Health and Health Care in Illinois

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By Robert Kaestner, Anthony T. Lo Sasso and Lorens A. Helmchen

In this chapter, we present an assessment of some of the major developments in health and health-care policy in Illinois during the past year. We also provide an update on the progress of some past policies. Finally, we identify some issues of future concern for health policy in Illinois.

To provide the basic context underlying all of these issues, we first present descriptive data on health and health care in Illinois. Surprisingly, there is little published information about Illinoisans' health and use of health care, information that we provide here. Specifically, we try to answer the following questions:

- Where does Illinois stand in terms of health and use of health-care services vis-à-vis the United States?
- How have the health and the use of health-care services of Illinoisans changed over the last 10 years?

After answering these questions, we discuss what the data imply for health and health-care policy in Illinois. To achieve our objective, we analyzed data from the Behavioral Risk Factor Surveillance System, which provides both a nationally representative sample of persons and a representative sample of persons from Illinois. We focus on persons between the ages of 18 and 64.

Trends in health and use of health care services in Illinois

The first aspect of health we examined was the proportion of the population that rated its health as good or excellent. In Illinois, approximately 60 percent of persons aged 18 to 64 consider themselves to be in good or excellent health, but over the past 10 years, there has been a downward trend. Whereas 62 percent of persons in Illinois rated their health as good or excellent in 1996, only 58 percent did so in 2005. Figures for the U.S. population reveal a similar decline over the past 10 years, but slightly more people (62 percent) considered themselves to be in good or excellent health during this period. Consistent with this general but modest decline in self-rated health in both Illinois and the United States, there have been modest increases in the proportion of days that people report being unhealthy or in which health has limited their activities.

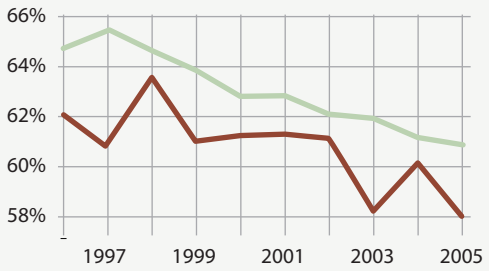
Whereas 62 percent of persons in Illinois rated their health as good or excellent in 1996, only 58 percent did so in 2005.

One potential explanation for part of this decline in health over the past 10 years is an increase in obesity. The proportion of the Illinois population that is obese increased from approximately 10 percent in 1996 to 15 percent in 2005. Nearly identical figures are found for the nation. This 50 percent rise in the prevalence of obesity is a major health problem for both Illinois and the nation. On the other hand, the proportion of the population that is currently smoking has declined from 30 percent in 1996 to 25 percent in 2005. This is a positive development that will likely improve the health of the Illinois population in the future. About the same proportion of persons in Illinois smoke as in the nation, and the decline in smoking in Illinois is similar to the decline in smoking nationwide.

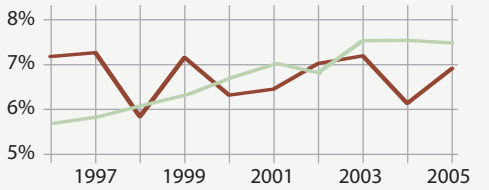
Approximately two-thirds of Illinoisans reported visiting the doctor for a routine checkup in the past year. This is six percentage points higher than the rest of the nation. However, in both Illinois and the U.S., the proportion of persons who received a checkup has been declining since 2001, when 70 percent of persons in Illinois and 69 percent of persons in the U.S. reported seeing a doctor for a checkup.

This decline corresponds with trends in the proportion of persons with health insurance coverage. In 1996, approximately 76 percent of the population in Illinois reported having health insurance and this figure grew to 78

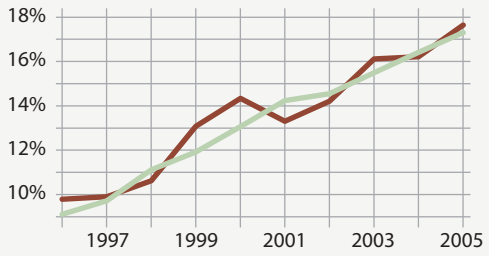
Proportion of People Reported Good Health in Illinois: 1996-2005



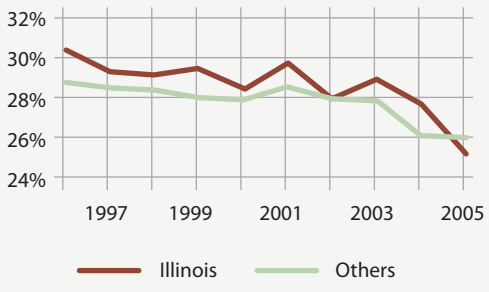
Proportion of Physically Unhealthy Days in the Past Month: Illinois 1996-2005



Probability of Being Obese: Illinois 1996-2005



Proportion of Current Smokers: Illinois 1996-2005



percent in 2001. Subsequent to 2001, the proportion of persons with health insurance in Illinois declined to approximately 75 percent in 2005. A similar time trend in health insurance coverage was observed for those in the U.S., although Illinois has a slightly greater proportion of persons covered by health insurance. Notably, there was little change in the proportion of persons covered by health insurance between 1996 and 2005. So while recent experience has raised concern that the problem of the uninsured is worsening, a longer term perspective does not support this view.

While the decline in routine checkups is consistent with the declining rate of health insurance coverage, a similar relationship was not found for three other preventive health care services: flu shots, pap smears and breast exams. Illinois and the U.S. have virtually identical proportions of the population that receive pap smears and breast exams, and that has remained constant over the past 10 years. Approximately 64 percent of age-appropriate women obtained a breast exam in the last year and approximately 73 percent of age-appropriate women had a pap smear in the last year. The proportion of Illinoisans who received flu shots in the past year rose from about 15 percent in 1996 to 18 percent in 2004 before falling relatively steeply to 14 percent in 2005. A similar trend was found in the U.S., but the rest of the nation had a slightly greater proportion than Illinois of people who received flu shots.

To summarize, Illinois is close in nearly all dimensions to the national average in terms of health and health-care utilization. Therefore, the problems that are of concern to Illinois are similar to those in the rest of the country. Second, besides the rise in obesity, there does not appear to be any dramatic, or even notable, changes in health, health-care use, or insurance coverage in the last 10 years in either Illinois or the United States as a whole.

However, the relatively steady state of health and health care does not mean that there are not some issues of concern. As noted, obesity is increasing rapidly and the causes of this increase remain largely unknown, as do solutions to this problem. The absence of clear solutions has resulted in relatively few public policy initiatives.

Approximately 60 percent of white men and women, but only 40-50 percent of black men and women, in this age bracket in Illinois report very good or excellent health.

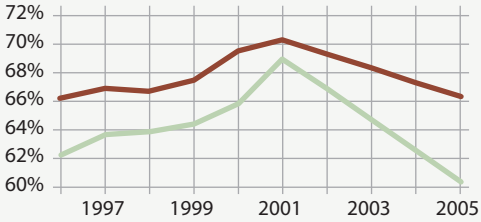
Meaningful advances in eliminating racial and ethnic health disparities will need to come from different policy initiatives and here too, public health initiatives may be key.

Moreover, the averages referred to above hide significant racial and ethnic disparities in health and use of health care. Approximately 60 percent of white men and women, but only 40-50 percent of black men and women, in this age bracket in Illinois report very good or excellent health. Hispanic men and women in this age group are the least likely to report excellent or very good health, especially in recent years. The disparities in self-reported health are about the same as those reported for mortality – black and Hispanic persons are approximately 1.5 times as likely as white persons to report not being in excellent or good health.

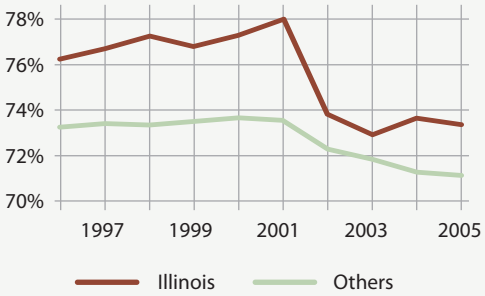
Second, insurance coverage has declined recently and a relatively large group of persons aged 18 to 64 are without coverage. It is exactly people in this age group who are most at risk of not having coverage. Medicare covers the elderly, and many children are covered through Medicaid. It is persons aged 18 to 64 who rely primarily on employer-sponsored insurance and private, non-group insurance. The relatively high rate of uninsured in this group is an issue of concern and highlights the limitations of relying on private insurance markets to provide universal coverage. The fact that 25 percent of this group remains uninsured is strong testimony that government action is required if a goal of society is to significantly reduce the number of people who are uninsured.

Finally, self-reported health is declining slightly. This trend may be due, in part, to the rise in obesity. Notably, this decline in self-reported health is not due to an aging population as a result of greater longevity, as the age distribution of the group we examined (18 to 64) remained relatively unchanged between 1996 and 2005. The decline in self-reported health also conflicts with the declining rate of smoking, but the benefits of less smoking may not manifest for many years. The potentially important issue here is that the decline in self-rated health may be a sign that further improvements due to earlier improvements in living standards (income growth) and past

Probability of Seeing a Physician for Routine Checkup in the Last Year: Illinois 1996-2005



Proportion of People Having Health Insurance Coverage: Illinois 1996-2005



investments in public health are unlikely to be realized and that changes in health will largely come from changes in health behaviors and innovations in medicine. This is worrisome because medical science has not been very good at identifying interventions to prevent or cure disease. Instead, medical innovation has occurred primarily in treating illness. While there have been some spectacular successes that have increased longevity and improved health such as in treating heart disease and treating premature and low-weight infants, most other medical interventions have been costly and relatively ineffective, particularly the growth in spending on the elderly in recent decades.

Health behaviors also may be adversely affecting health and be a partial explanation for the increase in self-reported poor health. As noted, obesity has increased and currently there are no easy solutions to reverse this trend. Obesity is always a simple imbalance between calories consumed and calories expended. However, why this imbalance has grown, explanations of the timing of its growth (post 1980), and explanations as to why growth has been more severe in

some places and for some populations largely remain unknown. Until we know why obesity has increased, we will not have solutions. The trend toward worsening health and greater disability may be a signal to renew efforts to identify effective initiatives that can improve population health and limit the onset and severity of disease.

A similar concern characterizes the persistent racial and ethnic disparities in health in Illinois. Current policy is dominated by expanding insurance coverage and providing access to medical care when sick, but these initiatives likely do little to improve the underlying health of black and Hispanic persons relative to that of white persons. Disparities in health are the result of complex factors that are highly correlated with education. Health insurance coverage and use of medical services are weakly related to racial and ethnic health disparities. Meaningful advances in eliminating racial and ethnic health disparities will need to come from different policy initiatives and here too, public health initiatives may be key.

Trends in health care spending in Illinois

In Illinois, as in every other state and every other developed country in the world, growth in health-care expenditures is outpacing growth in income. The problem has been widely acknowledged by state officials, as evidenced by statements in annual Illinois State Budget Briefs:

- "Medicaid liability has increased 41 percent since fiscal year 1999 and is expected to grow another $580 million in fiscal year 2004."
- "In fiscal year 2003, state health insurance cost $818.0 million in General Revenue Fund (GRF). It is expected to rise by an additional $158 million in fiscal year 2004." (Illinois State Budget in Brief FY 2004)
- "… the costs of the Medicaid Program continue to grow at a rate in excess of state revenue growth. …basic Medicaid spending is projected to increase 7.8 percent in fiscal year 2005." (Illinois State Budget in Brief FY 2005)
- "Group health insurance is a major cost driver for the State of Illinois. The state's General Revenue Fund cost for group health insurance increased from a little over $589 million in fiscal year 2000 to almost $957 million in fiscal year 2004, an average annual increase of 13.1 percent." (Illinois State Budget in Brief FY 2005)
- "Health care services become more costly each year to provide both to the needy and disabled served by Medicaid as well as state employees." (Illinois State Budget in Brief FY 2007)

What are the consequences of this imbalance between the growth of health-care expenditures and growth of income? There can be only three: health care will take an increasing share of public resources; and/or spending on other items such as schools and roads will decrease relative to health care; and/or new revenue will be needed to maintain current spending shares.

The imbalance between growth in spending on health care and growth in income is particularly acute in Illinois because recent policies have expanded, or sought to expand, spending on health care, and there has been relatively little effort to significantly control that growth. So in the near term, spending on health care will continue to take up an increasingly large share of the state budget. Currently, health-care spending in Illinois absorbs nearly 25 percent of all tax revenue.

The real issue is what Illinois is getting for its money. Spending on health and health care is dominated by the provision of health insurance for state employees and low-income and disabled persons. Such spending is undeniably valuable, as the ability to pay for needed medical care when sick is something of great value to Illinoisans. However, as noted above, improvements in health are unlikely to come as a result of the state subsidizing health insurance and greater spending on medical care. There is at best a weak link between spending on health insurance and health. Subsidized insurance invariably leads to some excess and low-value utilization, and a surprising amount of medical care has been

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shown to have little value in terms of improving health. Moreover, the major health-care concerns in Illinois are obesity and racial and ethnic disparities in health. Health insurance will do little to address these fundamental problems.

The inescapable conclusion of this discussion is that Illinois, in the absence of significant federal initiatives, will have to take at least some of the following actions: slow the growth in health-care spending; cut back on efforts to expand insurance; and re-orient health-care spending toward initiatives that address the major health problems facing Illinois today. Unfortunately, there are few effective ways to slow spending, as evidenced by the worldwide growth in health-care expenditures. However, some proven methods could be implemented including: moving toward a mandatory, risk-based Medicaid managed care model; increasing the use of high-deductible health insurance plans by state employees; implementing a statewide "best practice" chronic care delivery model; and promoting the use and adoption of health information technology. Some of these actions are being discussed (see Health Care Reform below), but none of these policies is a panacea. Each has been shown to lower the cost of health care and to have some beneficial effect on growth in spending, but the effects are not dramatic. In terms of improving health, there are few known options available. The great public-health interventions of the early 20th century and the effective public-health campaign against smoking that dramatically extended longevity and improved health do not have current-day analogues. While it is probably correct to reallocate some public money away from paying for health care and toward improving health, exactly where to target spending remains an area for further investigation.

Health Care Reform

The most important development in health policy in Illinois last year was Gov. Rod Blagojevich's Illinois Covered proposal. This is primarily a plan to reduce the number of uninsured in Illinois, but it also has elements that will help improve health and hold down the costs of health care. Parts of this proposal have been implemented by the governor through executive authority and parts are still waiting legislative approval. The parts that have begun are the following:

- Expansion of the Family Care program to families with incomes up to 400 percent of federal poverty level.
- Creation of Illinois Assist, which provides primary care and non-elective inpatient care to persons with incomes below federal poverty level who are not eligible for Medicaid programs.
- Creation of the Illinois Covered Rebate program, which will provide up to $1,000 per year to help pay the cost of health insurance for persons with income below 300 percent of federal poverty.

Parts waiting legislative approval include:

- Creation of a 3 percent payroll assessment on employers with 10 or more employees that are not spending at least 4 percent of payroll on health.
- Creation of the Roadmap to Health program in which the state will coordinate efforts to improve patient safety, promote electronic medical records, improve access to information on quality of care and reduce administrative costs.
- Creation of the Illinois Covered Choice program in which small businesses and individuals will be able to buy into guaranteed, affordable (due to state-financed reinsurance) private plans regardless of health status or income level.

The Illinois Covered plan represents a bold initiative similar to proposals and plans in states such as Massachusetts and California that have been initiated in response to a lack of federal action to address the problem of the uninsured. Illinois Covered, as currently implemented, will reduce the number of uninsured in Illinois, although not by a significant amount. Expansion of Family Care will have a marginal impact because between 80 and

90 percent of targeted families (incomes between 185 and 400 percent of poverty) have private insurance. Therefore, the expansion will affect relatively few of the uninsured and risks spurring families to drop private insurance to obtain cheaper public insurance (crowd out). Similarly, Illinois Assist will have a marginal impact because it targets persons without children who are below the poverty line, of which there are relatively few. Finally, Illinois Covered Rebate will also have a marginal effect. The rebate represents a relatively small subsidy (20 percent) and evidence has shown that uninsured persons' demand for insurance is not that responsive to price.

The heavy lifting on reducing the uninsured will come from parts of the Illinois Covered program that are waiting legislative approval. The Illinois Covered Choice program combined with the employer payroll assessment has the potential to significantly reduce the number of uninsured. Unfortunately, this will be a very costly program that also has the potential to erode the employer-sponsored insurance market. The high cost of the program comes from two sources. First, the state reinsurance feature that is necessary to keep insurance premiums in the Illinois Covered Choice program low will be costly because the state will bear the burden for all high-cost enrollees. The skewed distribution of health-care expenditures, in which approximately 10 percent of the population account for approximately 70 percent of all spending, suggests that the state will pay a heavy price to keep insurance premiums low — basically paying for the most costly enrollees. Second, the size of the program is likely to grow because most employers will find a 3 percent payroll assessment much cheaper than providing insurance for their employees. Employers pay well over 3 percent of payroll to provide insurance so many employers will opt to pay rather than play (provide insurance). Moreover, creating a tax will legitimize not playing.

The high-cost of fully implementing the Illinois Covered plan was recognized by Governor Blagojevich, although he argued that much of the cost of care for the uninsured is already being paid in indirect ways such as privately insured persons paying higher premiums. To pay for the plan, the governor proposed a Gross Receipts Tax, which was controversial and ultimately did not receive sufficient legislative support to pass. The absence of a new revenue source to fund the Illinois Covered plan has prohibited full implementation of the plan.

In terms of health-care costs, the Illinois Covered plan proposed to reduce costs and improve health through its Roadmap for Health initiative. This initiative lacks specific details, but evidence suggests that more aggressive disease management and greater use of electronic medical records can improve health and reduce costs. While there is some evidence that such initiatives can reduce costs, the magnitudes of the reductions are likely to be small. Moreover, there is no evidence on whether such initiatives would be successful on the scale as large as a state that does not have direct control over disparate health-care providers.

The failure to obtain the required funding to fully implement Illinois Covered is a perfect illustration of the tension between expanding health insurance coverage to reduce the proportion of uninsured and the increasing fiscal burden of health-care spending. Expanding insurance coverage, either Medicaid or private coverage, will require additional state resources and it will exacerbate the imbalance between growth in state spending on health care and growth in state revenue. One way to mediate this tension is to redefine insurance coverage. The state could expand insurance in a low-cost way if it was willing to subsidize and provide mostly catastrophic coverage. Cost savings could also be found by moving state employees into similar high-deductible insurance plans.

In sum, the Illinois Covered plan represents a major commitment of the state to address

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the problem of the uninsured and, in this regard, Illinois is a national leader. However, full implementation of the program will be quite costly, and it is uncertain whether the state has the resources to fully implement such a bold initiative.

Health insurance coverage and markets

In 2006, 15.8 percent of the U.S. population was uninsured, up from 15.3 percent in 2005. Private health insurance coverage dropped nationally from 68.5 percent in 2005 to 67.9 percent in 2006. Medicaid enrollment nationally was 12.9 percent in 2006, down slightly from the 13 percent recorded in 2005. By comparison, in Illinois the percentage uninsured in 2006 was 14 percent, up from 13.7 percent in 2005. Overall, Medicaid enrollment in Illinois increased modestly in 2006 to 10.9 percent from 10.8 percent in 2005. In contrast to national trends, private health insurance coverage in Illinois increased (albeit modestly) from 72.7 percent to 72.8 percent.

For children 18 years of age and younger, a focal point of recent Illinois health-care policy, lack of insurance decreased from 10.3 percent to 9.6 percent, largely mirroring the drop nationally from 12.1 percent to 11.2 percent. Medicaid coverage of children increased in Illinois from 21.2 percent to 23.0 percent; nationally Medicaid coverage (which includes SCHIP) increased more modestly from 26.1 percent to 26.5 percent. Many are concerned about "crowd-out" or substitution of public coverage for private coverage, particularly given increases in children's eligibility for public health insurance coverage at higher income levels. Private coverage of children in Illinois fell from 71.2 percent to 70.7 percent, though not as steeply as the national decline in private coverage of children from 2005 to 2006 of 66 percent to 64.8 percent. Taken together, the nearly two percentage point increase in public coverage of children in Illinois combined with a 0.7 percentage point reduction in lack of insurance and a decline in private coverage suggests some degree of crowd-out in the state.

State health insurance mandates have attracted attention in recent years as potential sources of friction in health insurance markets. Mandates tend to increase premiums, which can make it incrementally more difficult for small businesses to afford to offer health insurance to employees and for employees to afford it when it is offered. A recent report issued by the Council for Affordable Health Insurance suggests that Illinois is in the middle of the pack regarding the extent of health insurance mandates with 38 (which happens to be the median number of state mandates nationally). One mandate was added in Illinois between 2006 and 2007 as the state now mandates coverage of speech and hearing therapists in policies sold within the state.

Illinois does not have strong regulatory mechanisms in the non-group health insurance market such as community rating and guaranteed issue requirements; the small-group market (defined as 2-50 employees) does have guaranteed issue on all policies and the state specifies a rating band for premiums, a regulation now present in the small-group market in every state. These types of regulations have been shown to reduce health insurance coverage and to skew risk pools towards unhealthier enrollees, leading to higher premiums. However, Governor Blagojevich's Illinois Covered plan proposes both guaranteed issue and tight community rating of small-group and non-group premiums. Presently, the small-group and non-group markets have a relatively large number of competing insurance companies offering products to small employers and individual buyers. Evidence from other states that have implemented such heavy-handed regulations suggests that insurers frequently decide to stop writing policies in the wake of these regulations.

Strong regulations such as community rating combined with guaranteed issue would also likely disrupt the nascent "consumer-directed" health-care movement that is taking

root in the non-group market in Illinois and other states (with the exception of community-rated states). There are 100 different health insurance policies available to individuals from seven different insurers via the web-based health insurance marketer eHealth Insurance.com, 31 of which are Health Savings Account (HSA) eligible. For a 38-year-old male, the premiums range from $60 per month to $320 per month. By contrast, in a heavily regulated state such as New Jersey there are only 14 plans available from three different insurers, none of which are HSA eligible. The premiums for these polices for a 38-year-old male range from $177 per month to $658 per month. Illinois consumers, legislators, and providers would want to be very cautious about pursuing a heavily regulatory regime in the state health insurance market.

A new approach to managing medical malpractice risk

A recently implemented initiative at the University of Illinois Medical Center at Chicago has the potential to reduce the frequency and volatility of medical malpractice claims and to improve the reliability with which victims of medical injury are compensated. Previously, the Medical Center's policy of non-disclosure failed to reduce the number of claims and the incidence of very large claims, limiting the Medical Center's self-insurance capability and raising its reliance on outside excess insurance. However, the new *Medical Error Full Disclosure with Rapid Remediation* process seeks to address proactively the possible financial liabilities arising from medical errors as soon as they are reported by any of the Center's personnel. The initiative is unique in the country in that it combines an apology with a judiciously crafted component of rapid remedy.

Now in its third year, the initiative shows signs that it may lead to a rapid and significant reduction in the Medical Center's financial burden of its medico-legal liability. The Medical Center's excess liability insurer has offered to reduce the Center's yearly premium, anticipating a reduction in exposure to very large claims. As part of a comprehensive assessment of the initiative, an interdisciplinary research team at the University of Illinois' Collaborative for Patient Safety Excellence is evaluating the initiative's effect on the Center's claims experience, rate of medical injury and compensation, patient satisfaction, and retention and recruitment of medical staff. Several Illinois hospitals are studying which elements of the initiative can be replicated successfully at their systems. The initiative has attracted the attention of national patient safety and health care quality organizations, and the Massachusetts legislature's Committee on Health Care Financing has commissioned a brief that describes the experience to date of the University of Illinois' rapid remediation program.

Fully disclosing medical errors to patients who suffered a medical injury and offering an apology with a financial settlement presents patients and providers with an alternative to litigation. While it is too soon to reach definite conclusions about the performance of the University of Illinois program, this initiative has the potential to compensate more victims of negligent care more fully, more rapidly, and more reliably than is achieved through the current system of litigation – without raising the overall cost of professional liability borne by providers. *Full Disclosure with Rapid Remediation* aims to avoid litigation by reducing the barriers that patients and their attorneys face in obtaining compensation without a trial. By contrast, commonly advocated tort reform measures – such as caps on non-economic damages, limits on contingency fees, and tighter statutes of limitation – aim to avoid litigation by raising the barriers that patients and their attorneys face in bringing a lawsuit and obtaining compensation through a court-ordered verdict.

While full disclosure and tort reform may reduce litigation, they will differ sharply in

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their effects on the twin objectives of any medical malpractice liability system, namely to compensate victims of medical injury due to negligent care and to deter negligent care. By including an offer of rapid remediation, a policy of full disclosure will likely raise compensation for medical injury, while tort reform measures will reduce compensation, as they reduce the expected return from filing a lawsuit. The research evidence to date, however, suggests that too few victims of negligent care are compensated, so tort reform measures will aggravate a shortcoming of the present litigation-based system rather than mitigate it. To the extent that tort reform also reduces the frequency and average amount of payments made by providers, it will erode the deterrent effect that the threat of legal liability carries and thus the incentive to improve patient safety.

Changing priorities for the regulation of hospital markets

The push by the state attorney general to hold nonprofit hospitals more accountable for the amount of charity care they provide in return for their tax exemptions did not resurface on the AG's 2007 legislative agenda with the same vigor as it appeared in 2006. At the time of this writing, the Tax-Exempt Hospital Responsibility Act, which would have required every "tax-exempt hospital to furnish aggregate annual charity care in an amount equal to at least 8 percent of the hospital's total operating costs," has not been passed in either chamber of the Illinois legislature and its prospects for passing in the foreseeable future are uncertain.

By contrast, the Fair Patient Billing Act, which "requires hospitals to give patients written notice that they may be eligible for financial assistance," was passed and has been effective since Jan. 1, 2007. In this context, the continued adoption of high-deductible tax-advantaged health insurance plans, more commonly known as consumer-driven health plans (CDHPs), is noteworthy. By exposing patients to a greater degree to the cost of their health care than conventional insurance products do, CDHPs raise the demand for information on the price and quality of the services offered by different providers. While this information is rarely disclosed or negotiated with non-group payers such as patients who pay for the service out of their individual account, several states are establishing quality reporting systems and make risk-adjusted quality metrics available to the public. The most prominent data collection initiatives focus on in-hospital mortality after cardiac surgery.

Currently, the public health departments in five states maintain data collection systems for outcomes of cardiac surgery, both at the physician level and at the hospital level.[1] The research evidence to date, however, suggests that few consumers rely on these publicly funded quality reports when selecting a provider. For their part, and taking into account the scant attention paid to report cards by consumers, providers do not seem to respond strongly to publication of their surgery outcomes either. Illinois currently does not collect and does not publish risk-adjusted cardiac surgery outcomes by hospital or by surgeon. In view of the aforementioned limited effectiveness of these reports in modifying patient or provider behavior, the state should focus on alternatives that encourage provider transparency about price and quality. Proprietary health quality rating firms, patient advocacy groups, and purchaser coalitions also have been publishing outcome data for providers, and competition among these diverse information vendors may well lead to the emergence of a less costly and more widely used alternative to publicly funded report cards.

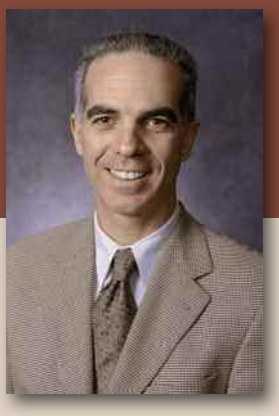
Where do we go from here?

All roads lead to health care cost containment. Growth in the costs of publicly-financed health care is outpacing growth in state revenues. This has created a structural deficit that will result in health care deplet-

[1] They are the California CABG Outcomes Reporting Program (CCORP), the Massachusetts Data Analysis Center (Mass-DAC), the New Jersey Department of Health and Senior Services Registry(NJDHSS), the New York Cardiac Surgery Reporting System (NY-CSRS), and the Pennsylvania Health Care Cost Containment Council (PHC4).

ing an increasingly larger share of state resources. The structural deficit related to health care has already created a political roadblock for reform and will continue to do so in the future. Efforts to expand health insurance, improve public health (e.g., racial disparities in health), and address other priorities for the state (e.g., education) will be stymied if these efforts do not save money or are proposed without addressing cost savings in other contexts.

Simply put, the state has to get serious about containing health care costs. While there are no magic potions, the state should consider a few proven methods: moving toward a mandatory, risk-based Medicaid managed care model; increasing the use of high-deductible health insurance plans by state employees; implementing a statewide "best practice" chronic care delivery model; and/or promoting the use and adoption of health information technology.



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