



## **STRETCHING STATE HEALTH CARE DOLLARS DURING DIFFICULT ECONOMIC TIMES**

### **OVERVIEW**

Summary of a Series of Four Reports Identifying Innovative State Efforts  
to Enhance Access, Coverage, and Efficiency in Health Care Spending

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All four reports are available on the Fund's Web site at [www.cmwf.org](http://www.cmwf.org).

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## OVERVIEW

Providing health insurance coverage for vulnerable populations—low-income, high-risk individuals with limited access to health care—is a challenge for states even in good economic times. But the past few years have been especially arduous. Higher private insurance premiums and tepid labor markets have swelled the ranks of the uninsured and underinsured. Budgetary-crisis conditions, meanwhile, have limited states' discretion, often obliging them to cut existing programs. Nevertheless, many states have managed to implement innovative strategies: they have stretched health care dollars by using a portion of state money to leverage private, federal, and additional state funds. In other words, these states have expanded health care access, coverage, and efficiency through sound financial management—by judiciously investing a little to gain a lot.

This study's set of four interrelated reports, prepared by health policy analysts at the Economic and Social Research Institute (ESRI), identifies and describes many of these innovations that may help other states use their own health care dollars more productively. Each report studied a different type of model. While certainly not exhaustive, the reports do illustrate the leading mechanisms—along with specific examples—of state initiatives that are already stretching dollars through greater sharing of responsibility, more effective purchasing, better management of diseases, and promotion of cost-effective primary and preventive care. The four reports explored, in turn, the following categories:

1. *Building on employer-based coverage.* These efforts, which aim to make coverage more affordable and acceptable to small businesses and their employees, help low-wage workers buy into private job-based or Medicaid coverage. They include approaches such as premium-assistance models, hybrid public-private coverage, and reinsurance.
2. *Pooled and evidence-based pharmaceutical purchasing.* The purpose of these programs is to reduce the cost and improve the effectiveness of pharmaceuticals for Medicaid and state-employee populations. Initiatives include multistate and intrastate purchasing and collaboration, state-negotiated prescription-drug discounts for additional populations, and use of evidence-based preferred-drug lists and supplemental rebates.

3. *Care management to enhance cost-effectiveness.* These efforts seek to enhance cost-effectiveness in public programs by identifying high-cost individuals and applying various types of care and disease management strategies. They are among the few policy options that hold the promise not only of containing costs but also of improving health outcomes for high-risk populations.
4. *Innovative use of uncompensated care funds.* These programs involve alternative ways to use uncompensated care funds such as Medicaid “Disproportionate Share Hospital” contributions. They promote access to early primary-care services—visits to primary care doctors, for instance, in lieu of reliance on emergency rooms—thereby enhancing cost-effectiveness.

### **Building on Employer-Based Coverage**

Whether subsidizing an existing employer plan or creating a new and more affordable program for uninsured workers, states are using their dollars, regulatory/legislative powers, and purchasing clout to leverage employer and employee contributions in order to cover more people.

As discussed in the corresponding ESRI report, this approach is manifested in a variety of ways:

- *Premium assistance for existing employer plan.* This mechanism generally targets low-wage workers directly, though it could subsidize employer contributions as well. States may implement it by tapping federal dollars—as part of a Medicaid or State Children’s Health Insurance Program (SCHIP) expansion—to match the state’s contribution.
- *Reinsurance.* While premium assistance offers direct subsidies to individuals for purchasing insurance, reinsurance is an indirect way to reduce the price of premiums, thereby providing a more affordable option for uninsured workers. Reinsurance means that the state covers a portion of private insurers’ claims; this “stop-loss” mechanism may cover catastrophic claims above a certain dollar amount, or it may cover claims within a designated corridor.
- *Direct subsidization of new public-private plan.* A number of states are exploring a public-private partnership model in which a new health plan is developed for small businesses. Either a state-designated board or a private insurer administers the plan, and the state subsidizes the premium for low-income workers.

- *State-negotiated health plan.* A way for states to help make coverage more affordable to small businesses without actually subsidizing the coverage is to bargain on behalf of employers. States have much greater clout than individual small businesses when negotiating prices with pharmaceutical firms or premiums with health care plans. A variation on this model is to allow small businesses and uninsured workers to actually buy into the state-employee health plan.
- *Pay-or-play approach.* In this model, the state requires businesses to either provide coverage to their workers or pay into a fund that purchases coverage, on a larger scale, for those and other workers. The major advantage of this strategy is that it is a way for states to expand coverage through the employer-based system without major public outlays. Also, it is said to “level the playing field” by requiring all employers to contribute toward coverage—as opposed to having some pay for their own workers as well as for the uninsured through taxes and higher health care costs. The financial burden on businesses (particularly small firms) and any possible effect on employment are the major concerns raised by this strategy.

### **Pooled and Evidence-Based Pharmaceutical Purchasing**

In recent years, rising pharmaceutical costs have contributed in a major way to the growth of overall health care costs generally and of Medicaid outlays in particular. As a result, many states are implementing drug-cost-containment mechanisms that do not merely pass state expenditures on to consumers in the form of higher copayments and deductibles but instead put innovative approaches in place that *reduce* state costs so as to expand or maintain access.

These strategies are grouped in the corresponding ESRI report as follows:

- *Multistate purchasing and collaboration.* By joining forces, states are able to enhance their bargaining clout—generally through a common pharmacy-benefits manager (PBM)—when negotiating drug prices with manufacturers. Because prices and rebates are tied to volume, potential savings to states rise as participation in a purchasing pool expands. States may pool purchasing for Medicaid beneficiaries, SCHIP enrollees, state employees, and other groups on whose behalf states buy pharmaceuticals.
- *Intrastate purchasing.* Another form of bulk pharmaceutical purchasing involves pooling *within* a state—across agencies. Like multistate purchasing, intrastate

pooling allows states to stretch their dollars by enhancing their purchasing power through administrative streamlining.

- *State-negotiated discounts and drug-only benefits.* Some states are using their purchasing clout in the form of “pharmacy assistance programs” aimed at the elderly and people with disabilities who are not eligible for Medicaid and may not have any drug coverage. A related strategy taps federal matching funds to essentially expand Medicaid with a drug-only benefit.
- *Substitutions, evidence-based preferred-drug lists (PDLs), and supplemental rebates.* For years, states have encouraged the use of less costly prescription drugs through generic substitutions or “therapeutic equivalents.” Also, as of April 2004, 33 states operated, were implementing, or had enacted legislation authorizing PDLs for Medicaid beneficiaries. States may select “preferred drugs” from different classes of pharmaceuticals based on a committee’s findings on therapeutic action, safety, clinical outcome, and cost. Drugs not on the list are not covered, or they require that the prescribing physician obtain prior authorization. Most states using a PDL also obtain supplemental rebates from manufacturers who want their products to be included on the PDL and available without prior authorization.

### Care Management to Enhance Cost-Effectiveness

With more than three-quarters of current Medicaid spending devoted to people with chronic conditions, and the number of Americans with at least one chronic condition expected to rise at least 25 percent by 2020, states are pursuing efficiencies through various types of “care management” strategies for high-cost individuals. These services can be provided directly or contracted out to specialized vendors.

Care management is the coordination of care in order to reduce fragmentation and unnecessary use of services, prevent avoidable conditions, and promote independence and self-care. Alternatively called advanced care management (ACM), targeted case management (TCM), high-cost or high-risk case management, care coordination, disease management, and other terms, care management programs manifest themselves in a wide variety of ways. While they vary in goals, strategies, target populations, specific services provided or emphasized, administrative practices, and assessment capabilities, all states but one make optional care management services available to at least one Medicaid population.

Care management programs may be categorized as follows:

- *Medical- vs. long-term-care-oriented.* Some programs target people with complex medical conditions, while others focus on those with multiple needs or disabilities who are eligible for nursing-home care but who—with proper support and coordinated social and long-term care services—could be maintained within the community.
- *Targeted diagnosis.* Some programs target individuals with specific diseases. For example, 14 states provide care management for Medicaid beneficiaries with asthma, 14 states focus on those with diabetes, and 6 target patients with congestive heart failure.
- *High service use or cost.* Some programs target people with high risk of hospitalization and adverse outcomes. These individuals may, for example, have more than a certain number of chronic conditions, take more than a specified number of prescription medications, be considered high-cost users (e.g., claims reach a designated amount or are within the top 10 percent of Medicaid cost per enrollee), or make a higher-than-average number of trips to the hospital emergency department (a.k.a. “frequent fliers”).
- *Key intervention.* Some programs (generally disease-based) provide educational materials on proper care that reflect evidence-based management guidelines; others focus on pharmaceutical management; and others use intensive one-on-one “advanced care” interventions by nurses or other health professionals.

Since results from past care management evaluations have been mixed, it is especially important to develop a national database that allows state high-risk pools and Medicaid programs to compare best practices for treating specific health conditions and better managing costs. Along with providing evaluations of emerging care management models, the information gained can potentially help states, the federal government, and private insurance and health delivery systems manage care—in a way that is both efficient and effective—for a U.S. population increasingly burdened by chronic conditions.

### **Innovative Use of Uncompensated Care Funds**

Hospitals are a significant part of the health care safety net because they provide services to the uninsured and other vulnerable people who cannot pay for these services themselves. States use Medicaid Disproportionate Share Hospital (DSH) funds, as well as state-based revenue streams, to reimburse hospitals for this otherwise-uncompensated care. But experts warn that providing uncompensated care could become more difficult for hospitals

in the years ahead as a result of their rising costs and lower operating margins, limited state revenues, cuts in Medicaid DSH, and a growing uninsured population. These trends have spurred strategies in several states aimed at reducing the need for expensive uncompensated services over the long term.

One such strategy is to use a portion of the uncompensated care funds proactively to finance primary and preventive care programs that could ultimately reduce emergency and inpatient hospital care costs. By tapping the federal DSH funds or state uncompensated care funds, states are developing programs that provide individuals with access to care in an appropriate, and often lower-cost, setting.

Specifically, states can divert a percentage of DSH or uncompensated care pool funds and combine this money with state/county/local funds or employer contributions to support safety-net providers working in the community. In this way, patients who would otherwise lack access to a “medical home,” such as a medical group practice or a clinic, can be served. States may require hospitals to create programs that improve service delivery and patterns of care for uninsured individuals, as well as to create “three-way share” coverage programs in which employer, employee, and the state contribute approximately equally to cover a range of primary and specialty services.

### **Leading Examples and Lessons Learned**

Given their dynamic political and economic environments, and the fact that initiatives typifying the four basic categories are at different stages and with a variety of prospects for implementation, this study does not directly compare them. Nor do we claim the study to be exhaustive—not all states involved in or contemplating any of this study’s program types are included—and analysis of the counties and local entities applying some of these tactics is generally beyond its scope.

The usefulness of this study is that it presents *leading examples* of state and collaborative efforts that can inform policymakers and administrators who are interested in the latest innovations for stretching their limited health care dollars. Further monitoring and evaluation of these programs will of course be critical for understanding their long-term strengths and weaknesses. But even now, lessons learned through such “experiments” at the state level can be invaluable for replicating, adapting, or expanding successful models in other states and, potentially, at the national level.

That these programs are worthy of emulation may be shown by the following outcomes, sampled from the cases documented in this study:

- By tapping unused federal SCHIP funds for a new program (FamilyCare) and for a previously state-only program (KidCare Rebate), Illinois has stretched its dollars and expanded eligibility without making cutbacks in other coverage programs.
- New York's reinsurance program (Healthy New York) offers businesses a lower-cost private insurance alternative, with recent modifications resulting in an average premium reduction of about 17 percent.
- By paying a Medicaid-eligible worker's share of his or her employer-sponsored health coverage, Pennsylvania's Health Insurance Premium Assistance Program relieves the state of having to offer direct Medicaid coverage for many of these individuals; one result is that the program achieved a savings goal of \$76.3 million in FY 2003.
- West Virginia's participation in the RXIS Multistate Pharmaceutical Purchasing Pool saved the state \$7 million in its first year, and \$25 million in savings is expected over the present three-year contract (with the pharmacy-benefits management firm that serves the five participating states).
- Michigan's preferred-drug list, representing about 70 percent of the drugs used in the state's Medicaid outpatient pharmacy benefit, saved an estimated \$60.5 million in its initial year.
- Colorado estimates that its "advanced care management" initiative—an integration of disease-management and care management interventions for its high-risk pool enrollees—generated \$2.3 million in direct savings to the state from May 2002 to September 2003.
- The General Assistance Medical Program, supported in large part by uncompensated care funds, saved Milwaukee County (Wisconsin) \$4.2 million in calendar year 2000.

These and numerous other findings are presented in the four theme-based reports (corresponding to the four basic categories) that follow, each in the same format: an introduction, a summary matrix of state activity, extensive "profiles" of selected state initiatives, and brief "snapshots" of existing and emerging state programs.

The profiles—based on in-depth interviews with program administrators or planners as well as on reviews of the programs’ written and Web-based outputs—present each program’s purposes and goals, key participants, description, time frame, required legislation or authority, financing mechanisms, efficiencies (whether achieved or expected), challenges and future plans, and sources of more information.

The snapshots describe, in concise summary fashion, additional state initiatives with respect to existing programs. In addition, we also offer snapshots of some “Initiatives to Watch”—programs that are being developed or were just being implemented at the time of the study.

## RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's website at [www.cmwf.org](http://www.cmwf.org).

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[\*Stretching State Health Care Dollars: Building on Employer-Based Coverage\*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Whether subsidizing an existing employer plan or creating a new and more affordable program for uninsured workers, states are using their dollars, regulatory/legislative powers, and purchasing clout to leverage employer and employee contributions in order to cover more people. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[\*Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing\*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Many states are implementing drug-cost-containment mechanisms that do not merely pass state expenditures on to consumers in the form of higher copayments and deductibles but instead put innovative approaches in place that reduce state costs so as to expand or maintain access. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[\*Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness\*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. With more than three-quarters of current Medicaid spending devoted to people with chronic conditions, states are pursuing efficiencies through various types of "care management" strategies for high-cost individuals. These services can be provided directly or contracted out to specialized vendors. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[\*Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds\*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Experts warn that providing uncompensated care could become more difficult for hospitals in the years ahead as a result of their rising costs and lower operating margins, limited state revenues, cuts in Medicaid DSH, and a growing uninsured population. These trends have spurred strategies in several states aimed at reducing the need for expensive uncompensated services over the long term. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[\*Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine\*](#) (June 2004). Jill Rosenthal and Cynthia Pernice. Jointly supported by The Commonwealth Fund and The Robert Wood Johnson Foundation, this report by the National Academy for State Health Policy comments on the status of Maine's Dirigo Health Reform Act, which aims to provide affordable coverage for all of the state's uninsured—approximately 140,000—by 2009.

[\*Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times\*](#) (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states

maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

[\*Small But Significant Steps to Help the Uninsured\*](#) (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

[\*Medicaid Coverage for the Working Uninsured: The Role of State Policy\*](#) (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs*, vol. 21, no. 6 (*In the Literature* summary). The authors conclude that insurance coverage rates for low-income workers would increase if state governments chose to do more for their uninsured workers. But states decline to tackle this issue for several reasons. Federal law requires them to cover many low-income nonworkers before they insure workers. As well, poorer states cannot afford much coverage for their low-income workers.