield of California Foundation, The California HealthCare Foundation, First 5 California and local First 5 Commissions. The California Endowment has funded a technical assistance consortium to work with counties to help them implement their CHIs (<http://ihps-ca.org/>).

⁴ Trenholm CA, Howell E, Hughes D, Orzol S. *Santa Clara Healthy Kids Program Reduces Gaps in Children's Access to Medical and Dental Care*. Mathematica Policy Research, Inc. April 2005 (http://ihps-ca.org/resources/eval_santaclara_2.html).

nearly one additional child to Medi-Cal or Healthy Families. This represented an increase in the latter programs of about 28%, bringing into the county an additional \$24.4 million in state and federal dollars during the initiative's first two years.⁵

The foundation support for Healthy Kids is intended only as bridge funding until a permanent source of public funding is established. A coalition of advocates called the 100% Campaign and Pacific Institute for Community Organization California are working to expand the program statewide and guarantee stable public financing, possibly with a private trust fund as a supplement.⁶ The coalition has sponsored legislation to expand health coverage to all children in the state, called Californians for Healthy Kids.

Oregon's Children's Group Plan: A Dependent-Only Option for Small Businesses

Oregon's new Children's Group Plan allows small business owners to provide comprehensive coverage for children of their workers *even if they cannot afford to cover their employees*. The Children's Group plan was designed by Oregon's Insurance Pool Governing Board (IPGB) at the direction of the 2003 state legislature.⁷ Two insurance carriers offer the plan through comprehensive HMO and PPO products, which are marketed through media campaigns, business groups, and insurance agents.⁸

For More Information: Insurance Pool Governing Board Web site, http://egov.oregon.gov/IPGB/certified_plans.shtml and Alternative Group Plan Manual, http://www.oregon.gov/IPGB/docs/cover_with_insert.pdf

Contact: Glen Knickerbocker, Program Manager Certified Plans, Insurance Pool Governing Board, glen.w.knickerbocker@state.or.us, (503) 373-1656, ext. 22225

A business may purchase the Children's Group Plan if it has two to 50 employees and has not provided insurance since July 2003. Employers must contribute at least \$50 but may contribute up to 100% of the monthly premium. The family pays the remainder, though lower-income workers may qualify for a subsidy through the state's Family Health Insurance Assistance Program. To

avoid adverse selection, 75% of eligible families with children in a firm must participate. Children up to age 23 are covered. All eligible children in an enrolling family must join, unless other group health insurance or the Oregon Health Plan already covers them.

⁵ Trenholm CA. *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative*. Mathematica Policy Research, Inc., June 2004 (http://ihps-ca.org/resources/eval_santaclara.html).

⁶ The 100% Campaign is a collaborative effort of Children Now, Children's Defense Fund, and The Children's Partnership, with primary funding from The California Endowment. The campaign's goal is to ensure universal access to health coverage for all children in California.

⁷ IPGB is a state agency dedicated to helping small businesses obtain health insurance for themselves, their employees, and their employees' dependents. In addition to the Children's Group Plan, IPGB is introducing a low-cost, limited benefits plan available to employees and their spouses.

⁸ Dental coverage is not included.

The premium rates for the Children’s Group Plan are created by a “group census” for each employer. A blended rate is based on the number and ages of the children enrolled in each employer group. Also, each carrier has its own rates and uses different age band groupings to determine the premiums for each employer group. The table below illustrates premium ranges by three age groupings that incorporate both carriers’ prices. This is a reflection of the highest rate per category and the lowest rate per category and could reflect either carrier’s rates in any of these low/high examples.

**Children’s Group Plan, Low/High Premium Range (per child),
Plan with \$500 Deductible**

Age	Premium
0–2	\$186/403
3–18	\$106/126
19–23	\$129/154

Note: The large range in the 0–2 age group reflects potential for very expensive birth/early childhood concerns and/or prior claims experience.

Coverage began March 1, 2005 and IPGB administrator Rocky King expects enrollment to grow over time, adding that he would be “happy if the children’s plan gets 5,000 kids after two years.” King doesn’t view the new plan as a magic bullet that will solve the problem of all uninsured Oregonians, but as an innovative approach to getting more of the most vulnerable covered.

The Illinois “3-Share” Model: County-Level Partnerships to Cover the Working Uninsured

Building on a pilot program begun in 2003, Illinois will implement “3-share” coverage in four counties this July to help small employers provide health insurance to their employees and dependents. The name refers to the fact that counties, employers, and employees will share the financing. This model was developed in Muskegon County, Michigan, and is being replicated in a number of communities across the nation.⁹

Program development began in St. Clair County with initial funding from a Health Resources and Services Administration State Planning Grant. (http://www.cmwf.org/publications/publications_show.htm?doc_id=274289). In order to keep premiums affordable for all three parties, the benefit package is less comprehensive than those offered by most large employers. This also was designed to help guard against crowd-out, when small employers drop their coverage to take advantage of programs that require lower contributions from them. 3-share plans, which will be offered through the Pan American Life and Health Insurance company, covers physician office visits, emergency department visits, inpatient hospital, surgery, intensive care, skilled nursing

⁹ Fronstin P, Lee J. A community expands access to health care: the case of Access Health in Michigan. *Health Affairs* 24(3):858-63, 2005 May/Jun.

facilities, mental disorder hospital stays, wellness care, lab and X-ray, prescription drugs, and discounted vision and dental care.

The premium structure is described below.

St. Clair County 3-Share Contribution Requirements

	Employee Share	Employer Share	County Share
Employee	\$50	\$50	\$50
Employee+One	\$90	\$90	\$90
Full Family	\$198	\$90	\$90

The state expects enrollment in the St. Clair program to begin at a modest level, with approximately 500 lives covered in the first year at a cost of \$300,000 to each of the three contributing parties. They predict 1,000 covered lives after three years and 5,000 covered lives by the end of the fifth year, with costs rising accordingly to \$3,000,000 per year per contributing sector.

In St. Clair, financing for the county share will come through a non-profit entity, the Illinois Health Access Plan for St. Clair County, which will receive funds from the county health department. The county health

department has agreed to provide funds to the extent that they are being “freed up” from subsidizing the losses that public health clinics typically incur (largely from treating Medicaid patients at below cost). By certifying those clinic losses as “certified public expenditures” that are eligible for federal Medicaid matching funds, the clinics will receive additional Medicaid payments. This will enable the county to use their “freed up” dollars for the 3-share program. Work is still being done to

finalize an agreement between the county and the state Medicaid agency on how the flow of funds will occur, so that “certified public expenditures,” as envisioned, are acceptable to the federal government. This strategy is possible through a change in the Medicaid State Plan.

Many of the above design elements are also being applied in Macoupin (Carlinville) and Sangamon (Springfield) Counties, where waiting lists for 3-share programs have already begun to form.¹⁰ In Winnebago (Rockford) County, the Rockford Health Access Plan began enrollment of a small test group in July 2003 and it is awaiting approval of the new financing mechanism to expand enrollment. Further, the state is seeking two additional counties in which to pilot the program: a metropolitan area with a large Latino population and a predominantly rural county.

For More Information: Illinois Division of Insurance State Planning Grant Web site, <http://www.ins.state.il.us/spg>

Contact: Tim Olmsted, Project Coordinator, Illinois Department of Financial and Professional Regulation, Division of Insurance, State Planning Grant (217) 557-9248, tim_olmsted@ins.state.il.us

¹⁰ These counties are working with the state’s Department of Insurance, based on their experiences as Community Access Program grantees, and enrollment is expected for July 2005.

Wisconsin's Co-Op Care: Cooperative Health Insurance for Farmers

Wisconsin farmers are pooling their purchasing power to enhance access to affordable coverage. Typically, farmers, farm workers, and their families are faced with limited and often unaffordable coverage options in the individual or small group insurance markets.

Made possible through a state law giving Wisconsin Federation of Cooperatives (WFC) the ability to form five health care cooperatives, the new health care purchasing co-ops will negotiate and contract with local insurers to establish health plans for their members. The first such plan is being implemented by WFC through a collaborate partnership between Group Health Cooperative of Eau Claire and AgStar Farm Credit Cooperative, which counts among its membership about 2,000 families involved in farming in 16 counties in the northwest area of the state. WFC is finalizing benefits and pricing, conducting focus groups, and expects to market the product in the summer of 2005.

For More Information: Wisconsin Federation of Cooperatives Web site, <http://www.wfcmac.coop/coops/wfcmac.html>

Contact: Melissa Duffy, Director of Government Relations, (608) 258-4402, Melissa.duffy@wfcmac.coop

A number of features are intended to make the WFC plan more affordable than existing options, including:

- Allowing those who are currently limited to purchasing individual health policies to buy into a group plan (the project's actuaries estimate a 15% savings from this, though rates will be lower for some individuals and higher for others);
- Building a significant amount of member education into the program and encouraging prevention and intervention (offering first-dollar coverage of preventive services, promoting disease management and workplace safety, and requiring members to undergo a health risk assessment as a condition of enrollment);
- Building an effective data tracking system that will allow the cooperative to identify cost containment measures, measure provider performance, and bolster member education and disease management programs;
- Utilizing elements of consumer-driven health care, such as educating members about costs and benefits of utilization, as well as encouraging use of generic medications and renegotiating provider fees;
- Ensuring a balanced risk pool by attracting and maintaining a stable membership through such rules as minimum participation requirements. WFC acknowledges that this is its biggest challenge. A FY 2005 federal budget appropriation of \$2.23 million will help establish and administer a "stop loss fund" that will pay for some of the higher-cost claims incurred by cooperative members. This should help maintain stable premiums and avoid rate hikes that often lead to "death

spirals,” whereby lower-risk individuals leave the plan, raising premiums still further.

WFC plans to implement Co-op Care statewide over the next three years. According to Melissa Duffy, director of government relations at WFC, “Success will pave the way for expansion. At some point, the cooperative purchasing arrangements will open up to other co-ops, small businesses, municipalities, and really any group that wants to join.”

I-SaveRx: States Facilitate Rx Reimportation

A number of states have joined together to allow residents, regardless of income, to purchase lower-cost pharmaceuticals from more than 60 approved pharmacies and prescription drug wholesalers in Canada, the United Kingdom, and Ireland. Illinois initiated the I-SaveRx program in October 2004, and since then Wisconsin, Missouri, Kansas, and Vermont have joined. Through a Web site or toll-free telephone number, residents can access information on nearly 150 brand name medications included in the program, prices in each of the three countries, enrollment forms, and guidance for purchasing. The program is administered by CanaRx, a Canadian

Pharmaceutical Benefits Manager. Individual purchasers have been achieving cost savings averaging 25 to 50%.

The program addresses common safety concerns about reimportation, including counterfeit and storage issues, through its stringent purchasing processes.

First, the program can only be used to purchase prescription refills. Second, the individual must mail or have their physician fax a completed health profile form and a signed prescription to CanaRx. The prescription is then reviewed by a physician in the country where it will be filled in order to make a final safety determination. Third, among the 150 available medications, there are almost no generic drugs, no narcotics, and no treatments that require refrigeration or other special care. Finally, only drugs manufactured for distribution in the program countries are dispensed to U.S. consumers.

While the program is still relatively small, with approximately 5,800 prescription orders processed as of April 7, 2005, the participating governors speak favorably of its ability to significantly reduce costs for those without prescription drug coverage. Illinois Governor Rod Blagojevich has been vocal in describing the program as one that allows individuals “access to better prices on the world market” without having to wait for federal action on the reimportation issue.

For More Information: I-SaveRx Web site, <http://www.i-saverx.net/>

Contact: Scott McKibbin, Special Advocate for Prescription Drugs, State of Illinois, (312) 793-1371, Scott_McKibbin@idpa.state.il.us

The Hawaii Rx Plus Program: Expanding Prescription Drug Coverage for the Underserved

In July 2004, Hawaii implemented the Hawaii Rx Plus program to provide discounted pharmaceuticals to residents who do not qualify for Medicaid, have an income below 350% of the federal poverty line, and have no other drug coverage. An estimated 300,000 individuals qualify for the program, with nearly half that number enrolled as of April 2005.¹¹ Enrollees receive a discount card to use at participating pharmacies, which allows them to pay the same prices that the State of Hawaii pays for drugs in their Medicaid

program. The program also covers pharmaceuticals that are not part of the Medicaid Preferred Drug List, including cancer and mental health drugs. Currently, 138 out of the state's 161 pharmacies participate. During this first phase, enrollees on average save 21% on pharmaceutical costs.

For More Information: Hawaii Rx Plus Web site, <http://www.hawaiiplusplus.com>

Contact: Tracy H. Okubo, Hawaii Rx Plus Program Coordinator, (808) 586-5036, tracy.h.okubo@hawaii.gov

The second phase of the program will begin in July 2005. The state will negotiate additional rebates with pharmaceutical companies on behalf of members and seek to expand the list of discounted drugs. The state hopes to have additional enrollees by July, and thus greater negotiating power. Eventually, program administrators want to save enrollees up to 60% off their out-of-pocket drug costs.

Updates

DirigoChoice, Maine's health plan designed to help small businesses and uninsured individuals obtain affordable, quality health coverage, has reported strong enrollment through March. A collaborative between Maine's Dirigo Health Agency and Anthem Blue Cross Blue Shield of Maine, DirigoChoice has 5,263 members, representing more than 400 small businesses and 1,200 self-employed individuals, as of April 1. Coverage for small businesses and the self-employed took effect January 1, 2005 and benefits for individuals without access to job-based coverage began April 1, 2005. DirigoChoice offers comprehensive benefits with full coverage for preventive care services. Enrollees with family income up to 300% of the federal poverty level receive discounts (up to 100%) on premiums and deductibles, based on a sliding scale.

In early May, the state announced that MaineCare will provide coverage for families earning up to 200% of the federal poverty level, up from the previous limit of 150%. In announcing the news, Governor John Baldacci

¹¹ Enrollment was 147,467 as of April 2005.

said that by expanding coverage, the state will save an estimated \$10 million in charity care and bad debt for those who previously had no health insurance.

DirigoChoice is one part of Maine's Dirigo Health Reform Act. Dirigo Health includes initiatives to control health care costs, improve quality, and achieve universal access to coverage in Maine by 2009. See: *Stretching State Health Care Dollars During Difficult Economic Times*, http://www.cmwf.org/publications/publications_show.htm?doc_id=243623; *Designing Maine's DirigoChoice Benefit Plan*, http://www.cmwf.org/publications/publications_show.htm?doc_id=253634; and *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine*, http://www.cmwf.org/publications/publications_show.htm?doc_id=230647.

Community Care of North Carolina, an innovative and cost-effective Medicaid disease management program in which local networks of primary care providers coordinate prevention, treatment, referral, and other services for Medicaid enrollees, has continued to expand toward statewide implementation. Enrollment has grown to 640,000 individuals. Planners and administrators are exploring ways to build on the disease management program to include congestive heart failure. They are also in the early stages of a provider incentive/pay for performance initiative. See http://www.cmwf.org/tools/tools_show.htm?doc_id=234404.

Kentucky is implementing a **Pilot Diabetes Disease Management** for Medicaid enrollees. The project will serve people in Bell and Floyd Counties, which together have 6,100 residents with diabetes—the highest incidence in the state. During the first phase of the project, the Medicaid program will contact health care providers and patients to collect health information and provide educational information to encourage patients to take a more active role in their care. In the second phase, nurses will contact patients to determine their progress and what other interventions may be needed. The results of the pilot will help determine whether the state pursues a broader, statewide disease management program. See http://www.cmwf.org/publications/publications_show.htm?doc_id=243635.

Related Publications

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The relationship between SCHIP enrollment and hospitalizations for ambulatory care sensitive conditions in California
Journal of Health Care for the Poor & Underserved. 16(1):96-110, 2005 Feb.

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Child & Adolescent Psychiatric Clinics of North America. 14(2):307-27, ix, 2005 Apr.

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Polednak AP

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Upcoming Meetings

2005 Annual Patient Safety and Health IT Conference—Making the Health Care System Safer Through Implementation and Innovation

Washington, D.C., June 6–10, 2005

<http://www.ahrq.gov/about/ptsafconf05.htm>

AcademyHealth State Health Research and Policy (June 25, 2005)
AcademyHealth 2005 Annual Research Meeting (June 26–28, 2005)
Boston, Mass.

<http://www.academyhealth.org/conferences/arm.htm>

State Coverage Initiatives Summer Workshop for State Officials
Chicago, Ill., July 27–29, 2005

<http://www.statecoverage.net/meetings.htm>

National Academy for State Health Policy 18th Annual State Health Policy Conference
Nashville, Tenn., August 7–9, 2005

<http://www.nashp.org>

*National Conference of State Legislatures 2005 Strong State Strong Nation
Annual Meeting*

Seattle, Wash., August 16–20, 2005

<http://www.ncsl.org/annualmeeting>

Useful Links

Henry J. Kaiser Family Foundation: State Health Policy and statehealthfacts.org

<http://www.kff.org/statepolicy/index.cfm>

<http://www.statehealthfacts.org>

Robert Wood Johnson Foundation's State Coverage Initiatives Web site

<http://www.statecoverage.net>

National Academy for State Health Policy

<http://www.nashp.org>



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