COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

CAN MEDICAID DO MORE WITH LESS?

Alan Weil
National Academy for State Health Policy

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ABSTRACT: As demographic shifts and declining rates of employer-sponsored insurance coverage cause Medicaid to grow, the program faces the same cost pressures that employers and employees are experiencing. Yet, Medicaid enrollees—who have extremely limited incomes—cannot absorb increases in out-of-pocket health costs as readily as the working population. Three approaches have gained currency as ways to cut costs without simply shifting the burden to program enrollees: 1) care management, which focuses on utilization and costs; 2) consumer engagement, intended to encourage or require enrollees to play a greater role in organizing and financing their care; and 3) employer engagement policies, such as premium assistance, which attempt to combine employer, employee, and Medicaid dollars to provide coverage to low-income working populations. In addition to efforts focused on greater program efficiency, broader health system reform will likely be needed to relieve the pressures causing the program to grow faster than state or federal tax revenues.

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ABOUT THE AUTHOR

Alan Weil, J.D., M.P.P., was named executive director of the National Academy for State Health Policy and president of its parent organization, the Center for Health Policy Development, in 2004. Weil served for the past seven years as director of the Assessing the New Federalism project at the Urban Institute, one of the largest privately funded social policy research projects ever undertaken in the United States. Previously, he held a cabinet position as executive director of the Colorado Department of Health Care Policy and Financing; served as health policy advisor to Colorado Governor Roy Romer; and was assistant general counsel in the Massachusetts Department of Medical Security. He is currently a member of The Commonwealth Fund's Commission on a High Performance Health System. Weil graduated from the University of California, Berkeley, and received a master of public policy degree from Harvard University's John F. Kennedy School of Government and a juris doctorate from Harvard Law School.

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INTRODUCTION

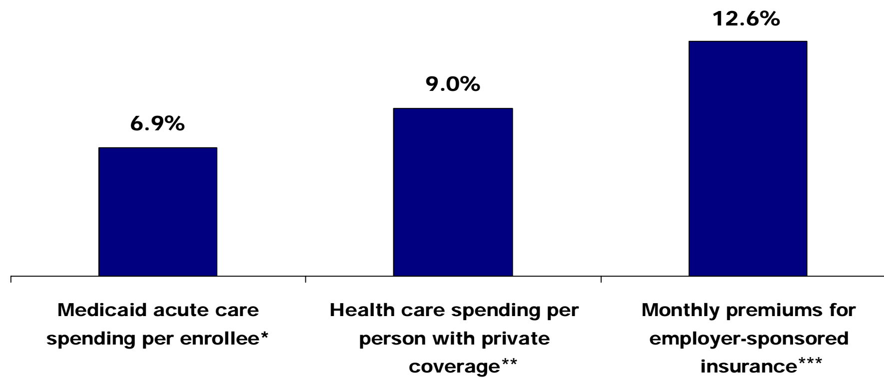
Medicaid, enacted in 1965, is the nation's health care program for low-income families, elders, and people with disabilities. It is administered by the states, with federal oversight and shared federal funding. In 2003, Medicaid provided services to more than 52 million people at a total cost of $266 billion.[1]

Medicaid is actually many programs wrapped into one. It provides comprehensive health benefits to poor children, some of their parents, and a small share of other poor adults. It offers necessary health and social support to people with disabilities ranging from severe mental illness and AIDS to spinal cord injury and cerebral palsy. For low-income elders and some people with significant disabilities, Medicaid wraps around Medicare by covering Medicare's premium and cost-sharing requirements and helping to pay for long-term care services; until the recent implementation of Medicare's prescription drug benefit, it also helped low-income Medicare recipients pay for prescription drugs. Medicaid also provides financial support to safety-net providers that serve the uninsured through the Disproportionate Share Hospital (DSH) program and other mechanisms.

Medicaid has been effective in helping people gain access to needed care. One study found that 75 percent of children in Medicaid or the State Children's Health Insurance Program (SCHIP) had a preventive or well-child health visit within the past 12 months, compared with 46 percent of uninsured children.[2] Another study found that Medicaid helps patients with chronic diseases receive the care they need to prevent their conditions from worsening.[3] Despite these generally positive results, concerns regarding access to services (particularly specialty care and dental care) have nagged the program since its inception.

Medicaid's costs are growing faster than state or federal revenue, but this elevated rate must be viewed in the context of the program's various functions. Medicaid coverage for low-income children and families costs less than private coverage for a comparable population, despite the program's comprehensive benefit package and limited cost-sharing.[4] This is primarily because Medicaid pays providers below-market rates, but also because it has lower administrative costs than private health insurance.[5] Indeed, Medicaid's per-person costs for acute services have grown more slowly than per-person costs for health care spending in private insurance and employer-sponsored insurance premiums (Figure 1).[6]

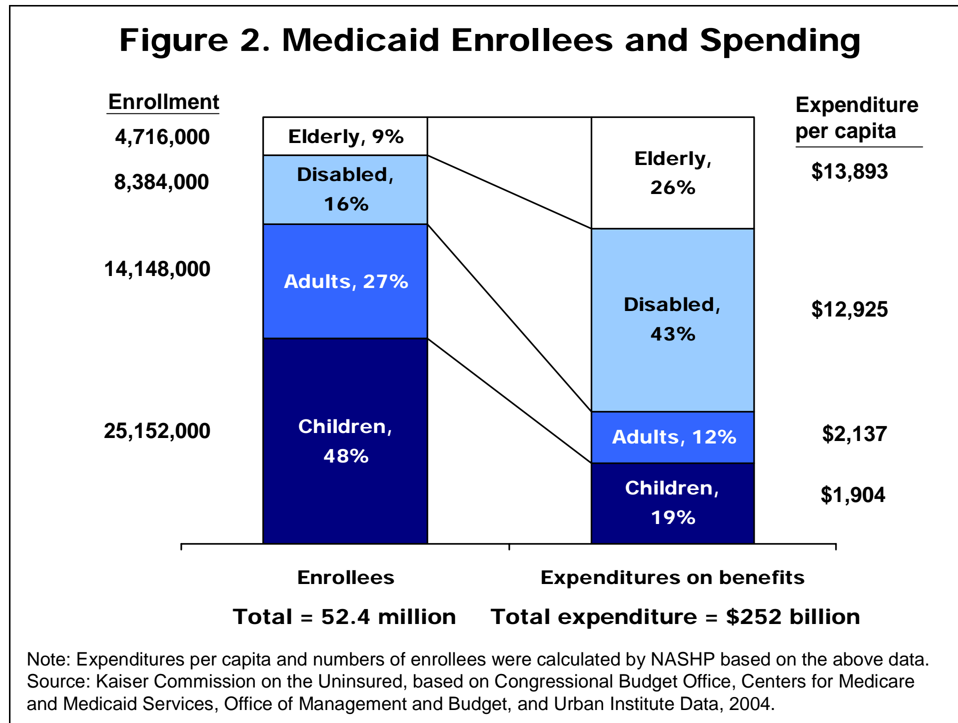
Figure 1. Average Annual Medicaid Spending Growth Compared with Growth in Private Health Spending, 2000–2003



Sources: *J. Holahan and A. Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* Web Exclusive, Jan. 26, 2005; ** B. C. Strunk and P. B. Ginsburg, "Tracking Health Care Costs: Trends Turn Downward in 2003," *Health Affairs* Web Exclusive, June 9, 2004; *** Kaiser Family Foundation Employer Health Benefits Survey, 2003.

The average cost per disabled Medicaid enrollee exceeds $12,000 (Figure 2). Medicaid provides services that are generally excluded from, or tightly constrained in, private coverage such as attendant care services, durable medical equipment, and physical therapy. The program covers millions of people who are otherwise "uninsurable" due to severe disabling conditions such as schizophrenia, multiple sclerosis, or developmental disabilities.

Forty percent of Medicaid costs are associated with "dual eligibles," people who are covered by Medicare and Medicaid.[7] More than 90 percent of elderly Medicaid recipients are dually eligible, as are about one-third of Medicaid enrollees with disabilities.[8] While about 45 percent of expenditures on behalf of dual eligibles go toward nursing home services, other high-cost areas include home- and community-based services.[9] (Prior to January 2006, Medicaid covered dual eligibles' prescription drugs costs as well.)



THE MEDICAID POLICY DEBATE

During the prosperous late 1990s, states expanded Medicaid eligibility, particularly for children and adults. Then, in 2001, economic conditions began to deteriorate rapidly. Coupled with the earlier expansion in eligibility, the severe downturn led to dramatic growth in program enrollment. With state revenues falling in nominal terms for the first time since World War II—and federal tax revenues shrinking as a result of the downturn and newly enacted tax cuts—the large and rapidly growing Medicaid program became the focus of state and national budget debates.

States adopted one or more cost-containment strategies, including tightening Medicaid eligibility standards, freezing or reducing provider payment rates, and eliminating or capping covered services. No state took these steps lightly; indeed Medicaid absorbed less than its proportionate share of cuts in state budgets in the most recent downturn.[10] Despite these measures, Medicaid enrollment grew from nearly 32 million to more than 41 million enrollees between 2000 and 2004.[11] This countercyclical growth is the primary reason that the number of uninsured children fell by 300,000 during this period. Meanwhile, the number of uninsured adults—for whom Medicaid eligibility is limited—increased by 6 million.

The Deficit Reduction Act of 2005 makes a number of important changes to Medicaid. The most hotly contested features are provisions that modify how much states

pay for prescription drugs, place tighter restrictions on eligibility for people who transfer assets prior to applying for Medicaid, and provide states with new options for charging premiums and higher copayments and restricting benefits to some enrollees. Since the effects of these changes are not yet known, this report focuses on long-term trends within the Medicaid program.

As in the broader health care sector, states and the federal government are searching for cost-containment strategies that do not simply shift financial burdens to Medicaid enrollees. Three approaches have gained currency: care management, consumer engagement, and employer engagement.

Care Management

Care management refers to a broad range of activities designed to reduce the need for services among the Medicaid population. In the 1980s and 1990s, states moved a large share of their Medicaid enrollees into managed care plans and primary care case management (PCCM) programs. In the former, a health plan agrees to provide all necessary and covered services to a patient population for a fixed monthly payment. The plan decides on the precise mechanisms it uses to contain costs, but these generally include rate negotiations, utilization controls, and provider selection. In PCCM programs, enrollee care is coordinated by primary care physicians, who are paid monthly management fees, while other services are provided on a fee-for-service basis.

After almost a decade of rapid growth, Medicaid's reliance upon managed care has leveled off in recent years. As of 2004, 60.7 percent of Medicaid enrollees obtained some or all of their care in managed care—only a marginally higher proportion than the 53.6 percent in managed care six years earlier.[12] States routinely use managed care for non-disabled children and their parents, who tend to have similar health needs to commercially insured populations. Use of managed care, particularly capitated managed care, has been much more limited among higher-cost and more complex disabled and elderly enrollees.

But with a large share of Medicaid costs attributable to elderly and disabled enrollees, states recently have become interested in contracting with managed care plans to serve these populations. Managed care plans have, in turn, become interested in serving the Medicaid elderly and disabled. A provision in the Medicare Prescription Drug Improvement and Modernization Act of 2003 created "special needs plans," smoothing the way for greater use of managed care for dual eligibles. Still, most managed care plans have limited experience caring for complex populations.

Other, more limited versions of care management include disease management, case management, and high-cost case management—programs that supplement traditional care delivery and focus on subgroups of the covered population, such as people with diabetes or asthma. The services are generally provided by a vendor that contracts directly with the state. Twenty-six states were using one of these approaches in 2005, and 25 states say that they will begin new programs or expand existing ones in 2006.[13]

For example, North Carolina's Community Care program employs local networks of primary care providers to coordinate prevention, treatment, referral, and other services for Medicaid enrollees across the state. Using care managers and medical management staff, each network seeks to manage utilization and costs in four areas: disease management (for such conditions as asthma, diabetes, congestive heart failure, and gastroenteritis); high-risk, high-cost patients; pharmacy management; and emergency department utilization.[14]

Florida provides disease management services to individuals enrolled in MediPass, the Medicaid PCCM program. The disease management program targets patients with HIV/AIDS, hemophilia, diabetes, asthma, cancer, congestive heart failure, kidney disease, hypertension, and several other chronic conditions. Altogether, the patients targeted for disease management make up approximately 19 percent of the MediPass program's population.[15]

Despite the intuitive appeal of such management techniques, there is as yet scant evidence to support the claim that these techniques can save money. North Carolina's program did result in lower costs for a portion of the target population,[16] while an evaluation of Florida's program concluded that care improved but costs did not decline.[17] Most care management programs are in the early stages of development and implementation; determining whether such programs can produce results for people with multiple chronic conditions will be a crucial test.

Consumer Engagement

Consumer engagement includes a range of policies designed to encourage or require Medicaid enrollees to play a greater role in organizing and financing their care. In its simplest form, this can mean requiring premiums or increasing copayments at the point of service. Such changes are designed to make Medicaid less like welfare and to encourage enrollees to exercise restraint in their use of services.

Changes of this nature are quite controversial. Medicaid enrollees have extremely low incomes, and evidence shows that when faced with premiums or copayments, they

are likely to drop coverage or forgo necessary services.[18] Even if these policies reduce service utilization and costs in the short run, such costs may be shifted to other systems (such as the criminal justice system, as mental health needs go unmet) or accrue to Medicaid in the long term, when enrollees' preventable or manageable health conditions deteriorate. Some states have proposed using savings from such provisions to expand coverage to the uninsured; other states have used savings to address broader fiscal problems.

Another, more creative consumer engagement model comes from the "cash and counseling" demonstration, which waived the policy requiring disabled enrollees to obtain services through home health agencies, instead enabling them to choose their own personal care services. Evaluations show that enrollees consider the approach a success, but early study results demonstrate increased cost, with some evidence to suggest longer-term savings.[19]

Florida has embarked on perhaps the most ambitious and high-profile experiment with consumer engagement, or "consumer-directed" care. Florida obtained permission from the Centers for Medicare and Medicaid Services to waive traditional Medicaid rules and move toward a defined-contribution program, in which the state will provide enrollees with risk-adjusted premiums and allow them to choose among coverage options. Managed care plans will have new authority to determine the benefit packages for adult enrollees, subject to state approval, and the state will also establish a maximum benefit limit for adults. Above this maximum dollar amount, the enrollee will be responsible for all health care costs. Enrollees can also opt out of Medicaid and use their risk-adjusted premium toward the purchase of employer-sponsored or individual market coverage. The program is set to begin as a pilot and then expand statewide.[20]

Since the waiver has not yet been implemented, it is not yet clear what form these plans will take, how their benefits will vary from those guaranteed in the current Medicaid program, how costs and services will be controlled by the plans, or what will happen if enrollees select plans that do not meet their needs. Early results from Florida will affect whether other states seek to replicate this model. As the program is implemented, it will be important to evaluate the changes closely to determine how beneficiaries, providers, costs, and the overall health care system are affected.

Employer Engagement

Many states are attempting to combine employer, employee, and Medicaid dollars to provide coverage to a share of their low-income working population. These premium-

assistance programs are designed to capture some share of employer funds even when employers cannot afford full health insurance premiums for their employees. As of February 2004, 14 states had such programs in place.[21] Depending on the type of federal waiver obtained by the state, the state may or may not be required to provide workers with "wraparound" coverage to supplement their employer's plan with the other benefits Medicaid typically provides.

Rhode Island has one of the nation's most established premium-assistance programs, RIte Share, which provides individuals eligible for Medicaid or SCHIP with access to approved employer-sponsored health insurance.[22] The state pays the worker's share of employer premiums, copayments, and wraparound coverage for Medicaid benefits that are not in the employer's health plan. Families with income higher than 150 percent of the federal poverty level make some contributions, according to a sliding scale. There is no minimum or maximum employer contribution, although most employers contribute at least half of the premium.

Despite the prevalence of premium-assistance programs, enrollment in them is generally quite limited. This is due to many factors: the administrative complexity involved in establishing the programs, the limited willingness of employers to participate, and the low availability of employer-sponsored coverage among the target population. It is unclear whether these programs will reduce Medicaid costs. Start-up and operational administrative costs are high and, while premium-assistance programs may deter employers from dropping coverage in the short run, they may ultimately lead to the state paying a share of premiums that were previously covered in full by employers and employees.[23]

KEY ASPECTS OF MEDICAID POLICY

States operate the Medicaid program on a day-to-day basis, while the federal government establishes broad parameters for the program and approves each state's Medicaid plan. In some areas there are federal minimum standards, such as the income threshold for coverage for children. Some federal standards are more prescriptive—for example, defining the meaning of certain covered benefits. Still, states have tremendous flexibility in how health care is delivered to Medicaid enrollees: whether to use managed care, how to set standards for contracting with plans and providers, and how to pay plans and providers, including the adoption of pay-for-performance strategies.[24] States can select and contract with disease management and other programs with very little federal review.

States have less flexibility with respect to the financial burden placed on enrollees. States cannot charge premiums; cannot impose cost-sharing on children, pregnant women,

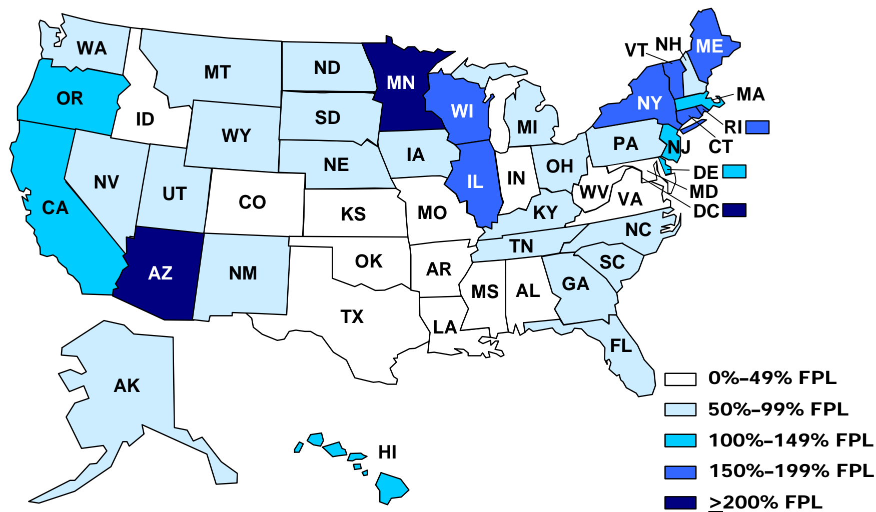
or people living in institutions such as nursing homes; and can impose only limited copayments on others. Some of these restrictions were lifted in the Deficit Reduction Act of 2005.

The secretary of the Department of Health and Human Services has broad authority to waive certain provisions of the Medicaid statute. The most sweeping authority appears in Section 1115 of the Social Security Act, which authorizes modification of many statutory provisions to further "research and demonstration" programs consistent with the goals of the statute. It is longstanding practice of the Office of Management and Budget to approve only those waivers that are budget-neutral from the perspective of the federal government (i.e., do not cost more than would have been spent under the statute), although this practice is not required by law. Waiver activity in Medicaid accelerated greatly during the Clinton Administration and has continued during the Bush Administration. In addition, the reach of approved waivers and the degree to which they embrace policies that differ substantially from the statute has grown in the last decade.

Because of these factors, Medicaid differs greatly from state to state. While a core of benefits and eligible populations remains standard, state programs do vary somewhat along these dimensions as well as on methods of care delivery (e.g., managed care, community alternatives to nursing home care) and payment rates. These differences make it difficult to generalize about the program from the perspective of any one state.

Fiscal Federalism

The flexibility granted to states leads to substantial variation in Medicaid policies across the country. For example, while federal law requires states to cover all children living in poverty, the absence of such standards for parents yields significant variation in coverage levels (Figure 3). The degree of variation that should be permitted across states in eligibility, covered benefits, payment rates, and quality is a perennial debate within Medicaid.



The issue of state variation became quite salient in the wake of Hurricane Katrina. Policymakers debated whether evacuees should be held to their home state or their host state's Medicaid eligibility rules, or whether evacuees should be granted a more generous, national standard of care.

As the source of 43 percent of all federal funds flowing to states, Medicaid plays a critical role in defining American fiscal federalism. The nation's governors have periodically advocated shifting entire portions of the program—particularly long-term care or care for dual Medicare–Medicaid enrollees—to the federal government to reduce the financial burden on states. When the federal government added prescription drug coverage to the Medicare program, it could have created a substantial financial windfall for states. But instead, through the "clawback" provision, the federal government will recover most of those savings.[25]

The recent economic downturn has led some states to call for revisions to the way in which the state and federal shares of the program are calculated. Specifically, states are interested in provisions that increase the federal share quickly during a recession and protect the states from large swings in the formula from year to year.

Administrative Complexity
Medicaid retains certain features that are tied to its roots in the welfare system. The program has multiple, complex eligibility categories that vary by family structure, age, health status, income, and ownership of assets. Certain populations are excluded from coverage—most notably adults who do not have children living with them and recent immigrants. Partly due to this complexity, states, counties, and providers must undertake constant outreach and education to encourage people to enroll; when these efforts flag, enrollment declines.

Covering the Uninsured
Medicaid policy is closely tied to efforts to cover the uninsured. By reducing the size of the uninsured population, Medicaid makes other coverage initiatives more affordable and imaginable. Furthermore, by covering the highest-cost populations the program reduces the share of the health care burden borne by private health insurers, making coverage more affordable for employers and employees. It subsidizes hospitals and clinics that provide services to the uninsured, thus reducing the gap in care received by uninsured and insured patients. Any policies that undermine these roles make solving the problem of the uninsured even more difficult.

At the same time, Medicaid's low payment rates impose a financial burden on the rest of the health care system, as providers seek to shift their costs to other payers. Medicaid's cumbersome eligibility rules leave many poor Americans ineligible and mean that many who are eligible for the program do not enroll.

MEDICAID GOING FORWARD

Medicaid plays a critical role in the U.S. health care system. As the program expands in conjunction with growing numbers of elders and people with disabilities, and declining rates of employer-sponsored insurance coverage, it faces the same cost pressures that employers and employees experience with respect to rising health costs. Yet Medicaid enrollees, with their extremely limited incomes, cannot absorb increases in out-of-pocket health costs as readily as the working population.

The expected budgetary savings due to the Deficit Reduction Act are quite modest in comparison to the expected rate of growth of the program over the coming years. Continued expansion of Medicaid costs will surely lead to regular efforts to restructure the program in a manner that brings its growth in line with revenue growth. Despite efforts by states and the federal government to make the program more efficient,

policies within Medicaid will not be able to offset the demographic and economic pressures that cause the program to grow faster than state or federal tax revenues.

Medicaid confronts the same challenges with respect to quality and efficiency as the overall health care system. Certainly, the program can contribute to a broader approach to improving health system performance, just as it can benefit from efforts made by other public and private purchasers. If the nation fails to move toward a more efficient and effective system, however, the fiscal pressures faced by Medicaid will almost certainly lead to cuts that harm the health of the nation's most vulnerable citizens.

NOTES

[1] "The Medicaid Program at a Glance," Kaiser Commission on Medicaid and the Uninsured (Jan. 2005).

[2] L. Dubay and G. M. Kenney, "Health Care Access and Use Among Low-income Children: Who Fares Best?" *Health Affairs,* Jan./Feb. 2001 20(1):112–21.

[3] T. Rice, S. A. Lavarreda, N. A. Ponce et al., "The Impact of Private and Public Health Insurance on Medication Use for Adults with Chronic Diseases," *Medical Care Research and Review,* Apr. 2005 62(2):231–49, cited in Leighton Ku, "Medicaid: Improving Health, Saving Lives," Center on Budget and Policy Priorities, Aug. 17, 2005.

[4] J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry,* Fall/Winter 2003/04 40(4):323–42.

[5] Administrative costs in Medicaid (6.9 percent of total costs) are about half as large as administrative costs in private insurance (13.6 percent of total costs) according to estimates by the Centers for Medicare and Medicaid Services. See C. Smith, C. Cowan, A. Sensenig et al., "Health Spending Growth Slows in 2003," *Health Affairs,* Jan./Feb. 2005 24(1):185–94.

[6] The average growth rate of per-enrollee Medicaid costs for acute care from FY 2000–2003 was 6.9 percent—lower than the 9 percent increase in per-enrollee costs of the privately insured and substantially lower than the growth in employer-sponsored insurance premiums (12.6%). See "A Sharp Rise in Enrollment During the Economic Downturn Triggered Medicaid Spending to Increase by One-Third from FY 2000–2003" (press release) (Washington, D.C.: Henry J. Kaiser Family Foundation, Jan. 26, 2005). See also J. Holahan and A. Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000–2003," *Health Affairs* Web Exclusive (Jan. 26, 2005):W5-52–W5-62; "Employer Health Benefits, 2003" (Washington, D.C.: Henry J. Kaiser Family Foundation/Health Research and Educational Trust, Sept. 2003).

[7] J. Holahan and A. Ghosh, "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003" (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, July 2005).

[8] Ibid.

[9] Ibid.

[10] T. A. Coughlin and S. Zuckerman, "Three Years of State Fiscal Struggles: How Did Medicaid and SCHIP Fare?" *Health Affairs* Web Exclusive (Aug. 16, 2005):W5-385–W5-398; J. W. Fossett and C. E. Burke, *Medicaid and State Budgets in FY 2004: Why Medicaid Is So Hard to Cut* (Albany, N.Y.: Nelson A. Rockefeller Institute of Government, June 2004), available at http://www.rockinst.org/publications/federalism/medicaid_managed_care/MedicaidandStateBudgets2004.pdf.

[11] E. R. Ellis, V. K. Smith, and D. M. Rousseau, *Medicaid Enrollment in 50 States: June 2004 Data Update* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Sept. 2005).

[12] CMS 2004 Medicaid Managed Care Enrollment Report, accessed Dec. 26, 2005 at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.pdf.

[13] V. Smith, K. Gifford, E. Ellis et al., *Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results from a 50-State Survey* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Oct. 2005).

[14] S. Silow-Carroll and T. Alteras, *Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness* (New York: The Commonwealth Fund, Oct. 2004).

[15] Ibid.

[16] T. C. Ricketts, S. Greene, P. Silberman et al, *Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000–December 2002* (North Carolina Rural Health Research and Policy Analysis Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, April 2004), as cited in Silow-Carroll and Alteras, "Stretching State Health Care Dollars," 2004.

[17] *Disease Management: The New Tool for Cost Containment and Quality Care* (Washington, D.C.: National Governors Association Center for Best Practices, Feb. 2003), as cited in Silow-Carroll and Alteras, "Stretching State Health Care Dollars," 2004.

[18] L. Ku and V. Wachino, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Washington, D.C.: Center on Budget and Policy Priorities, July 2005).

[19] S. Dale, R. Brown, B. Phillips et al, "The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas," *Health Affairs* Web Exclusive (Nov. 19, 2003):W3-566–W3-575.

[20] *Florida Medicaid Waiver: Key Program Changes and Issues* (fact sheet) (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Dec. 2005).

[21] "Premium Assistance Toolbox for States" (Portland, Maine: National Academy for State Health Policy), available at http://www.patoolbox.org.

[22] To be eligible for RIte Share, parents' income must be less than 185 percent of the federal poverty level and the family income of children and pregnant women must be less than 250 percent of the federal poverty level. The health plans are approved if they meet the state's coverage and cost-effectiveness criteria. The Rhode Island Department of Health and Human Services determines cost-effectiveness based primarily on the employer's health plan rather than each individual's situation; this is administratively simpler and limits adverse selection against the employer. "RIte Share: Premium Assistance in Rhode Island" (New York, The Commonwealth Fund, Oct. 2004).

[23] J. Alker, *Premium Assistance Programs: How Are They Financed and Do States Save Money?* (issue paper) (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Oct. 2005).

[24] Payment levels for health plans and providers must meet a variety of federal standards.

[25] The "clawback" is a monthly payment that, beginning in January 2006, each state must pay to the federal Medicare program. The amount of each state's payment is intended to reflect a share of the expenditures of its own funds that the state would have had to make had the cost of prescription drug coverage not shifted from the states to the federal government. State clawback payments are projected to increase from $6 billion in 2006 to $15 billion in 2013. See A. Schneider, *The "Clawback": State Financing of Medicare Drug Coverage* (issue paper) (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2004).

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