

Medicaid, SCHIP, and State Reforms

After several years of tight budgets, the fiscal outlook in many states has improved, driving new efforts not only to strengthen state-run public health coverage, but to formulate some ambitious reform plans as well. However, experts question whether the gains achieved through these improvements can be sustained over the long run without support from the federal government.

Fast Facts



- ▲ *Medicaid currently provides coverage to 55 million individuals at a cost of more than \$300 billion a year in combined federal and state spending. The program's 14 million elderly and disabled beneficiaries account for more than half of that spending. Page 78.*
- ▲ *The State Children's Health Insurance Program (SCHIP) was established a mere ten years ago in an effort to ensure that children from low-income families have access to health care. However, efforts to expand the program have resulted in some push-back in Congress. Page 82.*
- ▲ *Massachusetts is the first to actually mandate that individuals obtain health insurance coverage, but other states are taking their best stab at that goal with comprehensive reforms that combine elements of both public and private health coverage. Page 86.*

Health insurance coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) are cooperative efforts in which the state and federal governments share not only the cost, but many of the administrative decisions.



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Like Medicare, Medicaid is considered an entitlement program. As a result, Congress does not set the budget each year. Rather, whatever money the states put toward serving the program's beneficiaries, the federal government comes up with matching funds. Conversely, SCHIP is not an entitlement, which has caused some problems over the past few years when federal matching dollars allocated for the program ran out before the end of the fiscal year.

At this point, whether states can afford Medicaid may be less important than decisions made at the federal level, where much of the pressure to make cuts has originated. There is no indication that officials from the Department of Health and Human Services (HHS) have any intention of easing up on efforts to limit the federal government's spending on the program.

Medicaid's rising cost, which is largely driven by big-ticket items such as long-term care, has caused concern within the federal government as it focuses more attention on fiscal discipline than expanding coverage. Within the past few years, the Centers for Medicare & Medicaid Services (CMS) have implemented several strategies

meant to target waste, fraud, and abuse within the program. Those efforts have met with varying degrees of success as well as some push-back from the states frustrated by what seems like micromanaging by the federal government.

The states also have concerns about the size and expense of the program; but for many, the bigger problem is adjusting to the new cost-containment measures being imposed by the federal government. Several states have made significant cuts to the Medicaid program in response to the federal initiative.

Much of this concern is premised on the assumption that, given current trends, the program's cost will eventually become unsustainable. However, a recent analysis funded by the Kaiser Commission on Medicaid and the Uninsured suggests that, over the long run, the program's growth will remain in line with the overall rise in healthcare costs.

Assuming that spending growth stays around 7.5 percent, which is consistent with the government's own estimates, the cost of Medicaid can be expected to remain relatively unchanged at 16.6 percent of national health expenditures over the next cou-

ple of decades. The analysis also suggests that state revenues are likely to continue increasing during that period, making it more feasible for local governments to pay for the program. “There is little indication that Medicaid will be the ‘Pac-Man that ate state budgets,’” the authors conclude.

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An increase in federal funding for SCHIP should help the states maintain and even potentially grow enrollment. While most politicians agree that covering children is a worthy goal, some have complained that increasing access fuels “crowd-out,” whereby children already insured in the private market move into the public program because it is cheaper.

Much of the talk on the federal levels has remained that: just talk. But state governments have not been content to sit back and wait for federal action. During the past couple of years, governors and legislatures in several states have come together in a bipartisan fashion to address many of the problems facing the healthcare system, including the uninsured, medical liability premiums, and the need for better health information technology. In large part, these states have built their reforms on the existing structure of a healthcare system that integrates both private and public components.

Medicaid: Expansion and Contraction

The Medicaid program is more than 40 years old, having been established by law along with Medicare in 1965. Originally created to provide healthcare coverage for welfare recipients, over time the program has been gradually expanded into a public health insurance program for low-income families and individuals. It has also become the main provider of long-term care for elderly Americans and people with disabilities. Medicaid is now

the largest payer of health care in the country, responsible for one-sixth of all healthcare spending and nearly half of all nursing home care.

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Federal Law in the Way

As states attempt to reform their own small piece of the nation's healthcare system, they are running into several roadblocks. One of the biggest is the Employee Retirement Income Security Act (ERISA). One of the main provisions of the 1974 law is that self-insured employers—i.e., those large companies that can afford to bankroll their own health plans—are exempt from most state regulations of private health insurers. ERISA allows national companies to comply with one set of federal rules across the country rather than the variety of state laws where the companies have offices. It also makes it much more difficult for states to devise universal coverage proposals.

The main obstacle that ERISA has created for states is that it blocks most attempts to establish an employer mandate that applies across all companies, big and small. In general, state mandates have referred to requirements that private health insurers provide coverage for a particular disease, condition, or service. While such mandates have always applied only to companies and individuals who purchased coverage on the group market, the ERISA obstacle was not much of an issue since virtually all large companies chose to offer their workers relatively comprehensive benefit packages. However, with more employers now offering less coverage, state attempts to stanch the rise in the uninsured are being stymied by the ERISA preemption.

Despite these facts, several states have introduced a pay-or-play component with their healthcare reform. Such provisions generally require companies in the state above a certain size either to pay into a fund that offers coverage for low-income workers and families or to offer health insurance to their employees themselves.

State reformers want to create broad-based programs with an employer-financed component, and that makes sense from both a policy perspective as well as a financial one, according to Phyllis Borzi, JD, a health policy professor at George Washington University in Washington, DC, in a discussion on state reforms sponsored by the

disabled beneficiaries account for more than half of that spending. The federal government matches between half and three-quarters of spending, depending on the state's per-capita income.

Nationally, the growth in spending for Medicaid has actually slowed over the past couple of years, in part due to cutbacks states have made in response to their own budget crunches.

Kaiser Foundation and the National Governors' Association. But states have to be careful in how they go about designing a pay-or-play approach in order to avoid running afoul of ERISA, she cautioned.

"You don't want to be very proscriptive, you don't want to define the parameters of coverage," she said. "If you say you have to provide this package of benefits, you can only provide family coverage, [or] you can't charge more than 20 percent—the more bells and whistles that you put on the play component, the more likely it is that a court will find that you are forcing an employer to have a plan that looks a certain way."

Requiring companies to pay a fee or tax to support a healthcare purchasing pool can also invoke ERISA, said Ms. Borzi. "Even though you are imposing a requirement to pay, it still is an arrangement with respect to that employer's employees, so you could make an argument—opponents of this arrangement would certainly argue that in that case—even the pay component was forcing employers to have a plan," she said.

Several states have already faced legal challenges to reform efforts due to ERISA. Perhaps most prominently, a federal district court found that a Maryland law that would have levied an eight-percent payroll tax on Wal-Mart to support the state's Medicaid program violated ERISA.

"The important thing about the Maryland case wasn't so much that they lost, but that the court said that the association that sued, which was a national association, had standing to sue," said Joy Johnson Wilson, director of health policy at the National Conference of State Legislatures, a trade group that represents state legislators and their staffs. "Even if you have all the companies in your state saying tax me, tax me, there still could be someone outside of the state who could file a case, and your law could be overturned," she said at a briefing on state health initiatives sponsored by the Alliance for Health Reform, a Washington, DC-based nonprofit organization that advocates for improved access to health care.

According to a Kaiser Commission report, Medicaid spending increased in 2006 by 2.8 percent on average, the lowest rise in 10 years. Low enrollment growth as a result of cutbacks of 1.6 percent was a major factor.

However, despite the states' efforts to curb costs, legislation signed into law last year will require more cuts to the program. Several provisions contained in the Deficit Reduction Act (DRA) give states more flexibility to reduce their Medicaid spending with the goal of saving the federal government more than \$26 billion over 10 years.

Moving forward, cuts are likely to look much like measures taken to curb costs in the past. When forced to scale back spending on the program, states have generally relied on a combination of strategies, including freezing and, on rare occasion, reducing payment rates for physicians and other healthcare providers and implementing policy changes that effectively reduce the program's enrollment. The DRA also enabled states to more easily eliminate previously covered benefits or to require beneficiaries to share more of the costs, through either co-pays or premiums.

For example, a change in policy adopted by several states has been to require patients to re-enroll every six months rather than once a year. While this has been advertised as way to ensure that Medicaid is not paying for enrollees who are no longer eligible for the program, this strategy has also knocked many eligible patients off the rolls as well, simply because of the additional bureaucratic hassle involved. Another strategy that has affected enrollment levels has been to increase cost sharing, especially for those beneficiaries who may not qualify as the poorest of the poor.

"Some states do it as a cost-containment measure because Medicaid is eating up an ever-higher share of their state budgets. It's one way to hold the line on that," says Peter Cunningham, PhD, a senior fellow at the Center for Studying Health System Change (HSC) in Washington, DC.

Cost-sharing arrangements are designed to reduce costs by reducing unnecessary use of medical care. However, among low-income populations the cost savings may come instead from reduced enrollment.

“It’s not so much that the premium amount that people pay is going to make a big difference [for the state’s bottom line], but... it has a dampening effect on enrollment. A lot of people who might have enrolled if it was free, won’t if there is a fee or premium attached to it,” says Dr. Cunningham.

Over the past few years, nearly every state has also either frozen or reduced physician pay to help keep Medicaid spending increases down. State officials generally understand that equation, but the program has fallen so far behind that if states tried to suddenly bring pay up to even the level of Medicare, it would have an enormous and unaffordable impact on state budgets. When states do adjust reimbursements, they tend to give physicians only modest raises, usually on the order of perhaps five percent. That’s still going to keep the payment rates well below either Medicare or private insurance.

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The low pay has the effect of discouraging physicians from seeing these patients, especially given that they come at a time when office expenses and other costs of delivering care continue to rise dramatically. As a result, a diminishing number of physicians are taking care of the majority of Medicaid patients, says Dr. Cunningham.

“There is a very skewed distribution of physicians who take Medicaid patients, so that even though most physicians say that they accept Medicaid patients, there are relatively few physicians who see a lot of Medicaid patients,” he explains. “In places like community health centers, public hospitals, and other safety net providers, [physicians] tend to see a disproportionately large number of Medicaid patients.”

In fact, the main access that low-income Americans currently have to medical services is through a fragmented network of low-cost and charity-care providers that includes community health centers, public hospitals, emergency departments, and, to

a diminishing extent, charity care from office-based physicians. These types of facilities serve the bulk of the uninsured, but they also serve a large proportion of the Medicaid populations. As federally qualified health centers, they receive a higher rate of Medicaid reimbursement than private physicians do.

“These centers and safety-net providers depend to a large degree on Medicaid because they don’t get a lot of private insurance business, and they can’t survive by just treating uninsured people,” says Dr. Cunningham.

While cost-control measures do produce results in the short term, they may not be sustainable and may begin to impact patients’ access to care.

From a literal perspective, the federal government has not cut Medicaid spending, but steps it has taken to restrict the program’s growth still have impact on the money states can expect to receive from the federal government, says Matt Salo, Director of Health Policy for the National Governors’ Association. “Costs don’t exist in a vacuum. Population growth doesn’t occur in a vacuum,” he says.

For many states, their economies and Medicaid budgets are in relatively good shape as compared with just a couple of years ago. Historically, such trends tend to cycle up and down over time.

“We know that neither of those factors will remain true over the next five to ten years. State finances are going to take another dip. It’s just the nature of the beast. And Medicaid costs will go up in the near future,” Mr. Salo says.

SCHIP Shortfalls

In contrast to Medicaid, SCHIP is still very much in its infancy. It was established a mere 10 years ago in an effort to ensure that children from low-income families have access to health care. Support for the program among lawmakers is virtually universal, in part because it is relatively inexpensive and in part because its goals—covering children—remain politically popular.

“SCHIP was created to give states an incentive to cover kids that they could have covered through Medicaid, but for whatever reason didn’t,” says Mr. Salo. Part of that incentive was that the federal government would take on a greater share of the costs than it does under the Medicaid statute. Another part was the fact that

it would not be an entitlement program, allowing the states more flexibility in how they administered it compared with Medicaid.

That formula worked relatively well for the past 10 years, but there are still an estimated nine million eligible children that the program is missing. In recent years, outreach efforts have fluctuated due to funding uncertainty. Because the program is not an entitlement, the federal government sets aside a finite amount of money each year to fund its share—so an eligible child may not get coverage.

There is a perennial problem in SCHIP in which each year a few more states run through their federal share of funding

before September, the end of the fiscal year. Once those funds run out, states are on their own in terms of financing the program. Ironically, this problem has hit states that got a faster start building their programs because in the past they relied on redistribution from states that were unable to pull down their full share of federal dollars.

“Now that all the other states are starting to really ramp up, and as their programs are maturing, there is much less money to be redistributed,” Mr. Salo explains.

Some states have taken temporary measures to deal with the gap in coverage, such as handing out IOUs to physicians, shifting money from Medicaid or other programs, all in anticipation of the federal government’s stepping up with additional funding. Other states have had to freeze enrollment or reduce benefit packages to compensate for the shortfall in federal dollars.

Such shortfalls have brought proposals to convert SCHIP to an entitlement program, ensuring that federal funds are always available. That doesn’t seem likely, though, says Mr. Salo.

“The reason why [SCHIP] is such an enormous bipartisan success is that it is not Medicaid, it is not an entitlement. If you start to go in the direction of making it an entitlement, you will instantly lose a lot of good will toward the program,” he says.

Like Medicaid, SCHIP enrollment had been on the rise—until

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State Reforms Great and Small

While the federal government wrangles with issues like Medicare reimbursement rates and SCHIP reauthorization, individual states are taking action—large and small—to increase health coverage for their citizens. Massachusetts has taken sweeping steps to provide coverage to nearly all the state's residents, while Colorado has taken the more modest approach of adding new community health centers. In between, several states are planning or implementing a range of measures aimed at dealing with the problem of the uninsured and rising healthcare spending. Here's a roundup of what's happening:

Arkansas has received permission from the federal government to use Medicaid funds to help employers who don't already offer health benefits to provide their workers with access to state-approved private insurance. The standardized package includes restrictions on the number of prescriptions and medical services enrollees can get.

California Governor Arnold Schwarzenegger announced a plan at the beginning of this year that includes an individual mandate requiring all residents to have a minimum level of coverage, a pay-or-play mandate for employers with 10 or more full-time workers, low-income subsidies, expansion of Medicaid and SCHIP enrollment, and a tax on physicians and hospitals. The plan will need the approval of both the state's legislature and CMS.

Colorado has taken full advantage of the President's initiative to expand the network of community health centers. The state has received \$6 million in grants and built or expanded 60 health center sites.

Idaho has expanded SCHIP eligibility to children in families with higher incomes than previously were covered by the program. Families with eligible children also have the option of receiving premium assistance for their choice of private insurance.

Illinois has set the goal of covering all its children. Under the Covering All Kids Health Insurance Act, children—no matter what their family's income—are eligible for a state-run program that offers sliding-scale rates on premiums, co-pays for physician visits, and prescriptions. The plan includes case management services as a money-saving measure.

Kansas offers a tax credit to small companies that contribute to their employees' health savings accounts.

Maine, in January 2005, became the first state to pass a comprehensive package of reforms designed to achieve universal coverage within five years. Under the law, employers are required to cover at least 60% of employees' health benefit costs, and there are limits on

how much low-income workers can pay toward premiums and cost sharing. The state also expanded Medicaid to poor young adults without children and to low-income parents.

Massachusetts is the first state to require all of its residents to obtain health insurance. To assist them, the government created the Commonwealth Health Insurance Connector, a purchasing pool for small businesses and individual residents, and the Commonwealth Care Health Insurance Program, a subsidized health plan for the state's low-income residents. Under the plan, SCHIP eligibility was extended to more middle-income families.

Montana established a new tax credit last year to support small companies that offer health insurance to their workers. The tax credit is also available to small employers who don't currently offer coverage but want to take advantage of a choice of state-approved options.

New Mexico has implemented a program that leverages unspent SCHIP funding to offer premium assistance to families with incomes up to twice the federal poverty level. The plans are offered through employers who pay part of the premium. Families pay a smaller share for coverage that limits their out-of-pocket spending to five percent of their annual income.

Pennsylvania Governor Edward Rendell has introduced a plan that would require college students to have healthcare coverage and, if uninsured numbers don't decline fast enough, a mandate requiring individuals to purchase health insurance or enroll in public coverage if available to them. The proposal calls for the creation of a government-approved and -subsidized health insurance product provided by private insurers to help individuals and small businesses that cannot currently afford coverage.

Vermont is in the process of implementing a series of measures including premium subsidies for low-income residents and streamlined Medicaid enrollment procedures. The state plans to provide assistance to low-income workers who are eligible for employer-based coverage. Those without access through their jobs can sign up for private insurance with benefits and rates that meet established standards. There is also a pay-or-play mandate for all but the smallest employers, requiring companies to either provide benefits to all their workers or contribute to the state's assistance program.

Wisconsin has devoted \$3 million of its budget to support community health centers, allowing the existing network of 330 sites to add dental services, expand the clinics, and hire more physicians and other providers.

last year. “In the past year or two, we have seen enrollment, at least nationally, level off and even decrease a little bit. That could reflect both improvements in the economy as well as some of the cost-containment efforts by the states,” says Dr. Cunningham.

Where the Fed Fears to Tread

Federal efforts to reform the healthcare system have been largely confined to incremental changes such as increasing funding for community health centers and the creation of health savings accounts. While several states are working to take full advantage of the federal dollars those reforms free up, they are not waiting for Congress to devise more comprehensive solutions to the problem of the uninsured and rising healthcare costs.

“You’ve got the states out there, like Massachusetts, California, Maine, and others, that are thinking really bold thoughts on big-picture healthcare reform. They are thinking about how do we get on the state level as close to universal coverage as we can,” says Mr. Salo.

Massachusetts is the first to actually mandate that individuals obtain health insurance coverage, but other states are taking their best stab at that goal with comprehensive reforms that combine elements of both public and private health coverage. Those efforts generally include other measures designed to lower barriers to coverage. Lowering barriers can be achieved by providing more affordable insurance options, government subsidies, or an expansion of public coverage.

Other states are making more modest reforms. A number are using Medicaid and SCHIP funds to help residents purchase private insurance. Other states are making pared-down versions of the public insurance programs available to a wider pool of residents. The states are also incorporating an element of shared responsibility by requiring individuals to bear some of the cost in order to benefit from the reforms.

“There’s a sense that since they are expanding into groups that aren’t the poorest, they have some ability to contribute to the cost of the program,” says Dr. Cunningham.

However, this trend has detractors; many are concerned that an expansion of public programs will encourage people who already have insurance or coverage through their employers to

drop it in order to get subsidized care.

Several states have plans on the table. Based on the recommendations of a healthcare task force, Illinois Governor Rod Blagojevich recently proposed reforms designed to extend coverage to the state's varied population of uninsured residents, says Krista Donahue, chief of policy for Illinois's Department of Health Care and Family Services.

For the state's 300,000 single adults and adults without dependent children, Illinois would offer access to a state-funded insurance plan that includes everything that Medicaid offers except long-term care coverage. In addition to the 183,000 parents in Illinois whose children have health insurance through SCHIP, Illinois would extend family eligibility up to three times the federal poverty level. For young adults—there are an estimated 500,000 residents between the ages of 19 and 30 without health insurance—the plan would allow them to continue to be covered under their parents' health plan.

“Many parents obviously encourage their children to get health insurance; but when you're that age, often you don't feel that you need it and may not want to pay for it,” Ms. Donahue says. But if something happens, it's the parents who often foot the healthcare bill.

For those residents who have insurance but are struggling to pay premiums, and for those who want to purchase private health insurance but haven't been able to, the state will create a state-mandated benefit package, called Illinois Covered Choice. Insurers who operate in Illinois are required to offer the product, but the state would provide them with stop-loss protection over \$40,000 to keep premiums low.

“We have a robust private insurance market, and we don't make any changes to that, we just simply require that insurers that are offering a product in Illinois also offer a Choice product. The Choice product will be a guaranteed product, and insurers will be prohibited from rating on health status in that product. So

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we think small employers will see less of a variation in their premiums according to the health status of their workers,” she says.

Pennsylvania Governor Ed Rendell has come up with a similarly ambitious proposal that has many of the same elements, but some important differences as well, says Donna Cooper, Secretary of the Governor’s Office of Policy and Planning for Pennsylvania. “Illinois took a stop-loss ratio

“Illinois took a stop-loss ratio approach to funding their healthcare package, whereas Pennsylvania and Massachusetts have tried to use their funds to underwrite the cost of the basic premium with the intention or the hope that better chronic disease management and pay-for-performance systems and decreasing hospital-acquired infections will drive down the overall cost in the system,” Donna Cooper says.

approach to funding their health-care package, whereas Pennsylvania and Massachusetts have tried to use their funds to underwrite the cost of the basic premium with the intention or the hope that better chronic disease management and pay-for-performance systems and decreasing hospital-acquired infections will drive down the overall cost in the system,” she says.

The Pennsylvania effort places a lot of emphasis on finding ways to bring down health-

care costs so that their reforms are sustainable over the long run. “One of our strategies for increasing access is trying to make sure that [healthcare] professionals can practice to the full extent of their training,” she says, referring to the possible expanded use of “physician extenders,” such as nurse practitioners and physician assistants. That has led to additional questions. “Now we’re having another debate: doctors versus nurse practitioners and what does that mean? And who knows more, who knows enough?” asks Ms. Cooper.

It is just those types of complexities in the healthcare system that states will have to deal with as they move forward. In fact, many of the states are discovering that they cannot expand coverage and offer rich benefit packages without also addressing the quality and cost effectiveness of care at the same time, according to Mr. Salo. “Coverage expansions almost have to go hand-in-hand with reviewing what kind of health care people are getting,” he says.

“The states themselves want these programs to work,” he says.

“If they’re not working, if providers are bailing out of a program at an alarming rate, if people are not getting the services that they need with negative consequences, the states are going to change those programs.”

But no matter how innovative and quick to respond to problems they are, the states are unlikely to succeed in their reform efforts without federal support, admits Mr. Salo. “In large part, states are moving forward because they know the feds are not going to,” he says. “Personally, I don’t think they are sustainable without some kind of federal assistance. What’s really needed is money and more tools for states to use to try to improve the system,” he adds.

When implementing these reforms, especially the more sweeping ones, states also face a lot of technical hurdles, such as funding them, finding private insurers willing to meet state-set standards, negotiating federal laws, and getting clearance from the CMS for Medicaid and SCHIP expansion. Once past those hurdles, they have to convince residents and businesses to sign up, or in the case of mandates, find a way to penalize those who don’t.

Even on the local level, county and city governments are trying to address gaps in the healthcare system. Some have established cooperative arrangements in which the cost for coverage is split among public funds, individuals, and employers. The coverage is usually pretty limited, including perhaps a set number of doctor’s visits, some prescription drug assistance, and even—in some cases—some inpatient services benefits.

Other local, non-governmental efforts include access networks that organize local physicians to provide uncompensated care so that the burden is shared equitably. Such an approach also helps ensure that primary care physicians have specialists to whom they can refer low-income patients.

However, at that level, the reforms are very limited. “It might be generous to even call them stopgap measures,” says Dr. Cunningham. “They are very modest, community efforts trying to deal with a problem that is beyond the means of most local governments and communities to deal with on their own. The communities recognize that they can’t solve the problem on their own, but there is just this feeling, in a lot of places, that they have got to try to do something.”