The Effect on Children of Curtailing Medicaid Spending

FEDERAL policymakers are considering a number of major changes for Medicaid and other social welfare programs serving children from low-income families. In this article we discuss the proposed spending reductions and programmatic changes for the Medicaid program because it is the single most important health program for low-income families with children. We present a description of the proposed changes, describe Medicaid's role in financing medical care to children, and assess the likely effects of the current proposals for reducing future growth in Medicaid expenditures on access to medical services and covered benefits.

See also pp 1429 and 1472.

Medicaid is an insurancelike program for financing medical, mental health, and dental services, as well as long-term care for low-income people. It is funded and administered jointly by federal and state governments. Medicaid is expected to serve 36 million people during 1995, up from 22 million in 1988.[1,2] Although Medicaid has increasingly been used to expand coverage for low-income persons, it still covers only 58% of poor Americans.[1] About half of all Medicaid enrollees are children, and the program finances health care for one in every four children in the United States.[3]

Medicaid expenditures have risen rapidly in recent years. For example, between 1988 and 1992 combined federal and state Medicaid expenditures more than doubled.[1] Rising expenditures are largely attributable to health care inflation, growth in the number of program recipients, and increased payments to compensate hospitals that serve disproportionate numbers of poor persons. In response to escalating expenditures and a desire to balance the federal budget, the Congress and the Clinton administration have proposed significant reductions in future levels of federal Medicaid funding.

At the time of this writing (the third week of October 1995), committees in both the House of Representatives and the Senate had approved a Republican-sponsored "MediGrant" proposal to radically transform the Medicaid program. This proposed legislation, as well as the congressional budget resolution previously approved by the House and the Senate, includes reductions of up to $182 billion in federal Medicaid spending growth over the next 7 years, or a cumulative reduction of about 19% from projected spending. These savings would be achieved by imposing a cap on the growth of federal Medicaid payments to the states. The Clinton administration has proposed reducing Medicaid spending growth by $55 billion over a 7-year period, roughly one-third that proposed in the Congress. These savings would be achieved by limiting growth in federal expenditures per beneficiary, rather than capping total payments to the states.

The House MediGrant proposal also would give states substantial added discretion in allocating Medicaid funds by converting Medicaid to a block grant program. While states are now required to make Medicaid payments for services provided to certain groups such as low-income children, states would be allowed far greater flexibility in selecting the beneficiaries as well as the services they would receive. With cutbacks in federal Medicaid contributions, the process of allocating funds among beneficiary groups at the state level is likely to be a contentious one.

In the past, children have fared poorly in battles over budget allocations at the state and federal levels.[4] For example, the last concerted federal attempt to reduce public social welfare spending occurred during the early part of the first administration of President Ronald Reagan. Substantial cuts in income-tested programs, including Medicaid, were engineered by the Reagan administration and authorized by the Omnibus Budget Reconciliation Act of 1981 and other legislation. From 1980 to 1982 there was an 8% decrease in real per capita public social welfare spending for children. In contrast, during the same period real per capita spending continued to increase for other population groups.[4]

Today, the stakes for children are even higher. With more children living in poverty than at any time in the last 30 years and a growing number of children losing private insurance every year, Medicaid has taken on greater importance as a health care financing source.[5] Nevertheless, laws that entitle poor children to needed medical services are, for the first time, being seriously threatened. Moreover, the level of budget cuts being contemplated is considerably greater than in the previous decade.

Medicaid's Role in Meeting Children's Health Needs

Medicaid finances health care for millions of Americans including the elderly, the disabled, and children and their families. For children, Medicaid serves two critical purposes: first, for all American families with children it provides a

From the Department of Pediatrics (Dr Newacheck) and the Institute for Health Policy Studies (Drs Newacheck and Hughes), School of Medicine, University of California, San Francisco; National Center for Youth Law, Chapel Hill, NC (Ms English), Fox Health Policy Consultants, Washington, DC (Ms Fox); Department of Pediatrics, University of California, Los Angeles (Dr Halfon); Department of Pediatrics, Harvard Medical School and Massachusetts General Hospital, Boston, Mass (Dr Perrin)

Reprint requests to the Institute for Health Policy Studies, University of California, San Francisco, School of Medicine 1388 Sutter St, Suite 1100, San Francisco, CA 94109 (Dr Newacheck)

safety net during difficult economic times; and second, for poor families with children it provi ongoing financing for needed preventive care and treatment for acute and chronic illnesses.

Medicaid as a Safety Net for All Children.—The majority of American children are covered by private health insurance, most often through their parents' employment. However, children have experienced substantial losses in private health insurance in recent years. Survey data from the US Bureau of the Census show that from 1988 through 1992 an estimated 3 million children lost private health insurance.[5] All of this net decline in private insurance coverage is attributable to losses of employer-based health insurance. These reductions resulted from elimination of insurance coverage for dependents by some employers and from shifts in the economy away from higher-paying jobs with generous fringe benefits to lower-paying jobs with fewer benefits.[5]

During the same time period that private coverage among children was shrinking, Medicaid coverage was growing. Part of the growth in Medicaid coverage was the result of congressional mandates enacted during the 1980s to broaden coverage for poor and near-poor children. These mandates require states to phase in Medicaid coverage by the year 2002 for all children under 19 years of age whose family income is below the federal poverty level. However, much of the increase in Medicaid enrollment resulted from a large increase in the number of families entering poverty. In fact, the number of children living in poverty grew by over 2 million between 1988 and 1992.[5] The gains in Medicaid coverage over this time period largely offset the losses that occurred in private health insurance coverage. The net result was that the number and proportion of children without insurance remained essentially unchanged between 1988 and 1992.

These results illustrate the central role that Medicaid plays in providing a safety net for children. In the face of large-scale losses of employer coverage and an economic contraction, the elastic nature of the Medicaid program has helped to provide millions of children with continued access to health care. Had spending for the Medicaid program been capped at the level proposed in the congressional budget resolution and the Medi-Grant proposal, we estimate that the uninsured population of children would have grown by as many as 3 million between 1988 and 1992. This would represent an increase of nearly 40% in the size of the uninsured child population in just 5 years.

More recent data suggest that the downward trend in employer-based coverage for children has not leveled off. In fact, the most recent data available from the Bureau of the Census show that an acceleration has occurred in the rate of decline in employment-based insurance coverage for children. Between 1992 and 1993, 900 000 children lost employment-based health insurance, compared with an average of about 600 000 a year for the previous 5 years.[5,6]

In addition to providing a safety net for families losing private insurance, Medicaid also plays an important role in preventing financial catastrophes in families where an uninsured or underinsured child experiences a severe and costly illness. This protection is provided in the 36 states that operate medically needy programs. These optional programs allow a moderate-income family who has incurred substantial uninsured medical expenses for a child to enroll the child in Medicaid. Coverage is available as long as the family continues to incur expenditures exceeding a certain proportion of family income.

Medicaid As a Financial Link to Health Care for P r Ch dren.—The second important contribution of Medicaid is its role in financing needed preventive and treatment services for children from poor families. Most children, including those from low-income families, experience few lasting or severe illnesses.[7,8] Because of their good health, these children typically require only routine preventive services and care for occasional acute illnesses.

Not all children are healthy, however, and the burden of illness falls disproportionately on children from low-income families.[9-17] Clinical studies and household surveys reveal that children from low-income families experience far greater numbers of health problems than children from higher-income families. Specifically, children from low-income families are significantly more likely to have vision and hearing problems,[18-20] oral health problems (including periodontal disease, decayed and missing teeth, and malocclusion),[21] speech defects,[22] sickle cell disease,[22] anemia,[22] skin lesions,[23] elevated blood lead levels,[24] and behavioral problems such as hyperactivity.[25]

Moreover, when afflicted with an illness, children from poor families are more likely to suffer unfavorable consequences. For example, when compared with children in higher-income families, poor children who suffer from appendicitis are twice as likely to experience complications.[26] Similarly, poor children with asthma are more likely to be hospitalized than nonpoor children[27] and poor children who contract meningitis are more likely to suffer neurological consequences compared with nonpoor children.[26]

Health problems also have a disproportionate impact on poor children's ability to participate in normal childhood activities. For example, children from low-income families are almost twice as likely as those from higher-income families to be limited in school or play activities by chronic health problems.[28] In addition, children from low-income families spend significantly more days restricted to bed due to acute illnesses.[29]

The added burden of illness experienced by children from poor families results in an elevated need for preventive and curative health services. Medicaid's value in facilitating access to such services has been demonstrated in numerous studies.[30-35] For example, in the area of preventive care, studies have demonstrated that poor children as a group tend to be low users of routine preventive services, such as physical check-ups.[30] But poor children with Medicaid coverage have been shown to use preventive care at significantly higher rates than poor children without Medicaid coverage. In fact, according to one study, over 80% of Medicaid-enrolled school-aged children received their most recent check-up at the professionally recommended interval. Their use of preventive services was comparable to that of nonpoor children.[30]

Medicaid is also effective in meeting the medical care needs of poor children when they are ill. The effectiveness of Medicaid in improving access in cases of illness has been demonstrated for both acute and chronic conditions. For example, among children from poor families, those with Medicaid are more likely than those without Medicaid to receive physician care for acute conditions where medical attention is normally indicated, such as pharyngitis, acute earache, and recurrent ear infections (tabulations by the authors of unpublished data from the 1987 National Medical Expenditure Survey).

Similarly, Medicaid coverage is helpful in improving access

to care for low-income children with chronic conditions. Among children with disabilities caused by chronic conditions, poor children without Medicaid coverage have only half as many ambulatory care visits as nonpoor children with similar health problems. In contrast, disabled poor children with Medicaid coverage use physician services at rates that are almost comparable to those of disabled nonpoor children (tabulations by the authors of unpublished data from the 1992 National Health Interview Survey).

In each of these examples, Medicaid is shown to play a powerful role in improving access to needed services for poor children. Medicaid helps to bring poor children's use of services up to near the level of nonpoor children and finances needed care for children who might otherwise go without medical services. Furthermore, it achieves these objectives at comparatively low cost. Indeed, while children and their families constituted 73% of all Medicaid beneficiaries in 1993, they accounted for only 27% of the expenditures.[1] In addition, Medicaid administrative costs average about 3% compared with 15% to 20% in private insurance plans (oral communication, Richard Jensen, US Government Accounting Office, Washington, DC, June 1, 1995). Further, a recent study by the Physician Payment Review Commission showed that Medicaid fee-for-service payments to physicians average about 47% of private insurance payments.[36] Data from the Prospective Payment Assessment Commission indicate that Medicaid payments to hospitals average only 72% of private payer levels.[37]

The Effects of Capping Federal Medicaid Contributions

Capping federal Medicaid contributions, as proposed in the congressional budget resolution, the MediGrant proposal, and the Clinton administration's budget proposal, would have several noteworthy effects on the program's ability to provide needed care for children. The effects in two areas are particularly important.

Effects on the Safety Net During Economic Downturns.—While a cap on federal spending would reduce the effectiveness of Medicaid as a safety net for individual children and their families even during prosperous or stable economic times, the effect of a cap would be especially pronounced during economic downturns. During recessions, unemployment rates rise and additional families turn to Medicaid for assistance. At the same time, reduced economic activity usually leads to reduced income and sales tax receipts at the state level, making it difficult for states to maintain spending levels for their Medicaid programs, much less increase them to meet growing needs. If federal spending is capped as proposed in the congressional budget resolution and the MediGrant proposal, states, at minimum, will be unable to finance expansions or, more likely, will have to reduce the scope of their existing Medicaid programs. In contrast, by placing a cap on expenditures per beneficiary rather than total payments, the Clinton administration proposal would permit states to cover additional families with federal matching dollars during regional or national recessions.

Effects on the Working Poor.—Capping federal Medicaid contributions could produce economic disincentives for poor families to make the transition from welfare to work. Health insurance typically is not offered by employers in low-wage industries. For parents who work in these industries, Medicaid can provide health insurance coverage for children who otherwise would go without. Indeed, the passage of the Family Support Act of 1988, which permitted certain families to retain Medicaid coverage after leaving Aid to Families With Dependent Children (AFDC) for work, was based in part on the widespread recognition that the loss of Medicaid on gaining a job is a major stumbling block for families trying to make the transition from welfare to work.[38] Medicaid has played an increasingly important role in providing health care to children in low-income working families. Between 1988 and 1992, the proportion of children with at least one working parent who were enrolled in Medicaid rose by 76%. By 1992, one half of children enrolled in Medicaid lived in low- and moderate-income households in which at least one parent worked.[5] These are families whose incomes are too limited to purchase private health insurance on their own. If capping federal Medicaid contributions results in reductions in Medicaid coverage for these families, the incentive to make the transition from welfare to employment would be diminished.

Limits on Savings From Implementing Managed Care

Although it is impossible to predict with certainty how states would react to a reduction in federal financial assistance for Medicaid, it seems likely that they would continue the rapid enrollment of beneficiaries in managed care as a major means of achieving savings. However, a recent comprehensive review of the literature on cost savings from Medicaid managed care found that evidence was almost equally divided between studies that show program savings and those that show costs similar to or above traditional fee for service.[39] The literature suggests that when savings are achieved, they typically range from 5% to 15% relative to fee for service.[39,40] Larger Medicaid managed care savings, if they are generated, are likely to come from rationing medical services. Rationing can occur either explicitly through restrictions on the scope and duration of covered services, or implicitly through lengthier waiting times or similar means.

Fiscal Implications of Capping Federal Medicaid Contributions

With respect to the overall budget deficit, the potential savings from cutting back on the children's portion of Medicaid are limited. In total, Medicaid accounts for less than 6% of total federal outlays. The children's portion of Medicaid represents slightly more than 1% of the federal budget. Consequently, even large cuts in the children's portion of Medicaid will yield only small reductions in the federal budget deficit.

It should also be recognized that children have accounted for a relatively small part of overall Medicaid spending growth in recent years. From 1988 to 1993, overall Medicaid spending for all enrollment groups grew from $54 billion to $125 billion. Children accounted for only 20% of that growth, even though they comprised about half of total program enrollment during the 5-year period.[41,42]

Conclusion and Recommendations

Medicaid has enabled millions of low-income children to receive needed medical services at a relatively modest cost to society. Medicaid utilization rates for children are reasonable and reflect the health needs of low-income children. Provider payments are already low and the prospects for additional savings through managed care are limited. Consequently, policymakers should carefully consider the effects

of making the large reductions proposed for future Medicaid spending. We believe the data presented in this review make a strong case for maintaining current Medicaid spending levels and coverage requirements for children.

However, it appears increasingly likely that substantial spending reductions will occur. If reductions are made, we believe that policymakers have an obligation to ensure that such reductions are implemented as fairly as possible, with no single group of eligibles bearing a disproportionate share of the burden. A block grant combined with a cap on federal contributions would not ensure such a result. Block grants would likely become a battleground at the state level as lobbyists and advocates for various groups of beneficiaries, programs, and providers scramble to maintain their share of a shrinking budgetary pie. As indicated earlier, children have fared poorly in such circumstances in the past.

To prevent such an outcome policymakers should ensure that spending reductions are applied fairly across categories of Medicaid recipients. That is, reductions should be applied in a manner that protects existing shares of Medicaid expenditures for aged, disabled, and child beneficiary populations at the state level. In this manner, no group of Medicaid recipients would be singled out to bear a disproportionate share of future spending cuts. The spending allocations for recipient categories could be adjusted periodically to account for changes in the size and composition of the medically indigent population.

In addition, two provisions of current federal Medicaid law are needed to ensure that children are treated equitably across the states. These provisions provide a framework for assuring that children from impoverished families continue to receive the basic health services needed for healthy growth and development.

- At minimum, children living below the poverty level should retain eligibility for Medicaid. Currently, some states use federal Medicaid eligibility options to cover children in families with incomes as high as 300% of the federal poverty level. However, all states are required to extend eligibility to children living below the official federal poverty level on a phased-in basis by the year 2002. We believe this latter provision should continue to apply to state Medicaid programs.
- Eligible children should be guaranteed a scope of benefits that is appropriate for children. A minimum package of benefits should continue to be available for all children eligible for Medicaid. The benefit package for children should emphasize prevention, as it does now, in order to decrease the likelihood of costly problems later in life. It should be appropriate to meet the health needs of children and adolescents, including their developmental as well as mental and physical health needs. Covered services should be available as long as they are medically necessary.

Paul W. Newacheck, DrPH
Dana C. Hughes, DrPH
Abigail English, JD
Harriette B. Fox, MSS
James Perrin, MD
Neal Halfon, MD, MPH

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Editorials

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Uninsured Children

An Unintended Consequence of Health Care System Reform Efforts

How well does our current health care system care for children? The article by Kogan et al[1] in this issue of THE JOURNAL provides information needed to answer this critical question. The article increases our understanding of three key issues related to health care system reform for children: first, the health impact of gaps in insurance coverage for young children; second, the extent of the problem with respect to the number of children affected and the duration of their gap in coverage; and third, the sociodemographic characteristics of children and families most likely to experience gaps in coverage.

Understanding the Health Impact of Gaps in Insurance Coverage

Having a gap in coverage affects access to and quality of needed medical care through two pathways: first, it requires financially strapped families to pay out-of-pocket for services; and second, it makes maintaining a continuous relationship with a primary care physician much more difficult. Many financially strapped families whose children are not covered by insurance delay or forgo needed pediatric medical services because of the out-of-pocket expense. As noted by Kogan et al,[1] children without insurance coverage are less likely to receive basic preventive care and immunizations, are less likely to seek care from a physician for both acute and chronic illness, and are more likely to delay care and require hospitalization when seen in an emergency department.

See also pp 1429 and 1468.

Gaps in coverage also affect the likelihood of a child having a continuous regular source of primary care during periods of time with insurance coverage as well as periods of time without coverage. Gaps in insurance coverage create a more chaotic environment in which families are more hesitant to seek out and maintain a regular source of primary care; concurrently, physicians are more reluctant to accept primary care responsibility for children and families who lose their insurance or frequently change health plans. Failure to maintain a regular source of primary care may influence the health status of children and access to medical services independently from gaps in insurance coverage. As noted by Kogan et al,[1] children without a regular source of care are less likely to be completely immunized, have lower rates of visits for well-child care and higher rates of visits for illness care, and have more frequent emergency department visits.

Kogan et al analyzed how a gap in coverage influences the availability of a regular source of primary care during the first 3 years of life. A regular source of care was defined as either one site of care or two sites with the second site being an emergency department. Children with an insurance coverage gap of less than 6 months were 47% less likely and children with a gap greater than 6 months were 74% less likely to have a continuous regular source of care. The likelihood of not having a regular source of care was also increased if the family moved, the child had a chronic illness, or the child was enrolled in a publicly funded program.

These data are consistent with Colorado Medicaid data showing that children are less likely to be assigned to a primary care provider if they are enrolled discontinuously in the program during the year.[2] Among children enrolled in the Colorado Medicaid program with at least one visit a year for otitis media, either discontinuous enrollment and/or lack of assignment to a primary care provider increased use of the emergency department as the single source of care for their episodes of otitis media and decreased otitis-related surgeries.[2,3] Further analysis will determine the extent to which these factors are independent and whether they constitute a double whammy adversely affecting accessibility to both primary and specialty care.

Understanding the Extent of the Problem

Kogan et al[1] have documented what many physicians caring for children have come to appreciate—gaps in health insurance coverage are common, affecting about one quarter of children during the first 3 years of life.[1] Furthermore, over half of these children lack coverage for longer than 6 months.[1] Why do so many children have gaps in their insurance coverage? Our employer-based private insurance system is not working well for children. From 1991 to 1993 over 3 million children lost their private insurance coverage.[4,5] The yearly rate at which children lost their coverage increased from 600 000 during 1991 to 1992 to 2.5 million during 1992 to 1993.[5] Children have lost coverage because of structural changes in the American economy resulting in a shift away from high-paying manufacturing jobs with good health benefits to lower-paying service jobs with poorer benefits. In addition, increasing numbers of employers have responded to the price escalation in health insurance by either dropping coverage for dependents in their policies or increasing the amount of the premium contributed by the employee.

When children lose their private insurance coverage there are usually two options for regaining coverage: Medicaid or a change in a parent's employment to a firm that offers a family health insurance plan. If the family qualifies for Medicaid, delays in coverage often occur because completion of the enrollment process and notification of acceptance can be a time-consuming process. Unfortunately, enrollment in Medicaid does not insure continuous insurance coverage. Participation in Medicaid is usually reassessed regularly to determine changes in family income. When parents have a change in employment and income, they may no longer qualify for Medicaid but still have no alternate insurance coverage for their children. In Colorado, 45.1% of children participating in

From the Department of Pediatrics and the Health Policy Program, University of Colorado Health Sciences Center, Denver.

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Medicaid were discontinuously enrolled during a 1-year period.[4] Children not eligible for Medicaid often cannot obtain private insurance coverage unless a parent has a job with good health benefits. However, even if insurance is offered by the employer, there is usually a waiting period before the parent is eligible to receive the benefit.

The failure of the employer-based private insurance system to cover children has resulted in a major shifting of children to the public sector. From 1988 to 1992, the number of uninsured children remained relatively constant because expansions in the Medicaid program provided insurance coverage to many of the children who lost coverage. However, more recently the number of uninsured children not shifted to Medicaid has been increasing.[5] In 1995 about one quarter of America's children, or 18 million children, are estimated to be enrolled in Medicaid.[6,7]

Understanding the Characteristics of Children Most Likely Affected

Kogan et al[1] found that children living in lower-income families were more likely to have an insurance gap and for the gap to be 7 months or longer. The families at greatest risk were the working poor with incomes of $10 000 to $20 000 per year. Hispanics were more likely than whites or African Americans to have an insurance gap at all income levels. Whites were more likely than African Americans to have an insurance gap at income levels below $30 000 but not at higher income levels. Mothers who are single parents, especially those who were younger and less educated, were more likely to report a gap in their children's coverage. Children enrolled in Medicaid and other publicly funded programs were over three times more likely to have gaps in coverage. Other studies document that children living in these working poor families have more acute and chronic health problems than children of higher-income families.[8-13] Thus, children who would benefit the most from having continuous insurance coverage and a regular source of primary care are the least likely to have them.

The Congress is considering allocating to every state a fixed amount of federal funds in the form of a block grant for Medicaid. While the precise formula that will determine how much money each state would receive has yet to be decided, it is clear that fewer federal dollars would be available compared with present methods of funding. The Commentary by Newacheck et al[14] in this issue of THE JOURNAL describes how cuts in the Medicaid program are likely to affect children. It is also possible that a block grant bill would not have provisions to enable states to respond to events such as (1) growth in state population, (2) downturns in the economy, (3) continuing trends by employers to reduce employee-dependent health care coverage, and (4) increasing numbers of elderly who will use long-term care. Passage of Medicaid block grants that reduce the capacity of the public sector to absorb the increasing number of children losing private insurance could swell the number of uninsured children. Reducing the level of services provided by Medicaid could increase the numbers of underinsured children and increase out-of-pocket expenses of financially strapped families. Potential savings in the pediatric component of the Medicaid program could be offset by the additional expense of providing services to a larger number of uninsured children without a regular source of primary care who will have higher health care expenditures per child. Having a regular source of care has been shown to reduce per child expenditures by 21.7% compared with not having a regular source of care.[15]

Pediatric health care system reform should be viewed as an investment in children rather than a means of deficit reduction. The achievable goal of health system reform is to provide all children with health insurance. Our public policy should provide tax incentives and subsidies that increase the number of children covered by private, employer-based insurance. Then the need to rely on Medicaid as a safety net would decrease. If tax incentives and subsidies fail to achieve this goal, health care system reform should include employer mandates and/or taxes to achieve universal coverage for children.

Stephen Berman, MD

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Physician Specialty, Systems of Health Care, and Patient Outcomes

Sixty-five years ago nearly 90% of the physicians in the United States were generalists.[1] Since then there has been a trend toward increasing specialization, particularly during the past two decades, with the result that two thirds of the practicing physicians in this country are now specialists. Coincidentally, medical expenditures grew uncontrollably, fueled by explosive growth in specialized and expensive technologies. Lately, various forms of managed care have emerged as a means to control costs, leading to controversy about the relative quality of care available from different systems.

Many managed care organizations restrict access to specialists because they tend to perform more tests and proce-

From the Department of Veterans Affairs Medical Center, Seattle, Wash.
Corresponding author: Stephan D. Fihn, MD, MPH, Department of Veterans Affairs Medical Center, 1660 S Columbian Way, Seattle, WA 98018

dures than generalist physicians.[2,3] This declining use of speciality services has created a surfeit of specialists that many authorities believe will persist until well into the next century.[4] Although anticipated for decades, this reduction in demand for specialty services in many communities has occurred suddenly and engendered further debate about the relative roles and merits of specialists vs generalists.

See also p 1436.

Unfortunately, arguments on all sides have usually relied more on emotion than fact because of the paucity of up-to-date studies comparing the costs and outcomes of care provided to similar groups of individuals in different systems of care or by different types of physicians. In this issue of THE JOURNAL, Greenfield and colleagues[5] present the results of a complex study addressing these topics. They collected a wide range of clinically important information, including mortality, disease-specific physiological markers, and well-accepted measures of overall physical and emotional health on cohorts of patients with hypertension or diabetes. Their results are remarkable for the similarities in outcomes observed among the disparate systems of care and types of physicians after extensive adjustments for differing characteristics of patients.

Coupled with earlier findings that individuals in highly managed plans, such as health maintenance organizations and preferred provider organizations, tend to be somewhat less satisfied than those in fee-for-service arrangements, these findings reflect an apparent trade-off between cost and satisfaction with negligible effects on clinical outcomes.[6] This interpretation is tempered by several limitations, many of which are candidly enumerated by the investigators themselves. First and foremost, this was an observational study; patients were not randomly assigned to physicians or systems of care. Despite the investigators' use of sophisticated techniques to adjust for potential confounding variables, there remains concern that unrecognized differences in patient characteristics could have biased the study's results.

Second, only two conditions, diabetes and hypertension, were examined. At least in some instances, specialists have better knowledge of the treatment of conditions within their specialty compared with generalist physicians, and specialists may provide care for such conditions that is at least as efficient.[7-9] This is probably most true for especially difficult cases or unusual diseases. On the other hand, generalists may provide care that is more cost-effective for patients with undifferentiated symptoms, simple common problems, and/or multiple conditions, while specialists may not perform as well with problems outside their expertise.[10]

Third, the length of follow-up was relatively short given the outcomes studied. Careful management of diabetes and hypertension prevents or postpones end-organ damage that often occurs only after many years.

Fourth, the number of patients studied was small, particularly in light of the very large populations from which they were drawn. Greenfield et al helpfully provide data (much of it available via the Internet) that argue against important selection bias, but the possibility persists that patients who refused to participate or withdrew differed according to system of care or type of physician.

Finally, systems of care are heterogeneous, and results obtained from three cities may not generalize to the rest of the country.

Despite these limitations, this study does suggest that a diabetic or hypertensive patient is apt to fare equally well under the care of a competent generalist or specialist or in a managed care or fee-for-service setting. Other investigators also have found this to be true for other conditions.[11] The current study does not address the more pertinent question of how services provided by generalists and specialists should be integrated within health systems. More studies comparing the quality of care for a broader range of medical problems are needed to provide a more complete picture of the advantages and disadvantages of various practice settings.

From a broader perspective, the current study is a good example of one kind of observational study that has emerged from the developing field of outcomes research. This field has developed during the past decade in an effort to assess the effects of medical interventions in a more comprehensive manner than typical clinical studies. The outcomes studied usually include not only traditional clinical measures, such as laboratory values and mortality, but also state-of-the-art measures of self-reported physical and emotional function and costs of care. Although many outcomes studies focus on a specific treatment that can be studied with standard experimental approaches, such as randomized trials, evaluations of complex interventions, like systems of care, are not often readily evaluated using these methods. Although there are outstanding examples of randomized trials of different health systems, they are uncommon because of their expense and the logistic and ethical problems involved in randomly assigning large groups of individuals to physicians or insurance plans.[12] Moreover, the rapidly changing nature of health care usually outpaces the time that planning and implementing large clinical trials entail.

Thus, despite their shortcomings, careful observational studies of different approaches to the provision of medical care should continue to be performed. Experimental investigations of more discrete interventions should also be conducted. Without both types of studies, many of the remarkable permutations transforming our health care system will go unevaluated, making it impossible to understand the consequences of these changes for our patients.

Stephan D. Fihn, MD, MPH

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Medicaid Plan Divides House, Senate GOP; Governors Also at Odds

"There will be a hang-up over the formula" for distributing Medicaid funds, said Rep. John A. Boehner.

By Judith Havemann and Eric Pianin
Washington Post Staff Writers

With only days to go before the scheduled liftoff of the GOP Medicaid overhaul, House and Senate Republicans are worlds apart on how to reduce spending on the program and Republican governors are arguing over how to divide up money among the states.

Medicaid, the health insurance program for the poor, elderly and disabled, is speedily becoming a more contentious issue for Republicans than welfare reform or Medicare, according to congressional Republicans.

"It's surprising it's not higher on the radar screen right now," said House Republican Conference Chairman John A. Boehner (Ohio). "It's a matter of continuing discussion with the governors. . . . There will be a hang-up over the formula."

After nine months of negotiations, Republican governors will make a last push to agree on a division of the federal share of the $155 billion annual program at a meeting this morning in the Rayburn House Office Building. Sources expect 15 of the 30 Republican governors to attend, and there will be pressure to reach consensus before a news conference scheduled for midafternoon.

Medicaid, which pays the medical bills of one out of every 10 Americans, is the largest single source of federal money for states.

"The formula is an intense issue for governors because it is such a huge portion of state budgets," said Kevin Keane, spokesman for Gov. Tommy G. Thompson (R), chairman of the National Governors' Association. He said it was uncertain whether the governors will be able to agree on a formula today, but they are going to "give it another try."

Meanwhile, the House and Senate are veering in different directions on how to restructure Medicaid to yield the $182 billion in savings over seven years called for in the budget resolutions passed by the Congress last summer.

House Republicans are pushing for legislation to turn over the program to states in a lump sum payment or block grant with few strings attached.

But Sen. John H. Chafee (R-R.I.), chairman of the Senate Finance Medicaid subcommittee, called the block grant approach "fraught with problems."

"I want to see Medicaid kept as an entitlement," under which eligible recipients would be guaranteed coverage, Chafee said yesterday. He said Senate Finance Committee members "haven't spent time on" the question of whether Medicaid should be turned over to the states in a block grant. "In committee we just haven't dealt with either" a block grant or an entitlement, he said.

At the same time, congressional leaders are pressing for early decisions on the program. Senate Finance Committee markup of the bill is planned to begin next Tuesday.

As Republican divisions emerged, the White House charged that the GOP budget plan would cut off 4.4 million children and 350,000 nursing home residents from Medicaid coverage in 2002.

The Republican-led Congress committed itself last summer to a budget plan that envisions reducing the growth of Medicaid from the current 10 percent a year to about 4 percent or less in the year 2002.

Democrats say that because the number of low-income people who would be eligible for the program is expected to grow, the number of beneficiaries would have to be reduced to reach the required savings.

"The Republicans say their Medicaid proposal is not a cut," a White House briefing document said. "However, a 1.4 percent cap on growth per beneficiary is a cut in real terms." The briefing paper said Republicans are attempting to reduce Medicaid growth far below the projected growth in private health spending per person, 7.1 percent.

Medicaid provides health insurance to 16 million low-income children and their mothers, but they account for only 27 percent of the cost. Medicaid pays for more than half of all U.S. nursing home care, pays the Medicare premiums of about 5 million recipients who cannot afford drugs or doctor payments and cares for an increasing number of disabled Americans.

Medicaid funds are distributed to the states under a complicated formula with major loopholes that some states have successfully exploited. New Hampshire receives $9,700 annually for each beneficiary while Mississippi gets only $2,381.

High-growth states such as Florida have demanded formula changes to give them extra money to handle their rising populations.

However, because Congress has committed itself to balance the budget, the Medicaid account is a "zero-sum game" in which one state's windfall is another's loss. Republican state sources said congressional Republicans are considering guaranteeing that all states receive at least as much money as they will receive this year, with growing states with high poverty populations being allowed to spend a higher percentage each year than states with stagnant populations.

Democratic governors, who have had little influence in the budget negotiations, have complained that the cuts are too large for a state to absorb.

Colorado Gov. Roy Romer (D) wrote to his colleagues last week that "as governors, I think we must make clear to those of both parties in Washington that the proposed cuts in Medicaid and the burden they will place on states, are simply too great. We must also make clear that if members of Congress want our participation in modifying the Medicaid program, they must maintain the federal-state partnership in Medicaid and they must make the size of the cuts more reasonable."

Republican Plans to Curb Medicaid Spending May Hit Purse Strings of Middle-Class Families

By CHRISTOPHER GEORGES
Staff Reporter of THE WALL STREET JOURNAL

KENSINGTON, Md. – Beverly Scafide, 69, owns a home and car in very middle-class Wheaton. Her mother, Catherine Gilhooley, 88, a telephone operator for 50 years and now living in a nursing home here, also earned a modest but solidly middle-class living.

Though never poor, and almost always healthy, the family over the past few years has used up more than $250,000 in Medicaid benefits. Not Medicare, the government health program for the elderly, but Medicaid, the program for the poor and disabled.

That's because Medicaid, despite its image as the health safety net for the impoverished, also is the nation's main provider of long-term care for the elderly. "There's no way I could care for my mother by myself," says Ms. Scafide, a widow of 15 years. "I just don't have it physically or financially," she adds, referring to both her bad back and the $40,000-a-year average price tag on nursing-home care.

And that's why Republican plans to scale back planned increases in Medicaid spending to help balance the budget will touch many middle-income families nationwide. It is true that a proposed reduction of $270 billion over seven years in planned spending for Medicare, which pays for hospital and doctor bills, will affect the largest number of elderly. But Medicaid also faces a decrease in planned spending by $182 billion over the same period.

Some Republicans are optimistic they can, as proposed, reduce Medicaid spending by about 20% below projected levels without cutting benefits. White House officials oppose the GOP plan, saying it would cause large numbers of recipients to lose coverage. And there is a growing sense among health-care experts and government officials that a squeeze on millions of elderly and their families would be inevitable.

Decisions May Fall to States

"Medicaid dollars will have to go to those really in need," says Kim Belshe, California's health director in Republican Gov. Pete Wilson's administration. While Congress will set the overall funding targets, decisions on exactly how, and on whom, the money will be spent are likely to fall to state officials like Ms. Belshe.

Basic numbers dictate that they are certain to be looking in the direction of the elderly. Although 23 million nonelderly adults and children make up the majority of the 31 million Medicaid beneficiaries, they absorb just 27% of the money. Meanwhile, about 59%, or about $75 billion annually, of the total is spent on the elderly and disabled. Put aside the disabled, and the amount Medicaid spends on its elderly beneficiaries – about $34 billion annually – is nearly $10 billion more than is spent on welfare's Aid to Families with Dependent Children.

Where does the money go? Mostly for nursing-home care.

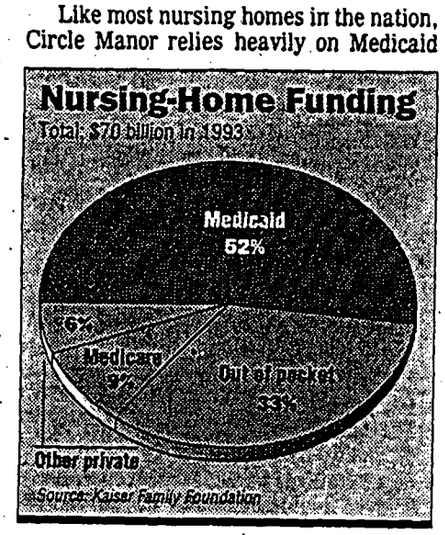
For these patients, Medicaid kicks in once their assets have been virtually depleted. With nursing-home care costing about $100 a day, that often occurs within a few months. As a result, nearly 70% of all nursing-home residents rely on Medicaid.

One who benefits is 101-year-old Sicily Ashwell, now in her seventh year at Circle Manor Nursing Home in Kensington. She sold her house years ago to help pay in part for nursing-home care for her husband, who has since died. Her 72-year-old daughter and 84-year-old son-in-law, a retired member of the Washington, D.C., fire department, make do with Social Security and his pension. They have a home, car and a few thousand dollars saved, but say they can't afford to take their mother in. Her daughter adds that she herself is due for back surgery in a few weeks.

"We had her home for a while, but I couldn't possibly handle her anymore," says Ms. Ashwell's daughter, Claudine Griggs, as she coaxes her mother, seated in her wheelchair in the Circle Manor common room, to finish her afternoon watermelon. Ms. Ashwell can no longer walk and can barely talk.

For seven years, Medicaid has paid Ms. Ashwell's bill at Circle Manor. That's not uncommon. Of the home's 86 residents, 74 are here courtesy of Medicaid. All of the Medicare recipients have depleted, or given away, virtually all their assets to qualify for the aid. But Circle Manor, a private facility, is no Medicaid mill. Instead, tucked away in a woody suburban village known for its "Antique Row," the home – a converted Victorian-style summer mansion erected by a turn-of-the century magnate – is widely regarded as a quality facility.

Like most nursing homes in the nation, Circle Manor relies heavily on Medicaid dollars because so few patients anywhere can afford the high cost of care. By 2030, 4.3 million Americans will need nursing-home care, experts say, which is more than twice the number in nursing homes today.



Republicans contend that reduced federal red tape and other efficiencies can help cut costs without cutting benefits. GOP leaders will propose overhauling Medicaid by relying on block grants – lump sums of federal dollars that would be turned over to states. The states, in turn, would decide how to divide up the funds. Some state Medicaid administrators, such as Wisconsin's director of health-care financing, Kevin Piper, say they would be able to survive without cutting services. "I don't foresee a problem. All we need is the authority," says Mr. Piper, whose governor, Republican Tommy Thompson, is a key ally of congressional Republicans seeking to roll back federal spending.

For example, Mr. Piper explains, states could save large sums through more efficient management, such as stricter reviews of where Medicaid dollars go. They also could save by moving more nursing-home residents into managed care, or if freed from the burden of complying with and enforcing an array of federal regulations.

Reduction in Services

But most Medicaid experts dispute the notion that spending can be reduced by proposed sums without shrinking the government's role as the nation's top provider of long-term care. "There is no doubt that states will have to reduce services for the elderly," says Diane Rowland, a health-care expert at the nonpartisan Kaiser Family Foundation. Recent analyses by the Urban Institute and the Center on Budget and Policy Priorities predicted that as many as 900,000 elderly would be denied coverage in the year 2002 if proposed Medicaid spending changes become law.

That's because most of the relatively painless remedies promoted by budget cutters won't save nearly enough to reach GOP budget targets, analysts say. For example, analysts say predictions of large Medicaid savings from greater use of managed care for nursing-home residents may be overly optimistic. "If nursing-home care isn't managed already, I don't know what is," says Ms. Rowland.

Attempting to squeeze more money out of the elderly and their families may also prove fruitless, experts say. Currently, the spouse of a nursing-home resident can keep between $14,000 and $75,000 (depending on the state) in assets. Various measures proposed to tighten asset requirements would bring in only about $1 billion to $2 billion a year, according to most estimates.

In the end, Medicaid changes may mean the burden of caring for the oldest will fall more on families, says John Holahan, a health-care expert at the Urban Institute. "This is going to affect the middle class more than people realize."

Review

Managed Care Plan Performance Since 1980

A Literature Analysis

Robert H. Miller, PhD, Harold S. Luft, PhD

Objective.—To compare the health care utilization, expenditure, quality of care, and satisfaction since 1980 of enrollees in managed care and indemnity plans.

Data Sources and Study Selection.—Studies selected met the following criteria: data from 1980 forward, private insurance or Medicare enrollees, a comparison group, a reasonable attempt at statistical adjustment for noncomparable managed care and indemnity plan enrollees, and peer-reviewed findings (with two exceptions). Few studies on preferred provider organization plan performance met the selection criteria.

Data Synthesis.—Compared with indemnity plans, health maintenance organization plans had somewhat lower hospital admission rates, 1% to 20% shorter hospital length of stay, the same or more physician office visits per enrollee, less use of expensive procedures and tests, greater use of preventive services, mixed results on outcomes, and somewhat lower enrollee satisfaction with services but higher satisfaction with costs. The evidence does not support the hypothesis that prepaid group practice or staff model health maintenance organizations are more effective than individual practice association or network model health maintenance organizations.

Conclusions.—Although this literature analysis found several clear patterns of results, several factors, including unmeasured selection bias, diverse and rapidly changing health plans and local market conditions, and relatively few research results, suggest that generalizations must be made with caution.

(*JAMA*. 1994;271:1512-1519)

MANAGED CARE plays an essential role in many health system reform proposals currently under consideration. The debate over which reforms to implement requires evidence on whether managed care plans can contain health care utilization and expenditures, while maintaining or improving quality of care. In the past, two studies on health maintenance organization (HMO) plan performance have been cited most often. Luft's[1] literature analysis evaluated studies using data through the latter half of the 1970s. The RAND Health Insurance Experiment (RHIE) compared the performance of a staff HMO plan, Group Health Cooperative in Seattle, Wash, with indemnity plans using 1976 to 1981 data.[2]

Since the Luft synthesis, no comprehensive literature analysis has evaluated studies that used data from 1980 forward, even though the health care marketplace has changed substantially due to many factors, including the rapid growth of individual practice associations (IPAs), network and mixed-model HMOs, preferred provider organizations (PPOs), and point-of-service (POS) plans; the creation and transformation of many new provider networks and organizations; increased market competition among health plans and among providers; reductions in indemnity plan coverage; changes in Medicare payment methods; and generally, a shift from the inpatient hospital to outpatient ambulatory care settings. Given conflicting claims made about managed care plan performance in the health system reform debate, it is essential to analyze studies on managed care plan performance that use more recent data from more types of health plans.

From the Institute for Health & Aging (Dr Miller) and the Institute for Health Policy Studies (Dr Luft), University of California–San Francisco.

Reprint requests to University of California–San Francisco, Institute for Health & Aging, Box 0646, Laurel Heights, San Francisco, CA 94143 (Dr Miller).

BACKGROUND

Because there is no universally accepted managed care terminology, we briefly define several terms that we use. Physician practice is what is "managed" in managed care. The selection of network physicians is the starting point for such management and is the single most important feature that distinguishes a managed care from an indemnity (fee-for-service [FFS]) plan with utilization management. Plans differ greatly in physician practice management features, such as provider selection, retention, and information feedback techniques, utilization management (UM) procedures, provider reimbursement and risk-sharing methods, and physician organization. The term *managed care plan* refers to all types of plans that base themselves on networks of providers, including HMO, PPO, and POS plans. Because there were no performance results for POS plans and very few for PPO plans, in many cases we refer only to HMO plans, rather than to "managed care" to avoid overgeneralization. The term *indemnity insurance* includes Medicare FFS.

A health benefit intermediary contracts with employer or government sponsors to offer its health plans to potential enrollees. A health benefit intermediary can be an HMO, insurance carrier, or an independent provider organization that contracts directly with employers. The extent of integration of the intermediary with delivery system providers varies greatly. Five types of HMO plans are distinguished by the organization that provides services and the exclusivity of the relationship between the intermediary and large medical groups. In the prepaid group practice (PGP) HMO, the health benefit intermediary (eg, Kaiser Foundation Health Plan Inc) has an exclusive relationship with one or more large medical groups (eg, the Permanente Medical Group), whereas in a network HMO (eg, Pacificare Health Systems) the relationship is nonexclusive. In a staff HMO (eg, Group Health Cooperative), the health benefit intermediary directly employs physicians. In an IPA HMO (eg, US Healthcare Inc), the intermediary either contracts with an IPA (that it may or may not own or control) that in turn

contracts with solo or small-group practitioners, or it contracts directly with the latter physicians. In a mixed-model HMO (eg, Prudential Health Care Plans Inc), the intermediary has various relationships with providers. For example, the intermediary may contract exclusively with medical groups and nonexclusively with solo practice physicians in the same area. For purposes of this literature analysis, a sample of "mixed" HMO enrollees included some enrollees that received services from one type of HMO whereas other enrollees received services from another type of HMO.

METHODS

We compared study results for key dimensions of managed care and indemnity plan performance, including health care utilization and expenditure; level of premiums; use of preventive tests, examinations, and procedures; quality of care; and enrollee satisfaction.

We analyzed studies that met the following criteria: (1) Data with ending dates of 1980 or later. (2) Private insurance or Medicare plan enrollees. We excluded studies of Medicaid managed care plans because the Medicaid population has different characteristics, receives generally less care than the privately insured population,[3-5] and often receives care from managed care plans dissimilar to private insurance plans.[6] (3) A comparison group. We eliminated studies that compared outcomes for people before and after switching from indemnity to managed care plans but made no comparison with an indemnity group for the same time period in the same area. Given major changes in some types of medical care use (eg, hospital days) since 1980, studies relying solely on historical controls would be biased. (4) A reasonable attempt at statistical adjustment for noncomparable managed care and indemnity insurance enrollees. Because all studies but one[7] used quasi-experimental research designs with comparison groups rather than randomly selected control groups, we included studies that examined enrollees with a particular diagnosis or condition only if they used regression methods to adjust for important differences in enrollee characteristics between plans, or if substantive differences in characteristics were minor. We included studies without a specific diagnosis or condition research design only if they used regression adjustment methods to adjust for health status and other enrollee differences between plans. (5) Peer-reviewed findings. However, we included results from reports from the recent Medicare Tax Equity and Fiscal Responsibility Act (TEFRA) Evaluation[8-12] and the Social/Health Maintenance Organization demonstration[13] because they met the remaining study selection criteria.

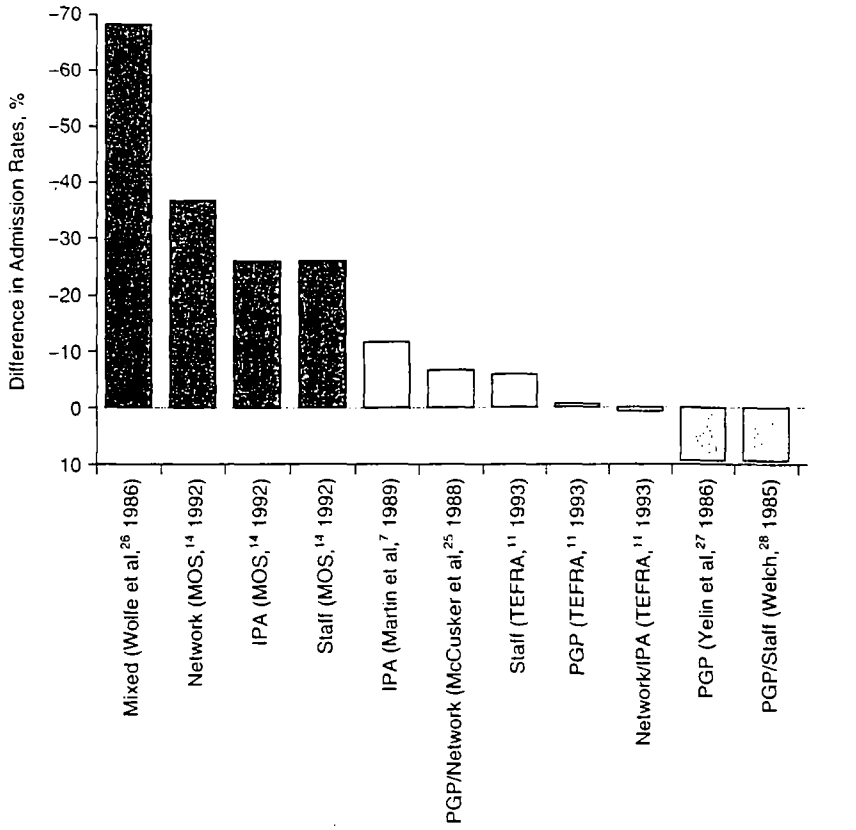


Fig 1.—Percentage difference in hospital admission rates, health maintenance organization (HMO) plans compared with indemnity plans. Black bars indicate statistically significant results; and lightly shaded bars, not statistically significant results. Although HMO plan results showed generally lower hospital admission rates, some differences were small, and a few results showed higher admission rates compared with indemnity plans. MOS indicates Medical Outcomes Study; IPA, individual practice association; PGP, prepaid group practice; and TEFRA, Medicare Tax Equity and Fiscal Responsibility Act Evaluation.

There likely is less publication bias against studies that show no performance differences than is the case in many other research areas. Because of the Luft literature analysis and RHIE evaluation findings of lower HMO health care resource use, researchers tended to test the hypothesis that HMO plans have lower utilization and expenditure relative to indemnity plans. Because of the potential negative impact of decreased resource use on quality of care, researchers have tested the hypothesis that HMO plans produce less favorable quality of care than do indemnity plans. In both cases, a finding of no difference in performance is of interest to health policymakers, and thus publication is likely to be pursued by the researchers.

For each study, we created one observation per dimension of performance for a type of managed care plan compared with indemnity plans. Studies produced more than one observation if they separately compared the performance of two or three types of managed care plans with indemnity plans[11,14-18] or they compared the use of more than one expensive test or procedure.[12,19,20] We included three studies that surveyed physicians about how they would treat hypothetical patients with certain characteristics.[19,21,22] In a few cases, we transformed available results to create performance difference estimates consistent with the presentation of other results. We considered a result statistically significant if its probability value was less than .05. There were no observations on POS plans and few acceptable observations on PPO plans. There were no acceptable observations for any plans on the growth rate of expenditures or premiums. Overall we had 127 observations on 15 dimensions of performance from 54 studies. Thirty-four peer-reviewed studies on the performance of managed care plans with data from 1980 did not meet our inclusion criteria.

We highlighted studies and observations that appeared to provide among the most credible and generalizable results. For example, the Medical Outcomes Study (MOS) examined 1986

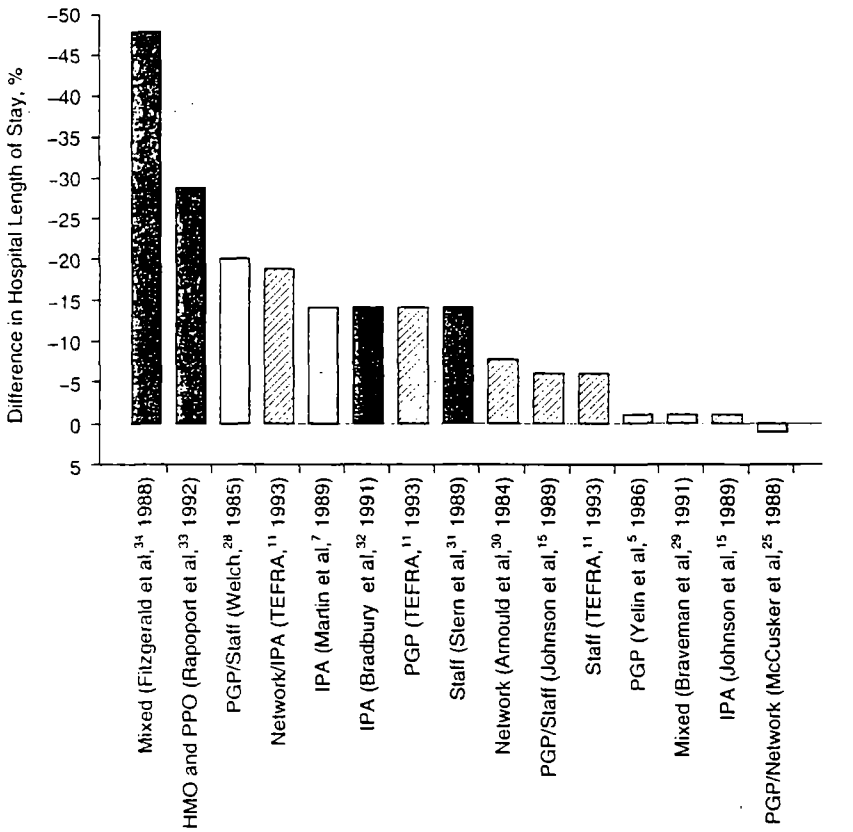


Fig 2.—Percentage difference in hospital length of stay (LOS), health maintenance organization (HMO) plans compared with indemnity plans. Black bars indicate statistically significant results; lightly shaded bars, not statistically significant results; and striped bars, no tests of statistical significance. One study[20] showed significantly shorter hospital LOS but provided no estimate of the percentage difference. The HMO plans had almost uniformly shorter hospital LOS compared with indemnity plans. PPO indicates preferred provider organization; PGP, prepaid group practice; IPA, individual practice association; and TEFRA, Medicare Tax Equity and Fiscal Responsibility Act Evaluation.

health care utilization and outcomes of more than 20 000 HMO and indemnity plan enrollees.[23,24] To simplify the presentation, we compared MOS utilization results for patients in each of three types of HMO plans (staff, network, and IPA) with all indemnity plan patients combined. The Medicare TEFRA Evaluation examined 1989 to 1990 health care utilization and outcomes of more than 12 000 Medicare enrollees,[10] half of whom were in 75 staff, PGP, or network/IPA HMO plans. Although highlighting these and other methodologically strong studies lends greater weight to their results, contributions from other studies that met our criteria remain important.

MANAGED CARE PLAN PERFORMANCE SINCE 1980

Utilization Performance

Hospital Admission Rates.—Compared with indemnity plans, HMO plans generally had lower hospital admission rates, although some differences were relatively small (Fig 1). Of 11 observations from seven studies, HMO plan admission rates were lower for eight[7,11,14,25,26] and higher for three.[11,27,28] The MOS[14] provides the strongest statistically significant evidence for lower HMO plan admission rates: compared with indemnity plan enrollees, 26% to 37% fewer HMO enrollees were hospitalized. Except for one of the methodologically weaker studies,[26] other studies, including the Medicare TEFRA Evaluation, showed small and statistically insignificant differences in admission rates between HMO and indemnity plans.

Overall, admission rate differences were not consistent across types of HMO. In the MOS,[14] staff HMO plans had the same admission rates as IPA plans and higher (but not significantly different) admission rates than network plans. In the Medicare TEFRA Evaluation, PGP and IPA/network plan admission rates were similar, whereas staff HMO plan rates were only slightly lower.

Hospital Length of Stay.—The HMO plans generally had from 1% to 20% shorter hospital lengths of stay (LOS) than indemnity plans. Of 16 observations from 13 studies, HMO plan LOS was shorter in 15 observations[7,11,15,27-34] compared with indemnity plans and 1% longer in the remaining observation (Fig 2).[25] In two methodologically strong studies, HMO plans had statistically significant, 14% shorter LOS.[31,32] Although it provided no estimate of the percentage difference in LOS, another strong study[30] showed that HMO patients had significantly shorter hospital LOS compared with indemnity insurance patients. Two methodologically weaker studies[28,34] produced the only other statistically significant HMO decreases in LOS. In the Medicare TEFRA Evaluation,[11] HMO plans had 6% to 19% shorter LOS (no test of statistical significance was available).

Once again, PGP or staff HMO plans did not perform better than IPA or network HMO plans when we examined either all comparisons or HMO plan performance comparisons within a study. In the Medicare TEFRA Evaluation,[11] when compared with network/IPA plans (rather than indemnity plans), both PGP and staff HMO plans had longer hospital LOS.

Hospital Days per Enrollee.—The HMO plans consistently had lower hospital days per enrollee compared with indemnity plans. Of eight observations from six studies (Fig 3), three observations[7,11,35] showed statistically significant 18% to 29% fewer hospital days per HMO enrollee, whereas five observations showed nonsignificant 2% to 15% fewer days.[11,25,27,28] Given the small number of studies, it was difficult to detect differences among types of HMO plans in hospital days per enrollee. Differences among types of HMO plans were not statistically significant in the Medicare TEFRA Evaluation.

Physician Office Visits per Enrollee.—Among 14 observations from 10 studies, seven showed lower physician service use[7,11,27,28,35-37] (of which three were statistically significant) balanced by seven with higher use[11,14,38,39] (of which five were statistically significant) compared with indemnity plans (Fig 4). However, nine of 10 observations with the most recent data showed either higher rates or little difference in HMO plan office visits per enrollee compared with indemnity plans.[11,14,35,38,39] The one other observation on HMO plans with more recent data showed statistically significant fewer mental health visits in HMOs compared with indemnity plans.[37] A study of PPO plans also showed lower mental health service use.[40]

Although PGP and staff HMO plans have a pattern of relatively lower physician use than other types of HMO plans, this pattern disappeared when we elimi-

nated studies with less recent data.[7,27,28,36] In the MOS, staff and network HMO plans had similar visit rates that were higher than IPA plans. In the TEFRA Medicare Evaluation,[11] staff and PGP plans had substantially higher visit rates than did network/IPA plans.

Our figures do not show results from two PPO studies on physician services per episode of care. One observation showed much higher PPO plan physician service use,[11] whereas another showed slightly higher and lower PPO plan physician service use for two different sets of diagnoses.[42]

We found no consistent evidence that substantially lower HMO enrollee hospital use compared with indemnity plans was accompanied by substantially higher use of physician services.

Use of Services That Are Expensive and/or Have Less Costly Alternatives.—In 18 of 20 comparisons from nine studies, HMO plans used an average of 22% fewer procedures, tests, or treatments that were expensive and/or had less costly alternative interventions (Table).[12,16,17,19-20,31,43-45] Conditions or diseases included childbirth, heart disease, colon and colorectal cancer, and cardiovascular accident. Fifteen of the 18 reductions were statistically significant.

Charge, Expenditure, and Premium Performance

There are relatively few results for the cost implications of managed care plans.

Hospital Charges per Stay.—Results for eight observations from seven studies[7,15,26,29-31,33] show mostly small nonsignificantly lower hospital charges per stay in HMOs. The usefulness of some of the charge data is questionable because charges billed and those actually paid sometimes differ substantially.

Hospital Expenditures per Enrollee.—Three studies on HMO plans[7,25,46] produced four observations, all of which were limited in usefulness. A study of PPO plan performance showed higher hospital expenditures per enrollee.[47]

Physician/Outpatient Charges or Expenditures per Enrollee.—Of three observations on HMO plans from three studies, one showed higher[46] physician outlays, and two showed lower[7,46] physician outlays per enrollee compared with indemnity plans. Two observations on PPO plans also showed conflicting results.[40,41] All results were statistically significant.

Total Expenditures per Enrollee.—The literature produced only two observations.[9,36] One study showed statistically significant, 13% lower expenditures for HMO enrollees compared with indemnity insurance enrollees,[36] whereas the Medicare TEFRA Evaluation expenditure results, which have methodological limitations (including no tests of statistical significance), showed at least 11% lower expenditures on health care services for HMO enrollees than for Medicare FFS enrollees.[9] Total expenditures per HMO and FFS enrollee may have been equivalent in the latter case, because Medicare HMO plans spend approximately 10% to 13% of total costs on overhead items, including administration, marketing, and profit.[10,48] The sole PPO observation showed significantly higher total expenditures for PPO enrollees compared with indemnity plan enrollees.[47]

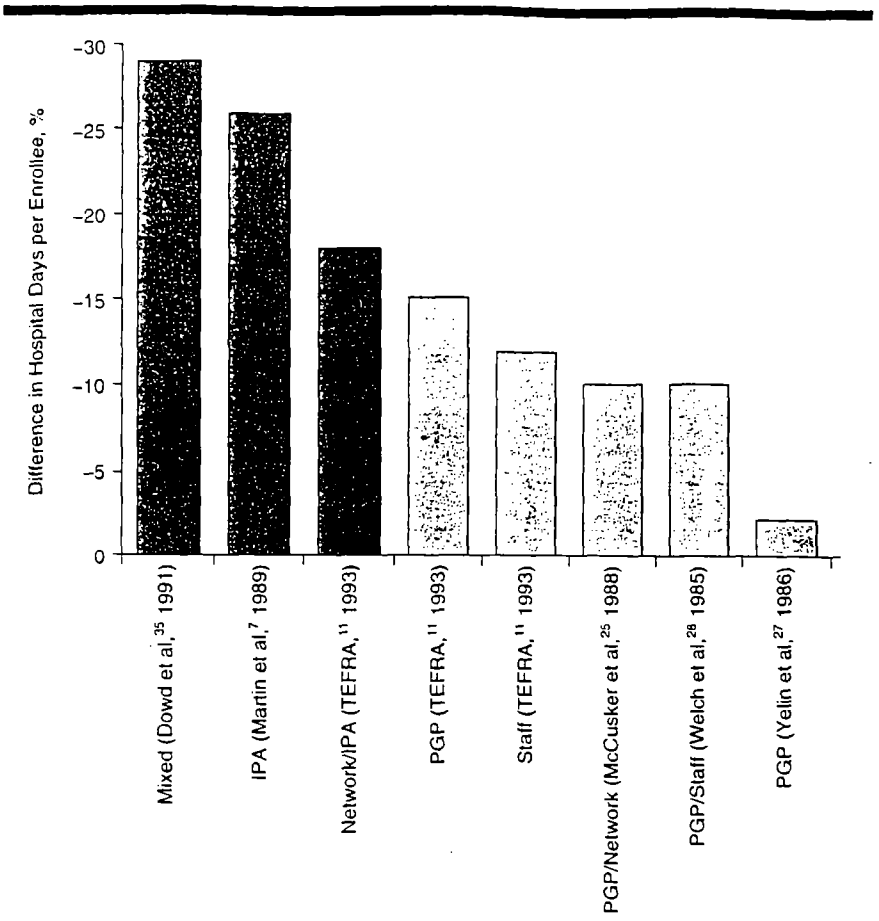


Fig 3.—Percentage difference in hospital days per enrollee, health maintenance organization (HMO) plans compared with indemnity plans. Black bars indicate statistically significant results; and lightly shaded bars, not statistically significant results. The HMO plans consistently had lower hospital days per enrollee compared with indemnity plans. IPA indicates individual practice association; PGP, prepaid group practice; and TEFRA, Medicare Tax Equity and Fiscal Responsibility Act Evaluation.

HMO Plan Market Penetration Impact on Hospital Costs.—No peer-reviewed studies estimated the impact of managed care plans on national or regional area health care expenditures, although some studies estimated the impact on hospital expenditures. Studies using data prior to 1985 found that HMO market share had no statistically significant relationship to hospital expenses per capita or per admission.[49-52] However, two studies[52,53] showed statistically significant reductions in hospital expenditures. In particular, a California study[53] using 1982 to 1988 data concluded that a 10% increase in HMO market penetration led to a 9.4% lower increase in hospital costs per admission (for all patients) during 6 years. The impact of HMO plan market penetration was greatest in areas with substantial hospital market competition. The HMO plans produced their effect via reducing the growth rate of indemnity plan hospital expenditures. Another study[54] provided limited evidence that PPO plan growth also significantly reduced overall hospital expenditures in California.

Premium Levels.—No peer-reviewed literature determined differences among plans in premium levels adjusted for differences in enrollee age, number of dependents, sex, health status, benefit coverage, location, or most other enrollee and plan characteristics. Survey data analyses[55-58] produced unadjusted estimates. One study of the 1986 Minnesota market[59] found that when an employer

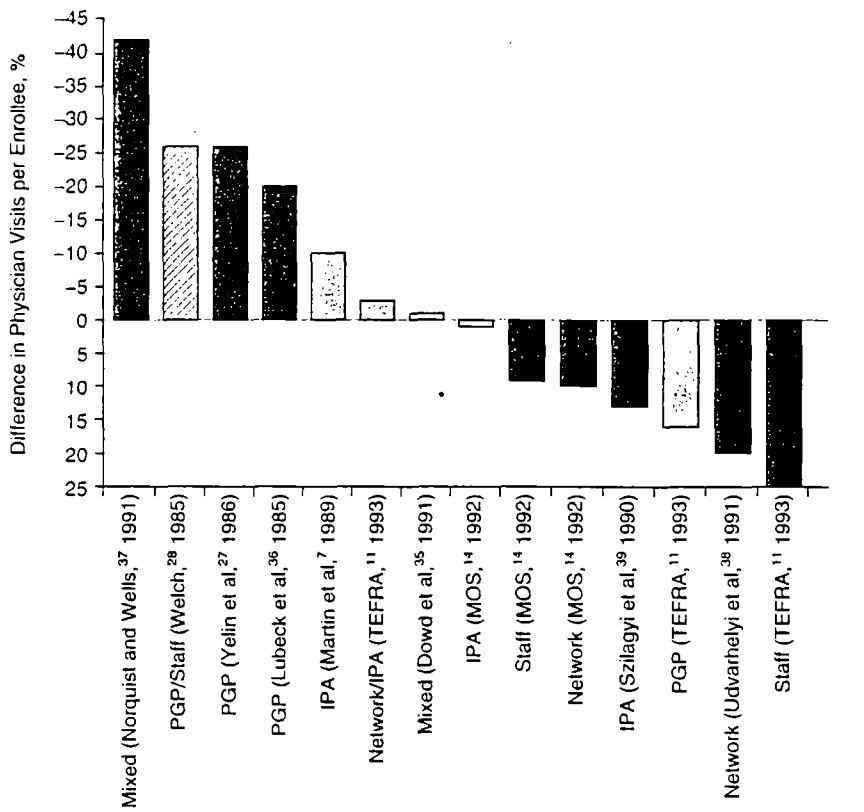


Fig 4.—Percentage difference in physician visits per enrollee, health maintenance organization (HMO) plans compared with indemnity plans. Black bars indicate statistically significant results; lightly shaded bars, not statistically significant results; and striped bar, no tests of statistical significance. Although lower physician visits balance higher physician visits in HMO plans compared with indemnity plans, nine of 10 observations with more recent data show either higher or similar HMO plan physician visits. PGP indicates prepaid group practice; IPA, individual practice association; MOS, Medical Outcomes Study; and TEFRA, Medicare Tax Equity and Fiscal Responsibility Act Evaluation.

offered an HMO plan, family premiums rose by more than $25 per month because HMO plan premiums were more expensive than indemnity plans, whereas indemnity plan premiums were 15% higher because of the HMO offering, due to adverse selection.

Rate of Growth of Premiums.—Even small differences in annual premium growth rates over an extended period can result in large premium level differences. No peer-reviewed literature adjusted for changes in differences among plans. Available survey data results can be misleading due to the distorting effect of the premium cycle,[60,61] the decline over time in indemnity plan benefits relative to HMO plans,[62] and changes in factors discussed herein.

Prevention, Quality of Care, and Enrollee Satisfaction Performance

Prevention and Health Promotion.—In seven observations from six studies,[9,19-21,22,28,63] HMO plan enrollees consistently received more preventive tests, procedures, and examinations (such as cancer and hypertension screening tests and breast, pelvic, rectal, and general physical examinations) or health promotion activities (such as smoking counseling practices) than did indemnity plan enrollees. One study[64] examining a mixture of HMO and PPO enrollees produced similar results. Because many observations contained a series of comparisons of preventive service utilization, it was difficult to clearly determine the number of observations that were statistically significant. However, of the 39 separate comparisons in the seven observations that were tested for statistical significance, 19 showed significantly more use, whereas only one showed significantly less use. Some studies used large, representative data sets, including data from the 1987 National Health Interview Survey[62] and National Medicare Competition Evaluation.[18]

Quality of Care.—The HMO and indemnity plans provided enrollees with roughly comparable quality of care, according to process or outcomes measures. Fourteen of 17 observations from 16 studies[8,12,18,20,27,28,43,65-73] showed either better or equivalent (same or a mixture of better and worse) quality-of-care results for HMO enrollees compared with FFS enrollees for a wide range of conditions, diseases, or interventions. Included were six National Medicare Competition Evaluation studies[18,43,65-68] that determined that quality of care was approximately equal for HMO and FFS enrollees, with similar treatment processes and outcomes for patients with congestive heart failure, colorectal cancer, diabetes, and hypertension and with similar ambulatory care and functioning outcomes. Two Medicare TEFRA Evaluation studies on patients with colon cancer, cerebrovascular accident, or chronic problems (joint pain, urinary incontinence, and chest pain) also indicated comparable quality of care, although a few differences suggest that HMO plan enrollees may receive less adequate care in some situations.[8,10,12] Two MOS observations[73,74] on HMO and indemnity insurance enrollees with mental health problems produced the only results that were solidly unfavorable for HMO plans.

Enrollee Satisfaction.—In seven of eight observations from five studies,[8,13,36,73,75] fewer HMO enrollees were as satisfied with, or evaluated as highly, perceived quality of care and patient-physician interactions than did FFS enrollees. Yet, in four of five observations from four studies with data,[8,13,36,76] HMO plan enrollees were very satisfied with, or rated highly, most aspects of their care, and in five of five observations they were more satisfied with, or rated more highly, the financial aspects of their health plan than were indemnity plan enrollees. In the MOS,[75] IPA plan enrollees rated highly all aspects of their care more often than did network or staff HMO plan enrollees.

COMMENT

Some of the findings in this literature analysis differ from those in the Luft literature analysis and the RHIE evaluation. Although more recent results show lower HMO plan hospital utilization, the size of the differences and the way in which the reductions took place differed from results in earlier studies. In this analysis, HMO plans had widely varying reductions in hospital admissions (as well as some increases), consistent but small to moderate reductions in hospital LOS, and widely varying reductions in hospital days per enrollee compared with indemnity plans. In contrast, the Luft literature analysis and RHIE evaluation found consistent moderate to large HMO plan differences in hospital admissions (usually 15% to 40% lower), no consistent differences in hospital LOS, and many fewer hospital days

Use of Expensive and Discretionary Services*

Source, y	Data Date	Type of HMO Plan Comparison	Condition or Disease	Procedure or Treatment	Ratio of Use, HMO vs Indemnity
Hlatky et al,[19] 1983	Early 1980s	PGP (vs community/) university MDs	Heart disease	Coronary angiograms Exercise thallium scans	<1.0†/<1.0 0.70†/0.65†
Retchin and Brown,[43] 1990	1983-1986	Mixed	Colorectal cancer	Liver, abdominal computed tomographic scans	0.71†
McCloskey et al,[44] 1992	1984-1985	Staff	Childbirth	Cesarean section rates	0.81†
Stafford,[16] 1990	1986	PGP	Childbirth	Cesarean section rates	0.68†
	1986	Network/individual practice association	Childbirth	Cesarean section rates	0.92†
Stafford,[17] 1991	1986	PGP	Childbirth after prior cesarean section	Cesarean section rates	0.81†
	1986	Network/individual practice association	Childbirth after prior cesarean section	Cesarean section rates	1.00
Young and Cohen,[20] 1991	1987	Mixed	Acute myocardial infarction	Arteriography Coronary artery bypass graft Angioplasty	0.80† 0.63† 0.89
Lessler and Avins,[45] 1992	1989-1990	PGP (vs non-PGP MDs)	Heart disease	Tissue-type plasminogen activator, not streptokinase	0.51†
Rapoport et al,[33] 1992	1989-1990	Mixed HMO/preferred provider organization	ICU patients	ICU days	<1.0†
Retchin et al,[12] 1992	1989-1990	Mixed	Colon cancer, cardiovascular accident	ICU days Electroencephalograms Percentage of hospital days in ICU Carotid Doppler ultrasonogram Echocardiograms Computed tomographic scans Carotid angiography	0.63† 0.65† 0.75 0.81† 0.82† 0.91† 1.09

*HMO indicates health maintenance organization; PGP, prepaid group practice; and ICU, intensive care unit.
†Statistically significant ($P<.05$) difference from 1.0.

per enrollee—an average of 35% in the Luft analysis and more than 40% in the RHIE evaluation.[1,2,77]

Compared with indemnity plans, HMO plans appear to have lower hospital bed use because they can implement a much wider array of methods of affecting physician practice, including physician selection, retention, and information feedback procedures, formal and informal UM, and provider reimbursement and risk sharing. To the extent that the difference in hospital admission rates between HMO and indemnity plans was smaller in the period after 1980 than before 1980, this may be due to some catch-up by indemnity plans in implementing precertification of inpatient care, increased economic incentives to shift indemnity-covered patient procedures from hospital to outpatient settings that have less UM and fewer price restrictions, and decreased enrollee benefit coverage over time in indemnity plans compared with HMO plans, creating financial incentives for patients to avoid hospitalization. The difference in hospital LOS between HMO and indemnity plans may be greater in recent years than in the earlier period because HMO plans improved their concurrent review procedures more rapidly than indemnity plans could initiate and improve theirs; hospital contracts obtained by HMOs put pressure on hospitals to discharge HMO plan patients as soon as possible; and physicians in IPA and network HMO plans had more financial incentives to discharge patients early than did physicians in PGP/staff HMO plans in the past.

In addition to lower hospital use, HMO plans used fewer (about 22%) services that had less costly alternatives compared with indemnity plans. Higher HMO physician office visits found in more recent studies are similar to results in the Luft literature analysis (9% more physician visits on average)[1] and the RHIE evaluation (2% to 23% more HMO enrollee visits compared with the "free" indemnity plan and 25% coinsurance plan, respectively).[2] Both the MOS and Medicare TEFRA results showed that higher physician office visits generally accompanied lower hospital use, similar to the pattern found in earlier studies.[1,2,77]

The recent literature on managed care plan performance does not provide policymakers with adequate bottom-line estimates of expenditure differences per enrollee compared with indemnity plans. Nevertheless, given that (1) inpatient services account for a higher percentage of total expenditures than do outpatient services, (2) HMO plans used fewer services that are expensive and/or have less costly alternatives, and (3) HMOs provided more comprehensive coverage than did indemnity plans, the findings suggest that HMOs provide care at lower cost than do indemnity plans.

Recent peer-reviewed literature did not produce estimates of three other central summary indicators of managed care plan performance: the rate of growth of expenditures and the level and rate of growth of premiums. As a result, we do not yet know if the rate of growth in expenditures or premiums has been similar in HMO and indemnity plans, as two studies concluded,[78,79] based on the analysis of limited data prior to 1982.

Although HMO and indemnity plan enrollees generally had roughly comparable health outcomes (similar to the results from the RHIE evaluation),[30,31] a few recent results reinforce the argument that monitoring health outcomes performance must be a crucial element of any health system reform plan. The fact that HMO enrollees were less satisfied with quality of care and physician-patient interactions but more satisfied with costs compared with indemnity plan enrollees suggests that, for some HMO enrollees, HMO plan cost advantages outweighed perceived problems with quality and physician-patient interactions.

We found no evidence to support the hypothesis that PGP/staff HMO plans had performance superior to network or IPA HMO plans, whereas the Luft literature analysis[1] did find differences between PGP/staff and IPA HMO plans. There are several possible reasons for the difference in results: (1) we have few observations for each type of HMO plan, making comparisons difficult (although some of the within-study comparisons were from stronger studies); (2) some group practices in network HMO plans have oriented themselves to capitation and risk bearing and so have

become increasingly similar to groups in PGP HMO plans; (3) physicians in long-established physician groups in older PGP/staff HMO plans likely have more power over their medical practice than do their counterparts in newer primarily capitated medical groups, making some practice changes more difficult to accomplish in PGP/staff HMOs; (4) to compensate for their arm's-length relationship to physicians, and to respond to increased competition from other managed care plans, during the past decade IPAs have tended to implement far more UM controls and reimbursement (dis)incentives to control physician behavior than in the past, and more than in PGP or staff HMO plans.

Although we conclude that there is no evidence from the literature supporting a performance difference between PGP/staff model HMO plans and IPA/network model plans, we cannot conclude that there is no average performance difference among types of HMO plans for three reasons: (1) There were simply too few observations; moreover, some observations examined a mixture of network and IPA (network/IPA) HMO plans, so that it was impossible to determine whether the two types of plans differed in their performance. (2) Definitions of types of plans were inexact and frequently vague. (3) In the Medicare TEFRA Evaluation, poorly performing IPA HMO plans likely were underrepresented because they may not have entered the Medicare marketplace.

Several other factors make it difficult to generalize from the results of the studies we analyzed. (1) Substantially more observations showed favorable rather than unfavorable HMO plan enrollee risk selection relative to indemnity plans, which is consistent with results found elsewhere (eg, Lichtenstein et al[82] and Riley et al[83]). If analyses insufficiently adjusted for favorable HMO selection, some results may have been biased in favor of HMO plans. (2) The HMOs that participated in research studies may have been more successful on average than those that did not, again biasing results in favor of HMO plans. (3) Few studies controlled for the more comprehensive benefits in HMO plans relative to indemnity plans, biasing utilization and expenditure performance results against HMO plans.[57,62] Moreover, no study produced estimates of out-of-pocket cost savings by HMO compared with indemnity plan enrollees, biasing results against HMOs due to omission of this critical dimension of performance. (4) Few usable observations on PPO plan performance restricted generalizations to HMOs. (5) Several important sets of factors can affect health plan performance, including the characteristics of managed care and indemnity health plan vendors, provider organizations, benefit coverages, local markets and state legislation and regulations. These characteristics are many, vary greatly, and are rapidly changing. This suggests that the relatively few research results are somewhat dated and limited snapshots of a diverse, dynamic, and multi-layered marketplace. Although enough studies made good use of available data to enable us to determine patterns of performance differences among health plans, the factors discussed in this paragraph call for caution in interpreting the results.

CONCLUSIONS

Compared with indemnity plans, HMO plans exhibit significantly lower utilization of hospital services and of more expensive or discretionary procedures and tests, likely more physician office visits, increased preventive services use, and mixed results on health outcomes. The HMOs may have reduced system-level hospital costs according to the sole well-designed study with more recent data. Although generally satisfied with their care, some HMO plan enrollees accepted the tradeoff of less satisfaction with their care in return for lower out-of-pocket premium and service costs. There was no evidence that PGP/staff model HMO plans performed better than IPA and network HMO plans. There were too few observations on PPO plans (and none on POS plans) to determine performance differences compared with indemnity insurance plans.

If there were no resource use differences between HMO and indemnity insurance plans, or if HMOs produced less favorable quality of care, then HMO plans might not pose a long-term threat to physicians depending on indemnity insurance patients. Even if HMOs had lower resource use and roughly comparable quality of care, HMO enrollment might still continue to grow at the relatively slow pace of the last several years in the absence of health system reform legislation. However, the combination of lower HMO resource use, roughly comparable HMO quality of care, and legislation that would greatly increase incentives for enrollees to choose lower-cost plans would speed enrollment shifts from indemnity insurance to HMO plans. At least in some regions, enrollment in indemnity insurance plans would become marginal, as would enrollment in managed care plans that are indemnity insurance plans with window dressing.

Our literature analysis indicates both the challenge and the urgency of additional research on managed care plan performance. There are not many results for most dimensions of performance, and there are few or no results for key summary measures of performance, including total health plan and system-level expenditures, out-of-pocket costs per enrollee, and the level and rate of growth of premiums. There is a particularly pressing need for more comprehensive studies that produce use, expenditure, and premium performance results side by side with physiology-, pathology-, morbidity-, and mortality-based outcomes, as well as functional health-related quality of life and enrollee satisfaction outcomes. Such studies also need to determine what "works" in managed care (as opposed to whether managed care "works"). Given rapid change in the health care sector, results must be timely. Although the existing literature provides useful results, policymakers clearly need much more evidence on managed care plan performance if they are to make evidence-based decisions about the future of the health care system.

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SPECIAL REPORT

A Publication of Families USA, March, 1995

Medicaid Cutbacks Harm The States

Members of the new Congressional leadership are planning major reductions in the Medicaid program, the largest single source of federal aid to the states. This year, Medicaid will provide states with $90 billion in federal funds. This is 40 percent of all federal aid to the states, and more than federal grants for transportation, education and housing combined.

Key members of Congress have proposed that, over the next five years, federal Medicaid spending should be capped to yield savings in the range of $75 to $100 billion, possibly more. Senate Majority Leader Robert Dole, speaking to the board of Dow Jones and Company, suggested that the program could be cut by $75 billion over five years. More recently, Senate Finance Committee Chairman Bob Packwood said that combined Medicaid and Medicare cuts should total $250 billion over five years and $400 billion over seven years, with about one-third of that amount coming from the Medicaid program. Senate Budget Committee Chairman Pete Dominici has spoken of cutting Medicaid by $100 billion over five years. House Budget Committee officials have floated proposals to cut Medicaid spending anywhere from $125 billion to more than $200 billion over the next seven years.[1]

This Families USA special report estimates, state-by-state, the impact of the smallest of the publicly stated targets for cutting federal Medicaid spending—$75 billion over five years. The estimates in this Special Report are based on Lewin-VHI's projections of states' future federal Medicaid receipts under current law. The Lewin-VHI projections use the Congressional Budget Office's (CBO) January 1995 estimates of future Medicaid spending nationally, adjusted to reflect each state's projected population growth and changes in age distribution. The estimates assume that the cuts would require a uniform cap on all states' federal Medicaid receipts.

Even with increased state flexibility, such savings cannot be achieved through increased efficiency or expanded use of managed care. Substantial reductions in federal revenue would force major Medicaid cutbacks, tax increases or cuts in a range of other state programs.

FUNDING TO STATES SLASHED

States would lose a significant portion of federal Medicaid dollars if federal Medicaid expenditures were reduced by $75 billion over five years.

- By the fifth year of such a reduction, federal Medicaid funds to the states would be cut by almost one-fifth (18%), compared to what states could otherwise expect to receive. In the fifth year alone, the reduction in federal funds would total over $26 billion. (See *Table 1.)*
- The impact of such federal Medicaid cuts would increase over time. In 1998, states would

Families USA FOUNDATION
THE CONSUMER VOICE FOR HEALTH REFORM
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

N A P H

ACHIEVING SUBSTANTIAL SAVINGS IN THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM

A Discussion Paper Prepared by
The National Association of Public Hospitals

The Medicaid disproportionate share hospital (DSH) adjustment (§ 1923 of the Social Security Act) was established in 1981 for the purpose of providing additional reimbursement to hospitals serving disproportionate numbers of low income and Medicaid patients. Throughout the early and mid-1980s the program was relatively small, but in the late 1980s and early 1990s, DSH payments grew exponentially due primarily to states' use of provider revenues to draw down large federal matching payments. As of FY 1993, DSH payments totaled $16.7 billion. In 1991 and again in 1993 Congress limited matching of provider funds and capped future growth in the program.

Despite reports that states have misused DSH funds or inappropriately drawn down federal payments, DSH programs have nevertheless provided crucial funding for hospitals that truly do serve a disproportionate share of indigent and Medicaid patients. This funding has enabled these hospitals to be able to continue to act as an institutional safety net for those with no other access to health care, and to provide highly specialized services -- such as trauma care, burn units, neonatal intensive care and emergency psychiatric services -- that are relied upon by entire communities. As Congress considers further cuts in the Medicaid program, it is more important than ever that this safety net be preserved.

The National Association of Public Hospitals believes that it is possible to achieve substantial savings ($40 billion over five years) in the DSH program while remaining faithful to Congress' original intent to provide supplemental funding for high volume Medicaid and low income providers. To do so, DSH adjustments should be restructured as a purely federal payment targeted exclusively on the highest volume providers of care to the poor. The following steps could be taken to achieve this goal:

- Modify § 1923 of the Social Security Act (copy of current statute is attached) so that eligibility for DSH payments is limited to:

    1) hospitals that have a low income utilization rate (as defined in § 1923(b)(3)) of 25% or more; and

    2) children's hospitals with either a low income utilization rate of 25% or more or a Medicaid utilization rate (as currently defined in § 1923(b)(2)) of 25% or more.

Under current law, states are permitted to designate ANY hospital as a DSH facility as long as it has a Medicaid utilization rate of 1 percent or more. Some states have gone so far as to designate ALL hospitals in the state as DSH providers.

Chris Lurch 408-0223

4/5/95

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS ■ 1212 NEW YORK AVENUE, NW ■ SUITE 800 ■ WASH., DC 20005 ■ (202) 408-0223 ■ FAX (202) 408-0235

- Only those hospitals that meet this criteria would be eligible for DSH payments. States would no longer have the flexibility to designate additional hospitals as DSH providers.

- Federalize DSH payments. Elimination of the state share of the program would not only relieve the burden on states, but it would also eliminate the loopholes that have allowed states to claim large federal payments without putting up real state dollars as match. (See General Accounting Office, Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government, GAO/HEHS-94-133, August 1994.) A purely federal program would acknowledge this reality, and ensure that on a net basis the dollars are distributed where they are most needed.

- The amount of funds available for DSH payments in each state would be equal to the sum of the federal share of all FY 1995 DSH payments to hospitals eligible under the new criteria in the state.

- The targeted DSH funds would go to states to be distributed among eligible hospitals as the state sees fit. This would allow states to adapt DSH payment methodologies to reflect changing utilization patterns. The money could not be used for any other purpose than making DSH payments to eligible hospitals.

- NAPH estimates that $4 billion per year would be sufficient to fund a properly targeted DSH program, as compared to over $16 billion in current annual DSH payments. This amount represents approximately one-third of the amount currently spent by the federal government on DSH payments and less than one-quarter of total (state and federal) DSH spending.

- Depending on whose numbers you believe, the federal government would save approximately $4-8 billion per year, or $20 billion over five years.

- Because so many states are implementing Medicaid managed care programs on a broader and broader scale, Congress should require that Medicaid managed care utilization and revenues be counted both in determining eligibility for DSH payments and in determining the payment methodology within states.

- In states with section 1115 waiver programs, states would be required to ensure that hospitals that meet the eligibility criteria outlined above receive additional compensation -- either through supplemental pool payments, enhanced capitation payments or otherwise -- to compensate them for the additional burdens of providing large volumes of low income care.

- Intergovernmental transfers of DSH funds would be prohibited, to ensure that the money is used for the hospitals, as originally intended by Congress, and not "recaptured" by the state for other uses.

1988 Amendments:

Section 8433(a) of the "Technical and Miscellaneous Revenue Act of 1988," effective November 10, 1988, applicable to any proceeding in which there has not yet been a final determination by the Secretary (as defined for purposes of judicial review) as of November 10, 1988:

Added "(including failure to provide active treatment)" after "residents" in subsection (a),

Added ", and to provide active treatment for," after "health and safety of" in subsection (c)(5).

Substituted "by January 1, 1990" for "within 3 years after the effective date of final regulations implementing this section" in subsection (f).

1987 Amendments:

Section 4211(a)(2) and (3) of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(l)(6)(E) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988," effective as provided by section 4214 of this Act at ¶ 17,798DD, redesignated section 1919 as section 1922, inserted it after section 1921, and added new section 1919 after section 1918.

1986 Amendments:

Section 1919 was added by section 9516(a) of the "Consolidated Omnibus Budget Reconciliation Act of 1985," effective April 7, 1986.

History:

Sec. 9516(a) of the "Consolidated Omnibus Budget Reconciliation Act of 1985" (P.L. 99-272); as amended by sec. 4211(a)(2) and (3) of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), sec. 411(l)(6)(E) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360), sec. 8433 of the "Technical and Miscellaneous Revenue Act of 1988" (P.L. 100-647).

[¶ 17,409] ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS.

[42 U.S.C. § 1396r-4]

Sec. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient services provided on or after July 1, 1990.

(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the

Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1915(b)(4).

1993 Amendments:

Section 13621(a)(1)(A) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, deleted "requirement" in subsection (a)(1)(A) and substituted "requirements".

1991 Amendments:

Section 3(b)(2)(A)(i) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806, substituted "subsections (c) and (f)," for "subsection (c)," in subsection (a)(2)(B).

1988 Amendments:

Section 302(b)(2) of the "Medicare Catastrophic Coverage Act of 1988," effective July 1, 1988, added new subparagraph (C) to subsection (a)(2).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988," and section 608(d)(15)(C) (OBRA 1987 technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(a).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by secs. 302(b)(2) and 411(k)(6) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360), sec. 608(d)(15)(C) (OBRA 1987 technical corrections subsection) of the "Family Support Act of 1988" (P.L. 100-485), and sec. 3(b)(2)(A)(i) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234), sec. 13621(a)(1)(A) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,410] [Hospitals Deemed Disproportionate Share]

[42 U.S.C. § 1396r-4]

Sec. 1923. (b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).

1993 Amendments:

Section 13621(a)(1)(B) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, deleted "requirement" in subsection (b)(1) and substituted "requirements".

1991 Amendments:

Section 3(c) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806, added new paragraph (4).

1990 Amendments:

Section 4702 of the "Omnibus Budget Reconciliation Act of 1990," effective July 1, 1990, added the sentence beginning "In this paragraph, the term 'inpatient day' includes . . ." to the end of paragraph (2).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and section 608(d)(26)(D) (technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(b).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360), sec. 608(d)(26)(D) of the "Family Support Act of 1988" (P.L. 100-485), sec. 4702 of the "Omnibus Budget Reconciliation Act of 1990" (P.L. 101-508), and sec. 3(c) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234), sec. 13621(a)(1)(B) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,411] **[Payment Adjustment]**

[42 U.S.C. § 1396r-4]

Sec. 1923. (c) PAYMENT ADJUSTMENT.—Subject to subsections (f) and (g) in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1886(a)(4)), and (B) the hospital's disproportionate share adjustment percentage (established under section 1886(d)(5)(F)(iv));

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph (b)(3)); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

[The next page is 7289-7.]

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients.

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

1993 Amendments:

Section 13621(b)(2)(A) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(b)(3) of these Amendments at ¶ 17,810, deleted "subsection (f)" and substituted "subsections (f) and (g)" at the beginning of subsection (c).

1991 Amendments:

Section 3(b)(2)(A)(ii) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806, substituted "Subject to subsection (f), in order" for "In order" at the beginning of subsection (c).

1990 Amendments:

Section 4703(c) of the "Omnibus Budget Reconciliation Act of 1990," effective as if included in the enactment of section 412(a)(2) of the "Omnibus Budget Reconciliation Act of 1987," inserted "or the hospital's low-income utilization rate (as defined in paragraph (b)(3))" after "State" in paragraph (2).

Section 4703(a) of the "Omnibus Budget Reconciliation Act of 1990," effective as if included in the enactment of section 412(a)(2) of the "Omnibus Budget Reconciliation Act of 1987:"

Deleted "or" from the end of paragraph (1).

Added "or" to the end of paragraph (2).

Added new paragraph (3).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6)(A) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and sections 608(d)(26)(A) and (E) (technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(c).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6)(A) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360) and secs. 608(d)(26)(A) and (E) of the "Family Support Act of 1988" (P.L. 100-485), sec. 4703(a) and (c) of the "Omnibus Budget Reconciliation Act of 1990" (P.L. 101-508), and sec. 3(b)(2)(A)(ii) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234), sec. 13621(b)(2)(A) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,412] [Requirement to Qualify as Disproportionate Share Hospital]

[42 U.S.C. § 1396r-4]

Sec. 1923. (d) REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL.—

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1886, in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2)) of not less than 1 percent.

1993 Amendments:

Section 13621(a)(1)(C) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, deleted "REQUIREMENT" in the heading to subsection (d) and substituted "REQUIREMENTS".

Section 13621(a)(1)(D) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, inserted new paragraph (3) at the end of subsection (d).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6)(B) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and section 608(d)(26)(F) (technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(d).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6)(B) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360) and sec. 608(d)(26)(F) of the "Family Support Act of 1988" (P.L. 100-485), sec. 13621(a)(1)(C) and (D) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,413] [Special Rule]

[42 U.S.C. § 1396r-4]

Sec. 1923. (e) SPECIAL RULE.—(1) A State plan shall be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c).

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a state-wide basis, beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) (other than the last sentence of subsection (c)) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) shall apply, and

(D) subsection (g) shall apply.

1993 Amendments:

Section 13621(a)(1)(E) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, in subsection (e)(1):

Deleted "and" before "(B)".

Inserted before the period at the end ", and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c)".

Section 13621(a)(1)(F) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, in subsection (e)(2):

Inserted "(other than the last sentence of subsection (c))" after "(c)" in subparagraph (A).

Deleted "and" at the end of subparagraph (A).

Deleted the period at the end of subparagraph (B) and inserted ", and".

Added at the end new subparagraph (C).

Section 13621(b)(2)(B) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(b)(3) of these Amendments at ¶ 17,810, in subsection (e)(2) (as amended by subsection (a)(1)(F)):

Deleted "and" at the end of subparagraph (B).

Deleted the period at the end of subparagraph (C) and inserted ", and".

Added at the end new subparagraph (D).

1990 Amendments:

Prior to amendment by section 4703(b) of the "Omnibus Budget Reconciliation Act of 1990," effective as if included in the enactment of section 412(a)(2) of the "Omnibus Budget Reconciliation Act of 1987," the introductory matter in paragraph (2) read as follows:

"(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a state-wide basis, during the 3-year period beginning on July 1, 1988—"

1989 Amendments:

Section 6411(c) of the "Omnibus Budget Reconciliation Act of 1989," effective December 19, 1989:

Added "(A)(i)" after "without regard to the requirement of subsection (a) if".

Added "or (ii) the plan as of January 1, 1987, provided for payment adjustments . . . provided by each participating hospital, and (B)" after "January 1, 1984," in subsection (e)(1).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and section 608(d)(26)(C) (technical corrections subsection) of the "Family Support

Act of 1988," effective December 22, 1987, added section 1923(e).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360) and sec. 608(d)(26)(C) of the "Family Support Act of 1988" (P.L. 100-485), sec. 6411(c) of the "Omnibus Budget Reconciliation Act of 1989" (P.L. 101-239), sec. 4703(b) of the "Omnibus Budget Reconciliation Act of 1990" (P.L. 101-508), secs. 13621(a)(1)(E) and (F) and 13621(b)(2)(B) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,413A] [Restrictions on Aggregate Payment Adjustments]

[42 U.S.C. § 1396r-4]

Sec. 1923. (f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

(1) IN GENERAL.—

(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

(I) the payment adjustments are made—

(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the year (as specified in paragraph (2)).

(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

(i) the national DSH payment limit for the fiscal year, and

(ii) the State DSH allotment for each State for the year.

(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

(i) The hospital's medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

(ii) The hospital's low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is equal to at least 1 percent of the total number of such days for all hospitals in the State.

(iv) The hospital meets such alternative requirements as the Secretary may establish by regulation, taking into account the special circumstances of children's hospitals, hospitals located in rural areas, and sole community hospitals.

(E) CONDITION FOR OPTION.—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a state exercising such option.

(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

(B) EXCEPTIONS.—

(i) LIMIT TO 12 PERCENT OR BASE ALLOTMENT.—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State based allotment.

(ii) EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

(3) STATE SUPPLEMENTAL AMOUNTS.—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

(A) DETERMINATION OF REDISTRIBUTION POOL.—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

(i) the total of the State base allotments for high DSH States;

(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal years; and

(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

(B) DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.—The supplemental amount for a State for a fiscal year is equal to the lesser of—

(i) the product of the amount determined under subparagraph (A) and the ratio of—

(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

(4) DEFINTIONS.—In this subsection:

(A) HIGH DSH STATE.—The term "high DSH State" means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

(B) STATE.—The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

(C) STATE BASE ALLOTMENT.—The term "State base allotment" means, with respect to a State, the greater of—

(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

(ii) $1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

(D) STATE GROWTH AMOUNT.—The term "State growth amount" means, with respect to a State for a fiscal year, the lesser of—

(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

(E) STATE GROWTH FACTOR.—The term "State growth factor" means, for a State for a fiscal year, the percentage by which the expenditures described in section 1903(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year.

1991 Amendments:

Subsection (f) was added by section 3(b)(1) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806.

History:

Sec. 3(b)(1) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234).

[¶ 17,413B] **[Limitations on Payment Adjustments]**

[42 U.S.C. § 1396r-4]

Sec. 1923. (g) LIMIT ON AMOUNT OF PAYMENT TO HOSPITAL.—

(1) AMOUNT OF ADJUSTMENT SUBJECT TO UNCOMPENSATED COSTS.—

(A) IN GENERAL.—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) LIMIT TO PUBLIC HOSPITALS DURING TRANSITION PERIOD.—With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) MODIFICATIONS FOR PRIVATE HOSPITALS.—With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

