States Taking Initiative on Health Care Reform

In the absence of a national plan, some states are tackling comprehensive coverage of the uninsured.

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — What was a trend is looking more like a wave as an increasing number of states, no longer content to wait on the seemingly glacial pace of national politics, are seeking their own comprehensive solutions to the growing ranks of the uninsured, state health care reformers said at a conference sponsored by AcademyHealth.

"Can state innovations work on a national problem? It's somewhat of a rhetorical question. There's a growing sense of insecurity among our people that more and more of our citizens … are losing access to affordable health care. It's becoming more like a lottery with more losers," said Jim Leddy, a former senator from Vermont who had helped ferry through a sweeping health care reform law in that state.

States are coming to realize that the uninsured are a shared problem, said Kim Belshe, secretary of California's Health and Human Services Agency.

"We've seen in California that when we can draw a connection between a problem that affects a minority of people, relatively speaking, and how it relates to the broader California, that it creates a policy environment where we have a greater potential to effect meaningful reform," she said.

In California, this meant demonstrating that the uninsured were having a significant impact on others in the community such as uncompensated care leading to higher health insurance premiums, overuse of emergency departments leading to closures, and high rates of uncontrolled chronic disease leading to lost productivity, she said.

Although states are taking this problem on themselves, they have, so far, shied away from single-payer approaches. Instead, they are building on existing public programs, including Medicaid and the State Children's Health Insurance Program, which together provide states with substantial, if still insufficient, federal funds.

If the states are to serve as laboratories for reform, they will need to be empowered, not abandoned, by the federal government, Mr. Leddy said.

"For too long, the laboratories have been bankrupt in terms of ability of states to address problems of their citizens because we fundamentally have not had the support of our national government," he said.

Some state reform plans also include provisions to enable and even encourage companies to continue providing coverage for their workers.

"The erosion of employer-sponsored insurance plans must not be allowed to become a collapse. Whether we agree philosophically with it, we simply cannot afford a collapse of what is the foundation for what we have now," Mr. Leddy said.

Beyond expanded access, state health care reformers are focusing on prevention and wellness.

"We not only have to treat chronic conditions better, we also have to have strategies that deal with the incidence and the prevalence of these conditions, in particular diabetes and obesity," Mr. Leddy said.

Personal responsibility has to be an important component of that equation, but that should not be interpreted as a code word for social Darwinism, or survival of the healthiest, wealthiest, and luckiest, he said.

While there remains a lot of variability between states and their ability to undertake such broad reforms, an increasing number are turning to the examples set by Vermont, California, and a dozen other states in the process of passing reform measures, not only for the lessons they hold, but also for the encouragement they provide, experts said.

"A lot of people feel if California as a state can make meaningful inroads in terms of our coverage and cost challenges, then that offers some hope and promise for other states, just given the size and the magnitude of our challenges," Ms. Belshe said. ■

As Costs Soar, Employer-Based Insurance Coverage Takes a Dive

BY JOEL B. FINKELSTEIN
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WASHINGTON — Companies both large and small are finding it increasingly difficult to afford the health insurance coverage they have traditionally provided to their workers, experts warned at a conference sponsored by AcademyHealth.

Employer-based insurance remains the dominant source of coverage in the American health care system. But the proportion of companies that provide health benefits dropped from 70% in 2000 to 60% in 2005. Small businesses, those with only a handful of employees, have been especially hard hit by rising premiums, said Todd McCracken, president of the National Small Business Association.

"We have reached a point in the past couple of years where for the first time in memory, most of these companies now do not provide health benefits to their employees," he said.

Of the small companies that can still offer health coverage, few can give their workers a choice of health plans, and they are often not happy with the plans they can offer. In any given year, 60% of small companies are shopping around for another health plan, but only 24% make a switch, according to data from the Kaiser Family Foundation.

"Small businesses are constantly in the marketplace looking for a better deal, sure that there's something out there for them that can bring prices in line, when in fact, they don't find much or they find choices that are even worse," he said.

Most companies have few options other than shifting more of the cost of premiums to their workers or reducing benefits, a trend that will continue over the next 5 years, according to projections by the Bureau of Labor Statistics. "The share that employees will be asked to bear simply outstrips any realistic ability they may have to pay," Mr. McCracken said.

Large companies also face rising health insurance premiums and are passing them on to their employees, said Mary Kay Henry, who leads the health systems division of the Service Employees International Union.

The union represents 700,000 workers worldwide. About half of them have no health coverage, and the other half are being asked to share more of the cost of their insurance. Over the past few years, SEIU has increasingly found itself in difficult negotiations with employers over health benefits at both the level of collective bargaining and that of individual workers.

"Beyond the bargaining problem, we also had a crisis happening for individual workers, which was [that] they were, by virtue of no coverage, having to face not getting the medical care they needed in order to live," she said.

Every physician has a horror story about some uninsured patient who should have come in sooner, said Dr. Eduardo Sanchez, director of the Institute for Health Policy at the University of Texas Health Science Center in Houston.

"My horror story involves a gentleman, a laborer who came in to see me for a 'blister.' When we got his shoe off, he actually had a through-and-through diabetic ulcer on one of this toes. He went straight to a hospital and had a couple of toes amputated. Do the math and you can figure out that had this gentleman been diagnosed with diabetes 5 years earlier, it would have cost a whole lot less money with a whole lot less trauma," he said.

The uninsured end up needing higher-level care, which is often uncompensated. That cost is passed on to those who can pay, which in turn causes insurance premiums to rise. The result: More employers drop coverage because of high premiums and the cycle starts over again. That cycle needs to be broken, he said.

What the solution will look like is not clear, but there does seem to be a movement for everyone to come to the table, the experts said.

"We're not going to stand on the sidelines of a political debate. We're going to engage the debate in our mutual interest and figure out a solution for everyone in this country," Ms. Henry said. ■

Rules May Be Relaxed for Schedule II Prescriptions

NEW ORLEANS — The Drug Enforcement Administration is close to completing a final rule that would let physicians provide up to a 90-day supply of schedule II controlled substances without requiring patients to come into the office each month.

Under this change, physicians would be able to issue three monthly prescriptions at once and specify a future fill date for each one. The DEA statute currently prohibits the refilling of schedule II prescriptions, an agency official said at the annual meeting of the American Academy of Pain Medicine.

The regulation, which is currently being finalized, will be "substantially" similar to a notice of proposed rule making issued by the DEA last September, said Mark W. Caverly, chief of the liaison and policy section of the Office of Diversion Control at the DEA.

"We're going to make some tweaks in the language and try to explain some things a little bit better," he said.

Mr. Caverly would not offer an estimate on exactly when the final rule would be published.

The public comment period on the proposal ended on Nov. 6 and the DEA received 264 official comments, 87% of which supported the proposal. Opponents of the rule said that it would increase the supply of highly abusable drugs to patients and that it's important to see pain patients every 30 days. Other critics noted that a 90-day supply of medications is inadequate and the limit should be 180 days or there should be no time limits at all.

This pending regulation and other recent communications from the DEA should help to demonstrate to the physician community that the agency is not interested in stopping physicians from writing valid and medically necessary prescriptions, Mr. Caverly said. "DEA and the pain treatment community have strong common interests in the effective and adequate prescribing of controlled substances for the treatment of pain."

Mr. Caverly also outlined some areas where DEA officials plan to clarify agency policy in the future. For example, agency officials plan to address the issue of whether locum tenens physicians who work in multiple states need to have multiple DEA licenses. They also will look at who should be authorized to call the pharmacy to change medications, how consumers should submit prescription drugs for destruction, and issues related to telemedicine and telepharmacy.

—Mary Ellen Schneider