To July / Gen

EXPANDING COVERAGE THROUGH STATE FLEXIBILITY: MEDICAID OPTIONS

OVERVIEW

In the absence of significant coverage expansions at the federal level, one option for expanding coverage is to provide states with greater flexibility and resources to pursue health care reform.

The federal government has two levers to encourage state coverage expansions:

1. Providing greater flexibility to states in administering health care programs (e.g., Medicaid).

2. Providing additional funding to states to help pay for new coverage.

ADMINISTRATIVE FLEXIBILITY

There are several areas in which providing flexibility to states could produce savings that could be channeled into expanded coverage:

- Encouraging or requiring greater use of managed care organizations;
- Permitting benefit reductions; and
- Reducing administrative complexity (which can reduce administrative costs).

ADDITIONAL FINANCING

The Federal government could encourage states to expand coverage by extending additional financial resources to states, either as matching funds or as a direct grant program.

To protect the federal budget, caps on new federal spending for the program may be necessary.

GENERAL CONSIDERATIONS

- States will want greater administrative flexibility under Medicaid program without expanding coverage to new populations.
- States are unlikely to make new money available for coverage expansions, so any additional financing will probably come from redirecting existing state resources or from the federal government.

- States may be more interested in fiscal relief than coverage expansion. If new federal financing is made available, the challenge will be to assure that it is used to expand coverage rather than to substitute for existing state or private spending.

- Increasing state flexibility reduces the ability of the federal government to influence health care policy and decisions. The ability to protect consumers would necessarily be diminished.

OPTIONS

Option 1 Streamlining Medicaid Waivers for States that Expand Coverage

Key Considerations:

- Budget neutrality is difficult to achieve.

- Retains some of the federal guarantees and consumer protections.

- Loosening Medicaid requirements without prior review of state programs may lead to problems with access and quality.

Option 2 Providing Additional Funds to States for Expanding Coverage

Key Considerations:

- If funds are provided on a matching basis, the States most likely to participate are these that already cover a significant portion of the poor through Medicaid or state-financed programs. Poorer states with the most needy populations may be financially unable to participate in the program.

Option 3 Maximum State Flexibility/Medicaid Block Grant

Key Considerations:

- A block grant program would cap federal spending on Medicaid. If the Federal grant is insufficient, states would need to either expand state funding or cut services or eligible populations.

- Uncertainy for future program growth would be borne by the states and program recipients.

- States may reduce eligibility or benefits for groups now covered under the program.

DRAFT November 21, 1994

EXPANDING COVERAGE THROUGH STATE FLEXIBILITY

OVERVIEW

In the absence of significant coverage expansions at the federal level, one option for expanding coverage is to provide states with greater flexibility and resources to pursue health care reform.

The federal government has two levers to encourage state coverage expansions:

- Providing greater flexibility to states in administering health care programs (e.g., Medicaid).

- Providing additional funding to states to help pay for new coverage.

Providing flexibility to states can lead to some expansions of coverage. However, there are limits to how far existing resources can be extended, and expanding coverage is not necessarily the primary state interest in pursuing flexibility or additional funding.

- Many states are interested in pursuing flexibility as a way to reduce costs -- not expand coverage.

ADMINISTRATIVE FLEXIBILITY

There are several areas in which providing flexibility to states could produce savings that could be channeled into expanded coverage:

- Encouraging or requiring greater use of managed care organizations;

- Permitting benefit reductions; and

- Reducing administrative complexity (which can reduce administrative costs).

There are limits, however, on how far existing resources can be extended to provide new coverage. Medicaid is not a generous payer, so there are limits to amount of savings that managed care can achieve (estimates from 0 to 10%). In addition, reductions in the projected Medicaid baseline will make it harder for states to produce "savings" through state health care reform initiatives.

ADDITIONAL FINANCING

The Federal government could encourage states to expand coverage by extending additional financial resources to states, either as matching funds or as a direct grant program.

To protect the federal budget, caps on new federal spending for the program may be necessary.

GENERAL CONSIDERATIONS

- States will want greater administrative flexibility under Medicaid program without expanding coverage to new populations.

- States are unlikely to make new money available for coverage expansions, so any additional financing will probably come from redirecting existing state resources or from the federal government.

- States may be more interested in fiscal relief than coverage expansion. If new federal financing is made available, the challenge will be to assure that it is used to expand coverage rather than to substitute for existing state or private spending.

- Increasing state flexibility reduces the ability of the federal government to influence health care policy and decisions. The ability to protect consumers would necessarily be diminished.

OPTIONS

Option 1 Streamlining Medicaid Waivers for States that Expand Coverage

Provide presumptive waivers for specified Medicaid requirements (e.g., managed care flexibility) to states that propose significant coverage expansions. States would be able to modify their Medicaid programs within bounds without prior federal approval. However, the federal government would have authority to verify that states meet waiver requirements.

Key Considerations:

- Budget neutrality is difficult to achieve.

- Retains some of the federal guarantees and consumer protections.

- Loosening Medicaid requirements without prior review of state programs may lead to problems with access and quality.

Option 2 Providing Additional Funds to States for Expanding Coverage

Additional Federal funds would be provided to States that expand coverage of the uninsured. States could be provided with substantial flexibility under this new program, but Medicaid would remain as under current law.

Funds could be provided to states on a matching basis or as a direct grant. The Federal contribution to the program would be capped.

Key Considerations:

- If funds are provided on a matching basis, the States most likely to participate are those that already cover a significant portion of the poor through Medicaid or state-financed programs. Poorer states with the most needy populations may be financially unable to participate in the program.

Option 3 Maximum State Flexibility/Medicaid Block Grant

The current Medicaid financing arrangements would be replaced with Federal block grant payments to States. Payments would include the Federal share of the Medicaid program and any new Federal funding. States would be given substantial flexibility in using these Federal payments -- and any required or optional State contributions -- to finance health services for low-income residents.

Key Considerations:

- A block grant program would cap federal spending on Medicaid. If the Federal grant is insufficient, states would need to either expand state funding or cut services or eligible populations.

- Uncertainty for future program growth would be borne by the states and program recipients.

- States may reduce eligibility or benefits for groups now covered under the program.

BACKGROUND
Section 1115 Statewide Demonstration

Overview

- Statewide Medicaid 1115 demonstrations have been approved in 6 States, in addition to the longstanding program in Arizona: Hawaii, Oregon, Tennessee, Kentucky, Rhode Island, and Florida. Kentucky and Florida require State legislation to move forward and have had difficulty getting it.

- South Carolina over the next year is working on developing the infrastructure (managed care networks, information systems) for a Medicaid 1115 demonstration. (South Carolina has not yet received official approval from HCFA.)

- Seven additional States have submitted proposals: Ohio, Massachusetts, Missouri, New Hampshire, Delaware, Minnesota, and Illinois.

- The States seem generally to be using 1115 demonstrations to experiment with the following:

    - o Simplifying eligibility. Most States are using 1115 demonstrations to break the link with welfare eligibility categories and are substituting percent of the federal poverty level in determining who is covered. States are also eliminating the Medicaid assets tests.

    - o Expanding coverage to the uninsured. All approved Statewide 1115 demonstrations would expand coverage to the uninsured, using Medicaid funding to do so. The expansions range from expansions for pregnant women and children only to eligibility for everyone under 300% of poverty. The number covered range from several thousand in Rhode Island to about 335,000 in Tennessee.

    - o Managed care. States are implementing comprehensive managed care arrangements in their programs to help finance the expansions and constrain cost growth. States are also using the 1115 authority to allow them to develop managed care approaches and lock beneficiaries into arrangements in ways not permitted under current Medicaid law.

    - o Cost Containment. A major goal of the proposals has been to control the growth in Medicaid spending or to redirect savings in Medicaid to expansions of coverage.

- Currently, 8% of total Medicaid expenditures is spent under waivers in States with approved Statewide demonstrations. Adding States with pending applications raises this percentage to about 18%.

Additional Interest from Other States

- Preliminary discussions have been held with the States of New York, Washington, Louisiana, Texas, Georgia, Kansas, Utah and Montana. Some of these discussions are at early, conceptual stages.

- It will be sometime before any clear effect is known of the recent elections on the interest in or direction of any of the proposals under review or those in the conceptual stage. In Missouri, for example, it has been suggested that the State legislature may reconsider the scope of the Statewide reform in light of the absence of action on national legislation.

Issues

- Protecting existing beneficiaries.
  Current waiver policy requires existing Medicaid beneficiaries to be held harmless under Statewide 1115 demonstrations. New York and Montana would like to reduce optional benefits to the Medicaid population under 1115 authority, and the States have been informed that this causes concern. Waiver policy also maintains that cutoff of Medicaid benefits cannot be used as a sanction to enforce work provisions in welfare reform waivers.

- Maintaining quality and access to services.
  All 7 States with approved demonstrations have waivers of certain managed care requirements. In exchange, States have been required to submit 100% person level encounter data and adopt focused quality assurance systems. These data are essential in evaluating availability and use of care for key vulnerable populations, such as pregnant women and children.

- Budget neutrality.

  - Limits have been set on federal funds over the life of the demonstrations at the expected level of spending in the absence of the demonstration.

  - The share of total Medicaid spending under 1115 authority is significant and continues to grow.

  - Common agreement on the approach to setting budget neutrality is critical, given the long range implications for the Medicaid baseline.

  - Some States are also looking at 1115 as a way to carry over high DSH payment levels and avoid OBRA 1993 reductions.

- Covering the Most Needy. Increasingly, States are asking that federal match be provided for services previously funded entirely by the State, or, in the case of Massachusetts, subsidize employers who already provide insurance to low-income workers. These proposals are of concern because they do not expand coverage to new populations and can leave the most needy without coverage.

- Operational feasibility.
  Some States have submitted 1115 demonstration proposals without having a fully developed operational framework for implementing the demonstrations. Operational readiness is critical in assuring access and avoiding beneficiary and provider confusion. This continues to be contentious, given the desire to review programs within a 120 day timeframe, even if States are not ready to implement them.

Using 1115 Demonstration Authority for Expanding Coverage

Description

- Continue to use 1115 demonstration authority to promote State flexibility and expand coverage to the uninsured. The 1115 authority provides an administrative, budget neutral approach to achieving these goals.

- Under 1115 authority, either State flexibility could be maximized, or Federal policies could direct State programs.

- Minor legislative proposals to simplify and reform Medicaid could provide States additional flexibility within the regular Medicaid program. This would lessen the incentive to States to use the waiver process as a mechanism for simplifying eligibility and circumventing managed care requirements.

Discussion

- **Budget Neutrality**

  1115 demonstrations currently must be budget-neutral, providing both certainty and protection to Federal Medicaid dollars.

  Budget neutrality formula is under pressure, and enforcement has yet to be tested.

  Over the long term, the baseline for measuring cost neutrality is not clear.

- **Appeal to States**

  Given the budget-neutrality constraint and the political changes at the State level, few States are likely to avail themselves of waivers to expand coverage.

- **Administrative Simplicity/Flexibility**

  The 1115 approach does not require additional legislation to provide States flexibility to design programs that meet their particular needs.

  The minor legislative proposals would also be used to take pressure off the 1115 process and promote State flexibility consistent with Federal priorities.

- **Opportunity for Feds to Guide State Reforms**

  Some states' proposals are designed principally to reduce State costs and not to implement expansions or innovations that will benefit low-income populations.

  In granting 1115 demonstration waivers, the Federal government could give priority to States that are seeking to expand coverage and pursue health system reform could be given priority.

- **Concerns about Substitution of Existing Coverage**

  Rather than expand coverage, states may seek Federal funds for people already covered in State-only programs.

  Similarly, employers may drop coverage if States create a subsidized program for their workers.

Providing Additional Funds to States for Expanding Coverage

Description

- Provide matching Federal funds to States that expand coverage of the uninsured. States would have substantial flexibility in targeting and designing the program.

- The Federal contribution to the program would be capped.

- This program is distinct from Medicaid (and Medicaid waiver programs).

Discussion

- **Simplicity and Flexibility:**

  Provides flexibility for States to design programs to expand coverage that meet their particular needs. For example, states may choose to enroll the uninsured in private insurance or a state employee health plan.

  Decentralizes decision making to the States.

  Relatively free from burdensome or restrictive "strings" usually associated with the Federal financial assistance.

- **Concerns about State Financing:**

  Rather than make new resources available for health care, States are more likely to redirect current state spending to attract federal funds.

  States may use financial schemes like those originally used in the Disproportionate Share Program to obtain federal funds.

- **Concerns about Substitution of Existing Coverage:**

  Employers may drop coverage if a subsidized program is available for workers.

  Rather than expand coverage, States may use funds for people already covered in State-only programs.

- **Targeting / Equity:**

  The States most likely to participate in the program are those that already cover a significant portion of the poor through Medicaid or state-only programs. By contrast, poorer states with the most needy populations may be financially unable to participate in the program. As a result, the program may provide fiscal relief to states that have been more generous in the past rather than expand coverage.

In any case, there will be a trade-off between fiscal relief and expanded coverage.

- **Implications for Medicaid:**

  Establishment of a capped program for the uninsured may create pressure for a cap on Medicaid.

  Establishment of a program with substantial State flexibility may create pressure for similar State discretion and flexibility in the Medicaid program. For example, Medicaid currently has many protections to assure access and quality of care for recipients. In a State-flexibility model with fewer Federal strings, such protections could be significantly weakened.

  States may have incentives to transfer people from Medicaid to the new program if the benefits in the new program are less comprehensive, the eligibility process is less complex, Federal regulations are fewer, or the Federal match is higher.

Medicaid Restructuring
Complete State Flexibility with Medicaid Integration

Description

Replace current Medicaid financing arrangements with Federal block grant payments to States. Payments would include the Federal share of the Medicaid program and any new Federal funding. States would be responsible for using these Federal payments -- and any required or optional State contributions -- to finance health services for low-income residents.

Discussion

- Formula for determining the amount of States' grants will be both technically and politically difficult to develop.

- Broad latitude for States to change their current medical assistance programs to enhance program efficiency, target new populations and solve other State-specific problems.

- Greater certainty for the Federal Medicaid budget.

- The Federal government would have little or no ability to influence the States' use of grant funds.

- The Federal government could do less to protect current eligibles. The Federal government's ability to monitor State Medicaid programs would be diminished. Federal monitoring of quality of care, access, and fraud and abuse would be restricted.

- States would be at risk for any unexpected increases in Medicaid spending resulting from an aging population, unemployment increases, etc. If the Federal grant is insufficient, they would need to either provide more State funding or cut services or eligible populations.

- The ultimate risk for program cost increases would be borne by beneficiaries.

Medicaid Restructuring
Medicaid-for-Welfare Swap

Description

Federal government takes over acute care portion of Medicaid; States take over welfare programs -- AFDC and Food Stamps.

Discussion

- Health program would be made uniform across States in eligibility, benefits, provider payments and delivery arrangements.
- Improve predictability of Medicaid spending if Federally financed program is operated on a fully capitated basis.
- Eliminate Federal/State conflict over program rules for both health and welfare programs, because of clear program responsibilities.
- The Federal costs of making health program uniform would be significant; i.e., higher eligibility and higher provider payments.
- No assurance that States would not drastically reduce commitments to welfare programs, without State maintenance of effort and/or Federal minimum standards.
- Decrease in the uniformity across States of welfare coverage. Also, the Food Stamp program, which is a Federal program that provides assistance based solely on income, and therefore reaches low-income working families, would be left to State discretion.
- Uneven State fiscal impacts -- significant number of winners and losers.
- No reduction in the perception of "Big government" running Federal programs, because of Federal health care for the poor.
- Significant administrative burden of administering a Federal health program that includes a "means-tested" eligibility requirement.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

06-Apr-1995 02:53pm

TO: (See Below)

FROM: Christopher C. Jennings
Domestic Policy Council

SUBJECT: Another Major Ways and Means Hearing

Besides the Finance Hearing, in which they have requested that all the trustees testify on the Medicare Trust Fund (and what we are going to do about it), the Ways and Means Committee has just scheduled one themselves on May 3rd. (finance will be in late April.) These hearings will occur immediately before or during (depending when the dates get locked in) the White House Conference on Aging.

CJ.

Distribution:

TO: Carol H. Rasco
TO: Laura D. Tyson
TO: Patrick J. Griffin
TO: George Stephanopoulos
TO: Gene B. Sperling
TO: William A. Galston
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CC: Jennifer L. Klein
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DRAFT

REPUBLICAN BUDGET: MEDICARE AND MEDICAID

Issue: Though precise numbers are not yet available, Dole and Packwood have discussed cutting Medicare and Medicaid by $400 billion over seven years -- three times more than any budget proposal in history. Republicans will claim they are "restructuring" the programs to shore up the Medicare trust fund and to give states more flexibility with their Medicaid dollars.

Democratic Message: Under the guise of "restructuring" Medicare and Medicaid, Republicans are proposing to dismantle these programs to balance the budget and provide tax cuts for the wealthy. This shifts a disproportionate burden of deficit reduction to children, working families and seniors living on fixed incomes. If they are truly concerned about ensuring Medicare's solvency and slowing the rate of health care inflation, Republicans would accept Democrats' invitation to sit down at the table and work on a serious effort to reform our health care system.

TALKING POINTS: REPUBLICAN BUDGET

- Republicans have proposed slashing Medicare and Medicaid to balance the budget and finance tax cuts for the wealthy. These types of draconian cuts are an assault on the seniors and working families that depend on these programs.

- Republicans may hide behind the convenient cloak of Medicare Trust Fund solvency, but make no mistake about it, this effort will dismantle Medicare and Medicaid, not strengthen these programs. They are looking for short-term deficit reduction, not long-term solutions.

- If Republicans are so sincere about saving the trust fund, why does the Contract propose raiding it to pay for tax cuts for the wealthiest Social Security recipients? [The Contract proposes repealing the tax increase on a small percentage of upper-income seniors, proceeds of which go directly into the Trust Fund.]

- The only ways to produce the level of Medicare savings Republicans propose are to limit seniors choice of doctors by putting all Medicare beneficiaries into HMOs, shift more costs onto the elderly, or cut reimbursement to providers, destroying the hospitals and clinics upon which we all depend.

- Older Americans already pay almost one-quarter of their income for medical care. Cuts of this magnitude will mean that seniors over the next 5 years would pay at least $2,000 more out-of-pocket than they are already paying.

- Seniors will also be hit hard by the Medicaid cuts -- two-thirds of the Medicaid dollars support disabled Americans and elderly in nursing homes.

- The remaining Medicaid expenditures are largely for children and pregnant women. Medicaid now covers one fifth of all children, the majority of whom live in working families. Cuts of this magnitude will simply force states to push children off of the rolls, raising the number of kids without insurance.

- Democrats believe we must tackle problems with Medicare and Medicaid in the context of health reform. If we don't, the costs and problems in these programs will simply be shifted from the federal government to businesses, working families, providers and states.

- We have our health reform proposal and are ready to roll up our sleeves and get to work on a bipartisan plan that will strengthen Medicare and Medicaid and improve health care quality and access. When are Republicans going to get serious about health reform?

Medicaid Block Grant

- A Medicaid block grant that has a fixed growth rate of 5% would reduce federal expenditures under the CBO baseline by **$192 billion** between 1996 and 2002. By the year 2002, federal spending on Medicaid would be reduced by over 30%.

- The Kaiser Commission on the Future of Medicaid recently examined the state-by-state impact of a 5% block grant. They found:
  - o Effects vary greatly, with the largest impact in the south and in mountain states;
  - o Lower income states would be more adversely affected since a greater portion of their Medicaid expenditures are paid for by the federal government under FMAP.

Colorado

- Colorado predicts that its Medicaid expenditures will grow at approximately 11% annually between 1994 and 1996. It is a high DSH state.

- Colorado would **lose $1.6 billion** in federal Medicaid expenditures under a block grant, according to the Kaiser report. This is a 20% reduction over the period.

Delaware:

- Delaware has applied for an 1115 waiver to enroll non-elderly recipients in managed care and expand coverage to 100% of poverty. It predicts that its expenditure growth rate without the waiver will be about 10.5%, and with the waiver will be about 9.5% (M-CPI plus 4%). Both these rates are significantly higher than 5%.

- Delaware would **lose $327 million** in federal Medicaid expenditures under a block grant, according to the Kaiser report. This is a 19% reduction over the period.

Missouri

- Missouri has applied for an 1115 waiver to enroll its non-elderly recipients in managed care and expand coverage to uninsured children up to 200% of poverty. It predicts that its expenditure growth rate without the waiver will be about 9.5%, and with the waiver will be about 9%. Both these rates are significantly higher than 5%.

- Missouri would **lose $1.3 billion** in federal Medicaid expenditures under a block grant, according to the Kaiser report. This is a 9% reduction over the period.

Vermont

- Vermont has applied for an 1115 waiver to enroll its AFDC recipients in managed care, extend a pharmacy benefit to low-income elderly, and expand coverage to 150% of poverty. It predicts that its expenditure growth rate without the waiver will be over 9%, and with the waiver will be over 7.5%. Both these rates are significantly higher than 5%.

- Vermont would lose **$328 million** in federal Medicaid expenditures under a block grant, according to the Kaiser report. This is a 16% reduction over the period.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

From: Chris J.
Phone: 6-5560

To: Jen

Date: 4/4/95

Remarks: Current draft of Daschle talking points re: Republican Budget

REPUBLICAN BUDGET: MEDICARE AND MEDICAID

Issue: Though precise numbers are not yet available, Dole and Packwood have discussed cutting Medicare and Medicaid by $400 billion over seven years -- three times more than any budget proposal in history. Republicans will claim they are "restructuring" the programs to shore up the Medicare trust fund and to give states more flexibility with their Medicaid dollars.

Democratic Message: Under the guise of "restructuring" Medicare and Medicaid, Republicans are proposing to dismantle these programs to balance the budget and provide tax cuts for the wealthy. This shifts a disproportionate burden of deficit reduction to children, working families and seniors living on fixed incomes. If they are truly concerned about ensuring Medicare's solvency and slowing the rate of health care inflation, Republicans would accept Democrats' invitation to sit down at the table and work on a serious effort to reform our health care system.

TALKING POINTS: REPUBLICAN BUDGET

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Jen FYI

Demonstration Trend Factors

Q: What trend factors have States requested in their demonstration proposals and how has that trend differed from the trend factor agreed upon once the demonstration is approved?

A: States have requested a variety of trend factors in their demonstration proposals. Each State's trend factors have been individually established. These trend factors reflect our and the States' best estimate of spending in the absence of the demonstration.

We have used different approaches in determining the trend factor. For example, Hawaii's trend factors were based on CPI for Honolulu, while Rhode Island's were based on State historical trends and Ohio's were based on national trends.

ADDITIONAL INFORMATION: Approved Demonstrations

OREGON

HCFA accepted Oregon's proposed per capita costs for each of five years. These will be multiplied by the number of persons who would be eligible under current requirements. No trend factors were involved. The State is at risk for costs of new enrollees.

TENNESSEE

Original State Request - Block grant to continue current levels of federal funding without commitment to maintain normal State matching funds.

Budget neutrality was computed based on an aggregate cap on total expenditures requiring normal State matching. The base year was State fiscal year 1993. The annual limitations are listed below:

Years	Limit (millions)	Annual Increase
1	2,108	***
2	2,283	8.3%
3	2,454	7.5%
4	2,594	5.7%
5	2,726	5.1%
Total	12,165	

RHODE ISLAND

Original State Request - HCFA agreed with the original State request which was consistent with State historical trends.

Budget neutrality was computed based on a Per Capita methodology. The base year is 1992. The trend factors are listed below:

Trend Factors

1994	8%
1995	6%
1996	4%
1997	4%
1998	4%
1999	4%

HAWAII

Original State Request - The State did not propose a trending methodology.

Budget neutrality was computed based on a per capita methodology. The base year is 1993. The trend factor is the consumer price index for health costs for Honolulu plus 4% (CPI-H + 4).

KENTUCKY

Original State request

Budget neutrality was based on a per capita methodology. The trend factor is CPI-H for Cincinnati-Hamilton + 3%. There is a separate limit on actual Kentucky Disproportionate Share Hospital payments.

FLORIDA

Original State Request - Based on a per capita methodology.

Budget neutrality was computed based on an aggregate methodology (with adjustment if enrollment exceeds 103% of estimate). The trend factors are listed below:

- Trend Factors

1993-94	17.75
1994-95	16.2
1995-96	15.7
1996-97	15.5
1997-98	14.9
1998-99	14.3

- DSH - actual 93-94 allotment increased by percentage change in projected benefit costs

OHIO

Original State Request - combined both basic benefit package (BBP) services and special health related services (SHRS) with a trend factor of CPI - H + 3%.

Budget neutrality was computed using a per capita methodology separating the two benefit packages. The base year is actual 1995 expenditures. The trend factors are listed below:

- Trend Factors (National)

	BBP	SHRS
1996	7.30	9.20
1997	6.88	8.55
1998	6.58	7.88
1999	6.52	7.73
2000	6.68	7.67

DSH: 9.39% (National)

Pending Demonstrations - State proposed trend factors. All use per capita rates unless otherwise indicated.

Delaware	SSI Adult - Basic Benefit Package	15.0% first yr. 8.1% subsequent
	Mental Health	29.8% first yr. 8.8% subsequent
	AFDC - Basic Benefit Package	8.8%
	Mental Health	29.8% first yr. 8.8% subsequent

Missouri 11.5% annually

Vermont	1996	8.9%
	1997	9.1%
	1998	9.2%
	1999	9.4%
	2000	9.7%

Illinois	AABD	10.33%
	AFDC	11.66%
	FOSTER CARE	3.92%
	OVERALL	11.02%

Louisiana 21% (aggregate growth factor including cost and eligibility growth)

South Carolina 6% annual inflation

Oklahoma	1996	7.40%
	1997	7.56%
	1998	8.00%
	1999	8.44%
	2000	8.88%

Pending Demonstrations continued --

Massachusetts	1995	7.60%
	1996	7.60%
	1997	7.60%
	1998	7.59%
	1999	7.58%

New York	1996	7.97%
	1997	6.24%
	1998	8.85%
	1999	8.76%
	2000	8.75%

Minnesota

	SSI	AFDC	AFDC-related
1995	7.46	1.66%	4.95%
1996	7.54	1.63%	9.33%
1997	7.01%	4.81%	8.03%
1998	7.27%	3.22%	8.68%
1999	7.27%	3.22%	8.68%

New Hampshire 7%

NATIONAL CONFERENCE OF STATE LEGISLATURES

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WILLIAM POUND
EXECUTIVE DIRECTOR

March 14, 1995

The Honorable Richard Armey
U.S. House of Representatives
Washington, DC 20515-4326

Dear Representative Armey:

On behalf of the National Conference of State Legislatures, we are writing to share the states' ideas and concerns regarding block grants. NCSL has long supported a reasonable sorting out of functions among the different levels of government. We also believe the devolution of certain federal responsibilities to the states should not simply be a way to deal with the federal deficit, but, following the lead of the unfunded mandates legislation, constitute a serious attempt at restoring balance to and productive partnerships within our federal system. To that end the NCSL has developed the set of enclosed principles to be considered with regard to any block grant proposal. Because state legislatures are the bodies that are most involved in the decision-making process with respect to program delivery in the states, we urge you to consider the following issues when constructing any block grant plan.

1. **Federal block grant funds should be expended "according to state law."** This is of vital importance to the proper allocation of funds within a state and allows for the most appropriate form of oversight. Failure to include such a clause in any block grant proposal is tantamount to a wide preemption of state laws governing the appropriation of funds and could lead to unnecessary disputes.

   Proposals that grant the authority to the governor of each jurisdiction are not conducive to achieving a balanced distribution of funds across the state and are basically the same as ceding congressional authority over the appropriations process to the President. Block grants, by their nature, include minimal amounts of guidance over the distribution of funds within a state, and the legislative process is needed in order to best allocate the funds once they reach the state treasury. State legislators also hold the power of the purse over state revenues and are uniquely equipped to leverage state funds in conjunction with federal funds in order to create the most efficient and powerful programs.

2. **The maximum level of flexibility in the use of the block grant funds should be granted.** Cuts in projected funding levels, if sought, require greater flexibility if the states are to have any opportunity to achieve program goals.

3. **Certain entitlement programs should not be changed into non-entitlement block grants.** For example, programs involving child nutrition and food stamps should not be treated as capped entitlement programs. We believe that the resources necessary to ensure that eligible children continue to receive benefits should not be limited.

4. **State legislatures will need transition and lead time to address these potential changes in a deliberate and comprehensive manner.** Since many state legislatures meet part-time or biennially, we ask your consideration that we work together to develop implementation timetables that are most conducive to a timely but thorough transition of program management.

Thank you for your consideration of these views when making your decisions with regard to any block grant proposal. Members of the National Conference of State Legislatures would be pleased to discuss these issues with you and/or testify with regard to any block grant proposal. Please contact Scott DeFife or Michael Bird in our Washington office at 202/624-5400 if you have any questions or need additional assistance.

Sincerely,

Jane L. Campbell

Jane L. Campbell
President, NCSL
Assistant Minority Leader, Ohio

Sincerely,

James L. Lack
President-Elect, NCSL
New York State Senate

payment accuracy Quality Control system to a broader system focused on self-sufficiency and program improvement.

The existing QC system requires an evaluation of all factors of eligibility and payment, except a few that are specifically excluded by the Statute, e.g., monthly reporting. The new system would focus on only error prone factors with significant dollar effects (e.g. earned income, filing unit, deprivation, etc.), or only on factors viewed as critical to public confidence in the program.

- Revise the regulations to reduce the verification and documentation required to substantiate a review finding.

The current system requires a detailed description and calculation of all errors found in a case review, and that a specified amount of verification be obtained to substantiate the error finding. Under this option, documentation/verification standards would be relaxed by establishing new minimum standards and the payment error determination process will be simplified.

- Revise the regulations to change the sample design.

The current system requires each state (or jurisdiction) to select a minimum of 300 to 1200 review cases each year. The Federal staff examines a portion of each state's sample to validate the review findings. The precision (confidence level) of the payment errors is primarily a function of the sizes of the State and Federal samples and the expected frequency with which the attribute being measured occurs in the population being sampled. They have been tested and judged adequate for holding States accountable for prescribed payment accuracy standards. Commitment of resources to achieve this level of precision may not be necessary in an incentive/technical assistance response to State performance. It should be noted that smaller sample sizes will reduce the amount and degree of reliability of performance data on the transitional system. We can study the potential impact of various reduced sample size models on the precision of payment error estimates and other process measures.

OPTION 2: Operational Design

States would be required to conduct periodic, internal audits of their JOBS and WORK processes to ensure the accuracy of reported data and annual audits to establish payment accuracy rates. The Federal government would specify the minimum sample sizes to achieve 90 or 95 percent confidence at the lower limit (the method generally used by OIG). States would also be permitted to use current QC resources to conduct special studies to test and improve the current system. To ensure that State data and procedures are valid and reliable, the Federal government would conduct periodic, targeted, and unannounced audits for that purpose.

4. Incentives vs. Penalties

- States would be eligible for performance-based incentive payments – for example, a 1-10 percent increase in FFP (administrative costs, or JOBS, or WORK).

- Sanctions for unacceptable performance could also be included, if needed to foster appropriate behavior.

- The incentive/sanction formula would be developed by the Secretary taking into consideration and appropriately weighting desired results, including payment accuracy.

SMOKE-OUT TALKING POINTS: EFFECTS OF CAPPING MEDICARE

- Medicare is the primary health care program for 32 million elderly and 4 million disabled Americans.

- Republicans have proposed to cut Medicare funding by at least $150 billion between now and 2000 -- a **20% cut** in 2000 alone.

- Medicare spending per person is already projected to grow at roughly the same rate as private sector health spending. So with a cut this large, both beneficiaries and providers will be forced to shoulder huge burdens.

  - Medicare managed care is unlikely to provide significant savings in the near future. CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

  - If cuts were allocated as under the Mainstream Coalition health reform bill, providers would bear about three-quarters of the reductions and beneficiaries would bear about one-quarter:

    - In 2002 alone, a 23% cut in Medicare payments to providers would be needed.

    - Elderly and disabled beneficiaries would have to pay $533 more for Medicare, a 12% increase over the premiums they pay today.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system, which would still bear the growing burden of uncompensated care. This is likely to shift costs to small businesses.

- Reducing Medicare payments also would disproportionately harm rural hospitals. Rural hospitals are more likely than other hospitals to depend heavily on Medicare as a source of revenue. Rural hospitals also are more likely to have negative Medicare margins than urban hospitals, which makes them less able to absorb large Medicare payment reductions.

- In the last Congress, bills proposed by Senator Dole and the Mainstream Coalition also proposed large Medicare cuts. However, unlike current Republican proposals, the Dole and the Mainstream Coalition proposals reinvested their savings into the health care system through subsidies to expand insurance coverage. By reinvesting their savings, they would have reduced the uncompensated care burden on provider and business and mitigated many of the adverse effects from Medicare cuts.

SMOKE-OUT TALKING POINTS: EFFECTS OF CAPPING MEDICAID

➤ Medicaid is a safety net for over 35 million mothers and children, the elderly and people with disabilities. By the year 2002, Medicaid will cover roughly 46 million people.

➤ Republicans have proposed (through the use of a block grant with 5% growth) to cut federal Medicaid funding by at least $180 to $190 billion between now and 2002 -- a **24% cut** in 2002 alone.

➤ There is no evidence that manage care alone can achieve this level of savings.

- States already are aggressively pursuing managed care, but the populations that can readily be managed – children and AFDC adults – account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

- As a result, the potential savings from expanding managed care actually is less than five percent of the needed savings.

➤ Contrary to Republican claims, Medicaid spending per person is already projected to grow at a slower rate than private health spending. So, with a cut this large, health care coverage for vulnerable Americans is at severe risk.

- To protect mothers and children, states could:

  - Drop coverage for as many as **3 million elderly and people with disabilities,** or

  - Eliminate benefits disproportionately used by the elderly and people with disabilities like home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services --- and, by 2005, begin to limit nursing home services.

- Alternatively, to protect the elderly and people with disabilities, states could:

  - Drop coverage for as many as **16 million mothers and children**, or

  - Eliminate all inpatient hospital, outpatient, and physician services for mothers and children -- and still not have enough savings to offset the loss of federal funds.

➤ States could decide to increase their spending by over $180 billion. But that would mean a 33% increase in state Medicaid spending in 2002 alone. States would be forced to raise taxes or slash spending for services like education and public safety.

EFFECTS OF CAPPING MEDICAID

- Medicaid is a safety net for mothers and children, the elderly and people with disabilities.

- Republicans have proposed to cut federal Medicaid funding by at least $180 to $190 billion between now and 2002 -- a **24% cut** in 2002 alone.

- Medicaid spending per person is already projected to grow at a slower rate than private health spending. So, with a cut this large, people will suffer.

  - If you want to protect mothers and children, you would have to:

    - Drop coverage for as many as **3 million elderly and people with disabilities,** or

    - Eliminate benefits like home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services --- and, by 2005, begin to limit nursing home services.

  - If you want to protect the elderly and people with disabilities, you would have to:

    - Drop coverage for as many as **16 million mothers and children**, or

    - Eliminate all inpatient hospital, outpatient, and physician services for mothers and children -- and still not have enough savings to offset the loss of federal funds.

- States could, of course, decide to increase their spending by more than $180 billion. But that would mean a 33% increase in state Medicaid spending in 2002 alone, and would force states to raise taxes or slash spending for services like education and public safety.

- In other words, there are no easy choices when you have to cut $180 to $190 billion out of a health care program for mothers and children, the elderly and people with disabilities.

EFFECTS OF CAPPING MEDICARE

- Medicare is the primary health care program for 32 million elderly and 4 million disabled Americans.

- Republicans have proposed to cut Medicare funding by at least $150 billion between now and 2000 -- a **20% cut** in 2000 alone.

- Medicare spending per person is already projected to grow at roughly the same rate as private sector health spending. So with a cut this large, both beneficiaries and providers will be forced to shoulder huge burdens.

  - If all the savings come from providers, in 2002 alone a 25 percent reduction in Medicare payments to hospitals, physicians and all other providers would be needed. This would cause serious financial distress to the nation's medical system, which would still bear the growing burden of uncompensated care. Many providers could no longer afford to see Medicare patients. Those that do, would have to shift costs to businesses.

  - If providers are protected, a staggering financial burden would be shifted to elderly and disabled beneficiaries. In 2002, beneficiaries would have to pay $3,640 more for Medicare, a 290% increase over the premiums they pay today.

No. 665

ISSUE BRIEF

NATIONAL HEALTH POLICY FORUM

Options for Reducing the Growth of Medicare and Medicaid Spending

KLEIN

Friday, March 24, 1995
9:00 to 9:30 am - Continental Breakfast
9:30 to 11:30 am - Discussion
B-369 Rayburn House Office Building
Capitol Hill

A discussion featuring

Richard Kogan
Senior Fellow
Center on Budget and Policy Priorities

John Liu
Policy Analyst
The Heritage Foundation

Gail Wilensky, Ph.D.
Senior Fellow
Project HOPE

Registration: Please call **Dagny Canard at 202/872-1392** as soon as possible.

The George Washington University
WASHINGTON DC

Options for Reducing the Growth of Medicare and Medicaid Spending

Current efforts to balance the federal budget and engineer a tax reduction are forcing policymakers to consider reducing the anticipated growth of the nation's major health care entitlement programs by hundreds of billions of dollars over the next several years.

In a February 27 speech, Senate Finance Committee Chairman Bob Packwood (R-Ore.) said that, to balance the budget by 2002, the Medicare and Medicaid programs would have to be restructured and their growth reduced by about $400 billion over the next seven years. Senate Majority Leader Bob Dole (R-Kans.) was quoted in the February 16 *Wall Street Journal* as saying that, over the next five years, Medicare spending would have to be restrained by $146 billion and Medicaid by $75 billion. In contrast, the President's budget is virtually silent on proposals to restructure the two programs and to reduce their projected spending increases.

The Congressional Budget Office (CBO) projects that the federal government will spend $208 billion on Medicare and $101 billion on Medicaid in 1996; by the year 2000, CBO projects Medicare spending will rise to $301 billion and Medicaid spending to $150 billion. Over the five-year period ending with the year 2000, CBO projects that the annual rate of increase in Medicare spending will range from 9.4 percent to 11.1 percent and the annual rate of increase in Medicaid spending will range from 9.8 percent to 11.1 percent. Over the same period, CBO projects that the annual rate of increase in private health insurance costs will range from 6.9 percent to 7.7 percent.

Discussions about restraining the growth of Medicare and Medicaid expenditures lead to several possibilities, including increasing costs to beneficiaries, reducing benefits, cutting provider rates, restructuring the programs, accelerating the shift to managed care, and changing the nature of entitlement. One proposal under discussion, for example, would convert Medicaid from an entitlement based on categorical requirements into blocks grants that would give states more flexibility on deciding which people might qualify for benefits. On the Medicare side of the ledger, one proposal would give beneficiaries vouchers worth a fixed amount and would offer them a choice of plans, thereby giving seniors a financial incentive to choose the most efficient option. However, such a proposal also might leave some people in financial jeopardy if the cost of health care grew faster than the value of their Medicare vouchers.

In order to provide policymakers with estimates of how much various measures might save in federal spending, CBO each year publishes a report entitled *Reducing the Deficit: Spending and Revenue Options.* CBO analysts caution that the budgetary impacts described in the report are illustrative in nature because they are not based on detailed legislative proposals; estimates of specific proposals could differ. Also, the report analyzes each policy change in isolation and does not account for the possible interactive effects that might result by implementing more than one change. Notwithstanding these caveats, the CBO document is useful in grappling with how much might be saved in federal spending if various changes to the Medicare and Medicaid programs were implemented. The chart presented on the following page is excerpted from the 1995 report on spending and revenue options and summarizes some of CBO's analysis of possible changes to the Medicare and Medicaid programs.

ISSUE BRIEF/No. 665

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NHPF is a nonpartisan education and information exchange for federal health policymakers.

1995 CBO ESTIMATES OF FEDERAL SPENDING REDUCTIONS RESULTING FROM VARIOUS CHANGES IN THE MEDICARE AND MEDICAID PROGRAMS*

(in billions of dollars)

Policy Change	1996 Savings	Cumulative 5-Year Savings through 2000
Reduce the 50 percent floor on the federal share of Medicaid, AFDC, foster care, and adoption assistance payments to a 45 percent floor	5.3	32.5
Make capitation payments to the states for Medicaid services ("Payments to each state would be based on its per capita spending in 1995 for all Medicaid services except long-term care [but would exclude payments to disproportionate share hospitals]. The 1995 per capita amounts would be indexed by the rate of growth of gross domestic product per capita.")	1.0	17.5
Freeze Medicare's prospective payment system rates for one year	1.0	6.6
Eliminate the disproportionate share adjustment for hospitals in Medicare's prospective payment system	3.7	22.4
Reduce Medicare's payments for the indirect costs of patient care related to hospitals' teaching programs to 3.0 percent from the approximately 7.7 percent now paid for each 0.1 percent increase in a hospital's ratio of full-time interns and residents to its number of beds	2.6	16.5
Reduce Medicare's direct payments for medical education	0.65	3.8
Increase Medicare's deductible for physicians' services from $100/year to $150/year on January 1, 1996, and subsequently index the deductible to the rate of growth of Medicare Supplementary Medical Insurance charges per enrollee	0.64	8.3
Increase the coinsurance rate for physicians' services under Medicare to 25 percent from 20 percent	1.4	12.4
Collect 20 percent coinsurance on clinical laboratory services under Medicare	0.51	4.4
Collect 20 percent coinsurance on all home health and skilled nursing facility services under Medicare	2.6	23.9
Prohibit medigap policies from covering any portion of the first $1,500 of an enrollee's copayment liabilities per year	4.2	34.9
Increase the premium for physicians' services under Medicare to 30 percent of program costs	2.7	26.3
Relate the premium for physicians' services under Medicare to enrollees' income		
Option one	0.96	13.9
Option two	0.63	11.8
Modify the process for updating physicians' fees under the Medicare fee schedule	0.41	6.6

*Excerpted from the 1995 CBO report, *Reducing the Deficit: Spending and Revenue Options.*

THE FORUM SESSION

During this session, speakers have been asked to outline options for reducing the rate of growth of the cost of the major health care entitlement programs. Among the questions to be addressed are the following:

- How much can the programs' growth rates be reduced and what policy changes would be needed to reach various budgetary targets? Given the levels of spending desired, what might be the impact on beneficiaries, providers, and others involved in the health care system?
- Given current law and administrative structures, how much control can the federal government actually exert in restraining spending?
- In the short term, what are the options for achieving major reductions in the growth of spending?
- What long-term structural changes need to be made?
- To what degree can the health care system and its various components absorb a lower rate of federal spending? At what point might lower spending levels begin to have adverse effects?

Speakers

Gail Wilensky, Ph.D., is a health economist and a national expert on health care reform issues. Before joining Project HOPE as a senior fellow in 1993, she served as White House advisor on health and welfare issues, coordinating the development of President Bush's health care reform legislation. As administrator of the Health Care Financing Administration from 1990 to 1992, she implemented Medicaid financing reforms as well as reforms of the Medicare payment systems for physician services and hospital capital costs.

Richard Kogan recently joined the Center on Budget and Policy Priorities as a senior fellow. Previously, he was a member of the staff of the House Budget Committee for almost 17 years. He specialized in aggregate analysis of spending trends, in budget accounting and scorekeeping concepts, and in the congressional and executive budget process. He helped draft Gramm-Rudman-Hollings I and II and drafted most of the Budget Enforcement Act of 1990.

John Liu analyzes federal health care legislation at the Heritage Foundation. From 1993 to 1994, he served as legislative counsel to Rep. Cliff Stearns (R-Fla.); before that he held a similar position in the office of Rep. Bill Lowery (R-Cal.). He also has worked on the staffs of Sens. John Seymour (R-Cal.) and Robert Kasten (R-Wis.). He received his J.D. degree from Tulane University School of Law in 1990.

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CAROL H RASCO
ASSISTANT TO THE PRESIDENT FOR
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THE WHITE HOUSE
WASHINGTON DC 20500

MEDICAID PROTECTIONS FOR DISABLED AND CHRONICALLY ILL PEOPLE

BACKGROUND

--Medicaid is a State/Federal program in which States receive Federal matching payments for health care services to certain poor people, so long as the State meets certain Federal requirements.

--Medicaid is the largest payor for AIDS health services in the Nation.

40% of all AIDS patients become Medicaid beneficiaries and probably a much larger proportion of the women and children with AIDS.

This number will rise as AIDS becomes a disease of more and more poor people.

AIDS spending will equal $1.8 billion in Federal matching funds in 1996, matching about $1.7 billion in State funds, for a total of $3.5 billion on AIDS care alone.

This number is rising as the epidemic spreads and as health care costs in general rise.

AIDS is a small part of the overall Medicaid budget, but Medicaid is a very important part of AIDS health care.

--In addition, Medicaid is probably the largest payor for all disabled children (AIDS and non-AIDS) and is certainly the largest payor for all poor pregnant women and non-disabled children.

WAIVERS UNDER CURRENT LAW (so-called "Eleven-Fifteen Waivers")

--Using current authority in the Medicaid law, States are being granted waivers of Federal limits and protections.

These waivers may allow States to restrict the types of health care that a Medicaid patient may receive, may limit the choice of health providers, or may even eliminate the ability of a patient to get some prescription drugs or treatments.

--These waivers are worth billions of dollars, and have become very political between the Federal government and the Governors, and between the Clinton Administration and the Congress.

CONGRESSIONAL PROPOSALS TO CHANGE THE LAW

--The Congress will soon be debate legislation to make enormous changes in the Medicaid program. Proposals include:

- a cap on Federal Medicaid spending (eliminating the guarantee that Federal funds will match State funds), effectively starving the program as medical costs rise.

- making Medicaid a block grant to the States (to allow States to run medical care for the poor however they see fit, with no basic guarantees for all Americans).

- requiring that all Medicaid beneficiaries be enrolled in managed care plans that are for poor people only.

--The basis for these legislative proposals is political (to turn power back to the States) and budgetary (to make large cuts in health care for the poor without making it immediately visible what is going on).

--Some form of this legislation will almost certainly pass.

OUR REQUEST

--First, thanks. The President's Budget for 1996 did not cut Medicaid, and that's a very good start to this fight.

--Second, the Clinton Administration should fight hard against substantial cuts in Medicaid. We'll all probably lose eventually, but it's worth the fight.

> This is especially true for women and kids. The other major Medicaid beneficiaries (the elderly and the nursing home industry) usually defend themselves well in political fights, so big cuts in Medicaid will probably come at the expense of women and kids.

--Third, the Clinton Administration should establish some form of minimum safeguards for health care for all disabled and chronically ill people in Medicaid.

> For example, such safeguards could include such things as assurance that an HMO has a qualified doctor for AIDS care or that a State will pay for substitute drugs if a child is allergic to the cheapest ones.

--Once developed, these safeguards should be applied under current law to the review and approval of all 1115 waivers.

--These safeguards should be part of any Medicaid legislation that the Administration agrees to.

--These safeguards should be developed quickly.

> 1115 waivers are already submitted to the Secretary of HHS and are being reviewed now.
>
> Congress will be moving immediately to put together legislation.
>
> Advocates for disabled Americans will need some time to work on these issues.

--These safeguards should be developed in consultation with the National AIDS Policy Director (Patsy Fleming), with the Pediatric AIDS Foundation, and with the Kaiser Family Foundation's Medicaid Commission.

MEDICARE AND MEDICAID SPENDING SLOWS UNDER THE CLINTON ADMINISTRATION

The Administration expects future costs of the Medicare and Medicaid programs to be significantly lower than projected just two years ago. The new price tag for these programs will cost $212 billion less for the years 1994 to 1998. The combined rates of growth for these programs will drop below the double digit level for the first time since 1988. The anticipated annual rate of growth for the two health programs combined fell from 12.7 percent a year to 9.5 percent.

Under the Clinton Administration, projected spending has dropped by $79 billion for Medicare and $133 billion for Medicaid. In fact, the growth rate for Medicaid spending is expected to slow from 13.9 percent per year to 8.7 percent. The anticipated growth rate in Medicare is reduced from an 11.9 percent rate of growth on average to 9.9 percent for the years 1994 to 1998.

The President's successful economic program which curbed both general and health care inflation provided the foundation for the improved future spending path.

- In the President's FY 96 Budget, announced today, the main contribution to lower Medicare spending is slower growth in Hospital Insurance (Part A) spending driven primarily by a decline in forecasted hospital cost inflation.

- Lower estimates for Medicaid spending stem from the successful implementation of a 1991 law to limit States' use of inappropriate financing mechanisms (the bipartisan Provider Taxes and Donation Law), lower actual State spending, improved economic conditions, and fewer Supplemental Security Income (SSI) recipients.

Combined with steps to improve efficiency in program administration, the Administration expects to maintain the new spending path.

In addition, the Clinton Administration has improved management of the Medicare and Medicaid programs by redoubling efforts to fight fraud and abuse, replacing contractors who performed poorly in accurately paying Medicare bills, promoting state flexibility through the Medicaid waiver program, and offering increased choice for Medicare beneficiaries. These endeavors will help to improve program efficiency and improve services to beneficiaries.

While we are encouraged by the Medicare and Medicaid spending reductions that have been achieved in the last two years, health care costs for both private and public payers alike are still growing too quickly. We intend to work with the Congress in the years ahead to find ways that would strengthen the programs for beneficiaries by improving both service and cost-effectiveness.

MEDICARE AND MEDICAID SPENDING SLOWS UNDER CLINTON ADMINISTRATION

Overview

- The President's deficit reduction package and economic program, combined with improved efficiency in Program administration, have resulted in a significant reduction in the projected baseline growth in Medicare and Medicaid spending. Under the Clinton Administration, projected spending on Medicare and Medicaid has dropped by more than $200 billion, and the projected average annual growth rate has slowed by 3 percentage points for the years 1994 through 1998.

- Health care cost growth continues to be a problem for both public and private payers, and more needs to be done to address these problems in the context of health care reform.

Lower Projected Growth

Medicare

- For Medicare, projections of the average annual rate of growth for FY 1994 to FY 1998 were lowered from 12 percent in the January 1993 baseline to 10 percent in the FY 96 President's Budget.

- The Medicare program has benefitted from the success of the Clinton economic program which has produced a slowdown in both general and health care inflation in the economy.

- In the FY 96 President's Budget, the primary contribution to lower Medicare projections is slower growth in Hospital Insurance (Part A) expenditures. The slower projected HI growth results primarily from a decline in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.

- The reduction in projected Medicare spending growth has occurred despite the fact that projected Medicare enrollment is higher than assumed in the January 1993 baseline. Over the 1994 to 1998 period, we anticipate that on average we will cover almost 700 thousand additional beneficiaries each year compared to the January 1993 baseline. The reason we are able to cover additional beneficiaries and still have lower projected spending is that growth in projected per capita spending has been reduced by 2.5 percentage points.

Medicaid

- For Medicaid, projections of the average annual rate of growth for FY 1994 to 1998 were lowered from 14 percent in the January 1993 baseline to 9 percent in the FY 1996 President's Budget.

- Recent trends indicate that 1992 may have been a turning point in the Medicaid program. Federal Medicaid expenditures grew more than twice the average rate from 1988 through 1992 compared with the growth from 1984 to 1988. Average annual growth from 1984 to 1988 was 10 percent, compared to 22 percent from 1988 to 1992.

  - The jump in the Medicaid growth rate from 1988 to 1992 can be attributed to many factors including Congressionally mandated eligibility expansions and the states use of creative financing mechanisms to increase Federal payments.

- The drop in projected Medicaid spending is attributable to several factors:

  - Similar to the Medicare program, Medicaid has benefitted from both the success of the Clinton economic program.

  - Lower projections of Medicaid spending also stem from lower actual State spending, improved economic conditions, slower projected growth in provider cost inflation, and slower projected growth of the population receiving Supplemental Security Income benefits.

  - The bi-partisan passage of the 1991 Provider Taxes and Donation Law and the successful implementation of its regulations have had a significant effect on the growth of Medicaid Disproportionate Share Hospital payments as well as limiting states' use of creative financing mechanism to increase Federal payments.

<u>Improving Program Management, Increasing Efficiency, and Increasing State Flexibility</u>

Medicare

- The Clinton Administration has made strides toward improved management of the Medicare and Medicaid programs. These items should help to improve program efficiency and potentially keep spending on a slower growth track. For example:

- Five underperforming Medicare contractors have been replaced in the past two years. Contractors administer the program on the state level. Strict HCFA oversight of the remaining Medicare contractors has resulted in more efficient provider payments.

- Increased efforts by HCFA to combat fraud and abuse have been successful in making sure that tax dollars are used for medically necessary beneficiary care. In 1994, HHS's Office of the Inspector General (OIG) recovered over $400 million through settlements. For example, a coordinated effort between OIG and several other Federal and State agencies yielded the largest health care fraud settlement ever to the Federal Government. Also, in 1994, the OIG successfully prosecuted 1,169 fraud and abuse cases, and imposed 1,334 administrative sanctions on Medicare and Medicaid health care providers who were caught abusing the system.

- As with the private sector, more and more Medicare beneficiaries are choosing managed care health plans.

  - Building on what we have already done, HCFA is working on ways to increase the number and types of managed care options available to Medicare beneficiaries. Although we do not expect federal budgetary savings in the short run, our immediate objective is expanded choice. Managed care options offer many benefits to enrollees, including reduced beneficiary cost sharing and coordination of care across an array of providers.

  - To help ensure that the growth in Medicare managed care produces savings, we have undertaken several research projects to improve our payment methodologies and risk adjustors.

  - HCFA is also working closely with the managed care industry to develop new standards for quality assurance and public accountability that will further help beneficiaries make informed choices.

Medicaid

- Many States, with encouragement and support from our Administration, are requesting waivers to restructure their Medicaid programs. This Administration has approved Statewide health reform demonstration programs in Florida, Hawaii, Kentucky, Ohio, Oregon, Rhode Island, and Tennessee. These States are reforming their Medicaid programs by incorporating managed care concepts, redirecting payments to hospitals for uncompensated care, and consolidating State

health programs. States are expected to use the projected savings to expand coverage to previously uninsured populations. In fact, 530 thousand previously uninsured individuals have already been covered in the States operating demonstrations.

****

- While we are encouraged by the Medicare and Medicaid spending reductions that have been achieved in the last two years, health care costs for both private and public payers alike are still growing too quickly. We intend to work with the Congress in the years ahead to find ways that would strengthen the programs for beneficiaries by improving both service and cost-effectiveness.

Jan-Fy

DRAFT

Medicare Cost-Containment and Cost-Shifting I

CBO and Cost-Shifting

During the health reform legislative process, CBO decided to include the impacts of cost-shifting from Medicare price reductions.[1] For a health reform proposal financed through Medicare price reductions, CBO would assume that 25% of the Medicare reductions are "cost-shifted" on to private payers. If one accepts CBO arguments, this shifting raises private insurance premiums by 25%. Increased private insurance premiums require additional federal subsidies to help cover individuals eligible for subsidies. Thus, other things being equal, a $100 Medicare price reduction will result in a $25 increase in private premiums. Since many employers pay some or all of their employee's health insurance premiums, increased premiums translate into lower wages which, in turn, result in lower federal tax revenues. Although we are not privy to CBO's estimation process, based on a 25 % cost-shift we estimate that a $100 Medicare price reduction translates into roughly $8 of lost federal tax revenue.

The implications of the decision are broader than health reform if CBO scores any Medicare price reduction as having a negative revenue impact. Informal communication with CBO suggests that they may not score cost-shifting impacts if Medicare reductions are proposed as part of a "normal" deficit reduction package (although no logical argument is offered).

Inconsistencies in CBO's Scoring Approach

- CBO scores cost-shifting impacts for hospital and physician price reductions only.

- It stands to reason that a threshold effect might govern cost-shifting--is there some dollar amount that triggers cost-shifting? CBO scores cost-shifting with no threshold effect. CBO would likely acknowledge a threshold effect, but assert that their 25% assumption accounts for both the threshold and the rate.

- If there is a threshold effect, logic dictates that it should be proportional to revenue and provider specific. In scoring cost-shifting impacts, CBO should be able to offer some evidence that providers cost-shift when some proportion of their revenues are threatened. Moreover, hospital price reductions should not trigger physician cost-shifting, and vice-versa.

- To our knowledge, only Medicare price reductions have been treated as having cost-shifting effects. Presumably, any federal reduction in Medicaid spending that could be interpreted as a price reduction could also cost-shifting impacts. For

[1] An example of a Medicare price reduction is to reduce the hospital market basket index used to update Medicare payments to hospitals under PPS or to lower the Medicare economic index used to update Medicare physician fees. In contrast, the decision to impose copayments on beneficiaries for certain services would not be considered a price reduction.

example, how would CBO score a cap on federal Medicaid payments? The implications of federal Medicaid cost-containment efforts may need to be pursued with CBO as well.

• Finally, providers supposedly cost-shift to recapture revenues lost from caring for the uninsured and revenues lost from public insurers paying less than costs. Thus CBO must also assume reductions in private premiums for many health reform proposal that results in increases in the number of uninsured. We need to more fully explore CBO's assumptions regarding increases in the number of uninsured.

Comments on CBO Cost-Shifting Assumption.

Most of the cost-shifting research pertains to hospitals, is dated (i.e., data from the early 1980s), and has produced mixed results. To the extent cost-shifting is found, this research estimates the shift to be very incomplete.[2]

The research ignores fundamental changes in the private insurance market over the last five years. Private insurers have become much more cost conscious, thereby reducing the opportunity to cost-shift. For example, as of 1992, 54% of the population with private insurance was enrolled in managed care plans.[3] The percentage of traditional, fee-for-service insurance plans with some form of utilization review has increased from 41% in 1987 to 95% in 1990.[4]

There is considerable evidence that hospitals deliver care inefficiently, [5] and the most recent research indicates that hospitals subject to fiscal pressure respond by controlling cost per case rather than by cost-shifting.[6]

Given the individual physician's smaller market power and given that, as of 1993, 75% of physicians participated in private managed care plans,[7] the opportunities for physicians to cost-shift appear limited. Moreover, the Physician Payment Review

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[2]Zuckermann, S. "Commercial Insurers and All-payer Regulation: Evidence on Hospitals' Responses to Financial Need," Journal of Health Economics, 1987: 165.

[3]Employee Benefits Research Institute. 1994. The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence. EBRI Issue Brief No. 154, October 1994.

[4]Hoy, E.W., R.E. Curtis, and T. Rice. 1991. "Change and Growth in Managed Care," Health Affairs, 10 (Winter): 18-36.

[5]See for example Chassin, M.R. et al., (1987) "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures" JAMA 258(18): 2533-7

[6]Hadley,J.,S Zuckerman, and L. Iezzoni. 1994. "Hospitals' Responses to Fiancial Pressure" (manuscript under review at Medical Care).

[7]Iglehart, J. 1994. "Health Policy Report--Physicians and the Growth of Managed Care," New England Journal of Medicine, 331 (October 27, 1994): 1167-1171.

Commission staff reported in the September 1994 meeting that private payer visit fees are moving closer to Medicare visit fee levels, again suggesting limited opportunities to cost-shift.

Finally, both CBO and the HCFA Office of the Actuary assume volume responses to Medicare price reductions. For example, physicians are assumed to recover 50% of any Medicare price reduction through increases in service volume. Given the weak evidence for cost-shifting, it seems excessive to assume both a volume offset within Medicare and that providers pass-on 25% of the reduction to private payers.

Taken together, we believe that the empirical evidence does not support CBO's assumption of cost-shifting. If hospitals have engaged in cost-shifting in the past they have done so as much to maximize operating margins as to survive. Changes in the insurance market make it unlikely they will be able to cost shift in the future. Indeed a report sponsored by the American Hospital Association[8] concludes that opportunities to cost-shift are past. There is no sound empirical analyses suggesting that physicians cost-shift, and the available evidence suggests they do not.

[8]Lewin-VHI, Inc (1994) "Analysis of Medicare PPS Operating Margins Under the Ways and Means Committee Health Care Reform Proposal", Prepared for American Hospital Association.

DRAFT

Medicare Cost-Containment and Cost-Shifting II

Congressional Budget Office (CBO)

- In a 1994 report, entitled "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift?," CBO argues that hospitals cost-shift and projects that further attempts to control public-sector spending would probably produce additional cost-shifting to the private sector.

- CBO presents data comparing sources of revenue to costs, and demonstrates that government programs are underpaying hospitals. In contrast, private payers are paying well above cost.[1] (Based on 1991 data)

Payment Source	Payment to Cost Ratio
Medicare	0.88
Medicaid	0.82
Other Gov't Payers	1.00
Uncompensated Care	n.a.
Private Insurers	1.30

- CBO notes that patients treated by facilities that were least able to cost-shift -- because of patient mix or market conditions -- could be adversely affected. For example, hospitals with a large share of uninsured or publicly insured patients might be less able to cover their unreimbursed costs, both because those costs are a larger share of their total costs and because they have a smaller pool of privately insured patients.

Prospective Payment Commission (ProPAC)

- In its June 1994 report, ProPAC asserts that hospital cost-shift to compensate for the losses they incur on one set of patients by increasing revenues received from others.

- ProPAC notes that between 1980 and 1992, gains from private payers as a percentage of costs almost exactly matched total losses from Medicare, Medicaid and other government programs.

- ProPAC claims that the variance in payment to cost ratios is evidence of cost-shifting (using 1992 data)[2]:

DRAFT

Payment Source	Payment to Cost Ratio
Medicare	0.89
Medicaid	0.91
Other Gov't Payers	0.98
Uncompensated Care	0.19
Private Insurers	1.31

Lewin-VHI

- In its "Analysis of Medicare PPS Operating Margins Under the Ways and Means Committee Health Care Reform Proposal," Lewin-VHI finds that hospitals have historically offset Medicare losses by increasing the amounts they charge to private payers. However, the report points out that as purchasers of care become more price sensitive and a growing number of patients are enrolled in managed care plans, hospitals will encounter increasing difficulty in cost-shifting to private payers.

Endnotes

1. The use of cost-per-case as the metric for judging the adequacy of payment is questionable. Reported hospital costs are not necessarily justified and may reflect inefficient service delivery.

2. Upon closer examination however, the data suggests an inconsistency in ProPAC's argument. Despite the fact that between 1990 and 1993 Medicare's payment-to-cost ratio was relatively constant and Medicaid's ratio actually increased substantially, the private payer payment-to-cost ratio increased 3 percent.

6743/

JEN – FYI

February 14, 1995

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

DRAFT

Please route to:	Alice Rivlin	Decision needed ____ Please sign ____ Per your request ____ Please comment For your information X
Through:	Nancy-Ann Min Barry Clendenin BC Mark Miller MM	
Subject:	Medicare Managed Care	
From:	Anne Mutti AM	With informational copies for: HD Chron, HFB Chron Phone: 202/395-7815 Fax: 202/395-3910 Room: #7002

This memorandum responds to your request for further information on Medicare managed care, and updates earlier memoranda following the discussion in Director's Review. Managed care has been cited as an example of private sector innovation that ought to guide reform of the Medicare program. This memorandum discusses the current managed care environment, the flaws of the current managed care options, and alternatives to improve the managed care option.

Current Managed Care Environment

Private Sector. The private sector has experienced recent declines in the cost of health care, largely due to the growth of managed care enrollment.

- According to the Group Health Association of America, managed care enrollment is growing at an annual rate of about 11 percent and reached 50 million at the end of 1994. GHAA reports (12/94) that managed care plan premiums declined 1.2 percent in the last year.

- According to a recent Foster Higgins report (2/95), employers with at least 10 workers experienced a 1.1 percent decline in medical costs, largely attributable to the growth in managed care enrollment. Foster Higgins estimates that managed care enrollment among employees is 63 percent as compared to 52

percent the year before.

- According to a recent Towers Perrin report (2/95), the growth in under-65 retiree health care plan premiums has slowed to 3 percent from 9 percent last year.

- In a forthcoming report, CBO is expected to increase its estimate of the one-time reduction in utilization resulting from enrollment in managed care (from 3.9 percent to about 8-9 percent).

Among the fastest growing managed care options are preferred provider organizations (PPOs) and point of service (POS) plans, which encourage enrollees to receive care from a predetermined network of providers, but provide enrollees some coverage if they receive care out of network. According to the Employee Benefits Research Institute, the percentage distribution of individuals with private insurance in 1988 and 1992 was:

	1988	1992
HMO	17.3%	20.6%
PPO	10.1%	32.1%
POS	0.3%	32.1%
Indemnity	72.6%	46.1%

Medicare. Given these private sector trends, Republican Members have suggested that the current Medicare program is a relic of 1960s medicine. Medicare expenditure growth continues to far out-pace general inflation with a 9.1 percent annual growth rate. Only 6 percent of Medicare beneficiaries are enrolled in risk contract HMO plans that are paid on a capitated basis (the traditional type of HMO arrangement). An additional 3 percent are enrolled in HMOs, but have their care reimbursed on a fee-for-service basis. While the number of new risk plans increased by 20 percent and newly enrolled beneficiaries by 16 percent in the last year, this growth is off a small base.

There are several types of managed care arrangements available to Medicare beneficiaries. An important difference to note is that risk contract HMOs provide the standard Medicare benefit package and supplemental coverage, while the Medicare SELECT program only provides supplemental coverage (beyond Medicare benefits), known as Medigap.

- Medicare SELECT -- This program was established in OBRA 1990 as a 3-year demonstration project in fifteen states. The project now provides some 400,000 Medicare beneficiaries with a Medigap option that requires they receive Medigap benefits from a designated network of providers at lower premiums than comparable fee-for-service products. In addition, utilization for all health

services (including the Medicare benefits) was expected to decline as beneficiaries in SELECT plans received coordinated care from managed care providers. The project was to expire last December, but was extended to the end of June 1995 at the close of the 103rd Congress.

- Risk contracts - Providers contract with Medicare to provide the full range of Medicare benefits at a capitated payment amount that is 95 percent of the cost of fee-for-service. Beneficiaries also receive coverage for the Medicare cost-sharing requirements under these plans. Depending on the plan, the beneficiary may pay a premium for these and other additional benefits.

- Cost contracts - Two types of cost contracts are available. Managed care organizations may contract with Medicare to provide the full range of Medicare benefits, and be reimbursed on a fee-for-service basis. Alternatively, organizations may contract with Medicare to provide a subset of Part B services only. These plans have the option of providing supplemental benefits.

Managed Care Options Currently Fail to Save Medicare Money

Given the current Medicare HMO payment methodologies and HMOs' ability to engage in favorable selection, increasing managed care enrollment among Medicare beneficiaries will not yield Medicare savings. Consequently, even though CBO believes managed care lowers use, it does not score savings for Medicare managed care. Consider the following characteristics of each managed care option:

- Medicare Select: When first proposed, it was expected that Medicare Select would result in Medicare savings because beneficiaries would have their utilization reduced as a result of coordinated care by PPOs. A preliminary evaluation by HCFA of SELECT reveals that because SELECT plans are achieving savings primarily through discounts, rather than managing care, there are no savings to Medicare. In fact, there is some concern that if Part B services are permitted to be discounted, volume, and therefore the cost to Medicare, might increase.

- Risk Contracts. Due to a flawed payment methodology, Medicare overpays risk HMOs. To briefly review the methodology, Medicare pays a capitated amount to HMOs that is calculated as 95% of the cost of providing care to fee-for-service beneficiaries. The amount is adjusted by geographic location and by other demographic factors of each beneficiary (age, gender, institutional status and Medicaid eligibility) to derive the Average Adjusted Per Capita Cost (AAPCC).

  If the plan provides Medicare-required benefits for less than the AAPCC, it must either provide additional benefits or reduce the premium for

beneficiaries. Therefore, the plans and beneficiaries benefit, but the Medicare program does not share in the savings. In addition, research has also shown that Medicare HMOs attract a healthier than average Medicare population. Because the AAPCC is does not adequately risk adjust, HMOs have an incentive to enroll less costly beneficiaries. A Mathematica study estimated that Medicare pays 5.7% more for beneficiaries in managed care than it would have if they remained in the fee-for-service sector.

- Cost contracts. HMOs have the ability, unlike hospitals, to choose whether to be paid under a prospective payment arrangement or reasonable cost basis. The cost contract includes no incentives for cost containment and potentially results in Medicare double-paying as beneficiaries are covered for care they receive out-of-plan.

Proposals to Strengthen Managed Care Options for Medicare Beneficiaries

HCFA has sent OMB a range of legislative proposals aimed at improving managed care options for Medicare beneficiaries. To a varying extent, depending on the proposal, HFB staff have a sense of Republican Members' positions. The highlights of the preliminary proposals are discussed below.

HCFA is now finalizing its legislative proposals for OMB review. The timing for legislative action on these proposals is unclear. The fact that Medicare SELECT expires June 30, 1995 may force some action. Alternatively, legislation may be considered in the context of Reconciliation. It is also unclear if legislation extending Medicare SELECT would be considered separately from other Medicare reforms or as part of a larger package.

1. Expand Medicare SELECT

HCFA position: In recent testimony, HCFA Administrator Vladeck expressed Administration support for an additional 6-month extension of Medicare SELECT to allow for further study and reform. He has reservations about the quality and lack of coordinated care provided by SELECT contractors. He argues that 1) Medicare SELECT providers do not adhere to the same quality and access regulations as risk and cost contractors and 2) SELECT contractors are controlling costs by obtaining price discounts from participating providers rather than managing care.

Republican Members' position: Rep. Nancy Johnson, with strong Republican and bipartisan support, is pressing for the permanent extension of the program to all states. She argues that SELECT provides beneficiaries greater choice and lower Medigap premiums at no cost to the Medicare program. (Currently, Rep. Johnson's legislation prohibits discounting of Part B services.) In addition, beneficiaries register few complaints with the program. Efforts to thwart her bill are portrayed as anti-

managed care and threatening to the Medicare SELECT industry.

2. Improving Payment Methodology for Risk Contracts

HCFA position: HCFA has a two pronged approach to improve the risk contract payment methodology. First, HCFA sponsors research projects aimed at better risk adjusters. HCFA staff believe implementation is several years away, however.

Second, HCFA has recently expressed interest in conducting a budget-neutral competitive pricing demonstration, in which Medicare payment rates would be established based on bids by plans in selected geographic areas. While not specified, Medicare payment could be linked to the low bid; beneficiaries who opt for a higher bidding plan would pay an additional amount. Because mandatory participation is required for plans in the demonstration areas, this demonstration would need to be authorized in legislation.

Republican Members' position: While no relevant legislation has been introduced this Congress and few specifics have been offered, there is evidence that Republican Members may support competitive pricing. In the 103rd Congress, former Senator Durenberger (R-Minn) introduced the Medicare Choice Act that would implement competitive pricing nationwide for Medicare risk HMOs. His proposal would require HMOs to bid premiums below a cap tied to the AAPCC to determine the Medicare payment amount. Beneficiaries enrolling in low cost plans would receive a rebate while those enrolling in high cost plans would pay an additional amount.

3. Creation of a PPO Option

HCFA position: The Administrator is interested in creating a payment methodology that would encourage preferred provider organizations (PPOs) to serve the Medicare population. As currently proposed, PPOs would be paid on a fee-for-service basis, but be at partial risk if a target payment amount is exceeded. Beneficiaries could receive care out-of-network subject to a higher copay.

Republican Members' position: While encouraging the expansion of beneficiary choice, Republicans have not publicly supported the creation of a PPO Option.

4. Third-Party Open Enrollment for Medicare Managed Care and Medigap

HCFA position: HCFA supports conducting a coordinated open enrollment period annually for all Medicare managed care plans and Medigap. Several current policies that contribute to the problem of favorable selection would be corrected by this policy. First, with no independent, coordinated method of informing beneficiaries of their options, Medicare risk plans freely target marketing campaigns to healthy beneficiaries. Second, because beneficiaries may disenroll every 30 days, there is

some evidence that they leave risk plans when they become sick.

Republican position: This proposal was part of Sen. Durenberger's Medicare Choice Act and likely has engendered some Republican support.

5. Other Managed Care Reforms

HCFA has sent OMB several legislative proposals to improve beneficiary protections and increase the ability of beneficiaries to compare plans through a more regulatory approach. In addition, these proposals are designed to "level the playing field," allowing beneficiaries to better understand the choice between Medicare fee-for-service, Medicare Select, fee-for-service Medigap plans and Medicare HMOs. In summary, HCFA proposes:

- Community rating for all Medigap plans; Medigap plans are currently permitted to experience rate, while Medicare managed care plans must community rate. HCFA argues that price comparison of the two types of plans would be easier if they were under similar pricing constraints.

- Extending the current quality and access provisions for Medicare risk and cost plans to Medicare SELECT plans.

- Establishing a basic benefit package and limit copays for Medicare managed care plans and Medicare SELECT. This provision would allow beneficiaries to more easily compare competing plans and prevent plans from using high copays for certain services to deter high risk beneficiaries.

- Expanding authority to terminate HCFA contracts with managed care plans.

General HFB Staff Reactions

While HFB staff have not had sufficient time to review thoroughly each proposal, we would offer the following initial comments:

- Competitive Pricing offers a promising alternative to payment based on the AAPCC. Thought should be given to whether it should be implemented on a demonstration basis or nationally. It is unclear what whether the value of a demonstration outweighs the immediate savings that could result from national implementation. Alternatively, an demonstration designed to produce savings should be considered.

- Cost Contracts should be eliminated. They offer no mechanism to control costs and allow inefficient plans to draw Medicare funding. Risk plans are an adequate alternative for most HMOs.

- Coordinated Open Enrollment by a third party could substantially increase managed care enrollment, attract sicker beneficiaries, and ultimately diminish the favorable selection experienced by Medicare managed care plans. Simply making information available on the benefit package and premium cost could entice more beneficiaries into managed care.

- "Centers of Excellence" represent an innovative approach to achieving cost savings in the fee-for-service sector. This proposal, included in HCFA's legislative proposals would expand a current demonstration program which pays providers a bundled discounted payment to perform high-cost, high-volume procedures. In turn, selected facilities could expect higher volume as a result of being recognized as a "Center of Excellence." Several private sector managed care plans have similar arrangements.

- Preferred Provider Organization participation in the Medicare program would allow beneficiaries a greater choice of health plans and may attract sicker beneficiaries who particularly value coverage of out-of-plan services. However, the details of the payment methodology must be carefully reviewed given budgetary implications and the potential for distorting incentives in the marketplace.

Change in Federal Payments to States Under Medicaid Capped Payments
Capped Payments at 5%: 1996 - 2002
(Dollars in millions, fiscal years)

DRAFT

Range: Reductions (-) or Increases (+) in Federal Grant

	State Baseline Growth National Rates *	State Baseline Growth at State Projected Rates (93-96)*
US	(192,580)	(192,580)
Alabama	(2,293)	(768)
Alaska	(375)	187
Arizona	(2,164)	(3,012)
Arkansas	(1,449)	(241)
California	(21,646)	(6,915)
Colorado	(1,841)	609
Connecticut	(3,258)	(4,182)
Delaware	(414)	(710)
District of Columbia	(1,037)	(794)
Florida	(8,008)	(14,572)
Georgia	(4,482)	(6,142)
Hawaii	(651)	(1,002)
Idaho	(445)	(401)
Illinois	(7,339)	(4,490)
Indiana	(3,674)	1,516
Iowa	(1,496)	(1,176)
Kansas	(1,208)	952
Kentucky	(2,468)	(163)
Louisiana	(5,117)	(124)
Maine	(1,208)	(374)
Maryland	(3,315)	(5,746)
Massachusetts	(5,881)	(3,531)
Michigan	(6,554)	(5,304)
Minnesota	(3,425)	(4,528)
Mississippi	(1,800)	(1,404)
Missouri	(3,373)	(1,913)
Montana	(446)	(170)
Nebraska	(851)	(1,011)
Nevada	(529)	78
New Hampshire	(856)	(1,072)
New Jersey	(6,130)	1,700
New Mexico	(913)	(1,524)
New York	(31,123)	(77,036)
North Carolina	(4,602)	(8,129)
North Dakota	(352)	(7)
Ohio	(7,659)	(7,403)
Oklahoma	(1,364)	103
Oregon	(1,648)	(4,444)
Pennsylvania	(9,230)	709
Rhode Island	(1,027)	468
South Carolina	(2,658)	19
South Dakota	(408)	(485)
Tennessee	(4,413)	(2,495)
Texas	(11,394)	(19,398)
Utah	(717)	(726)
Vermont	(378)	(196)
Virginia	(2,605)	(1,528)
Washington	(3,626)	(4,092)
West Virginia	(1,552)	(348)
Wisconsin	(2,964)	(1,127)
Wyoming	(214)	(236)

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996

*Baseline expenditures are adjusted to sum to CBO total reductions.

DRAFT PRELIMINARY

Why safety net entitlements must not be converted into block grants

A number of proposals are being circulated that would transform key means-tested "entitlement" programs (food stamps, school lunches and other child nutrition programs, Medicaid, AFDC, and Foster Care and Adoption Assistance, among others) into block grants. **Such a transformation of these key safety net programs would do incalculable damage to America's children and families, states' finances, and the nation's future.**

These programs exist to make sure that eligible needy children are served; that emergencies can be responded to flexibly; and that the nation fulfills its commitment to children and families facing hard times. They are ill-suited to treatment as block grants.

Some of the proposals to consolidate groups of federal discretionary spending programs, if carefully crafted, could improve services for Americans and make government more efficient. **But block grants must not be used as a means to unravel the safety net for a number of fundamental reasons:**

1) **If safety net programs are funded as block grants, children and states will suffer when recessions or emergencies create increased demand for services or assistance.** The structure of the existing programs allows elasticity. The needs-based programs grow when need grows, as in recessions or after natural disasters like floods and earthquakes. Program participation then declines when need abates. If such programs are converted into block grants with capped funds, this stabilizing effect will be abandoned and states will have impossible choices during recessions and other emergencies: they will have to choose whether to turn away tens of thousands of needy applicants, many of them children, or to dramatically reduce benefits for everyone, or to pay for the rapid growth of the program out of their own declining revenues. Recessions could be prolonged and deepened in individual states, and therefore in the nation as a whole. Federal allocations would be misdirected -- states hard hit by recession would get no more funds while states with vibrant economies would get no less. Creating a block grant does not do away with the needs of children and families; it just leaves states with impossible choices in hard times.

2) **The block grant proposals would dismantle programs that have proven records of success in helping children and that were made into federal guarantees because children suffered when the federal government provided funds but no leadership.** The Food Stamp program, which has reduced hunger and malnutrition for millions of children, is one example of why federal leadership is essential. In the late 1960s, doctors working with HEW's "Ten State Nutrition Survey" found that low income children in some parts of the country

were suffering from nutritional deficiency diseases at rates comparable to children in underdeveloped countries. At that time, states were left to set their own income eligibility and benefit levels for food stamps, even though the program was 100% federally funded. Many states set very low limits, and some of the poorest counties in the nation declined to operate a program at all. The findings about child hunger shocked the nation, and led President Nixon to institute national food stamp standards. When doctors returned ten years later to the areas they had studied, they found hunger and malnutrition had been reduced dramatically, with the Food Stamp program a major reason for this progress. A block grant that abdicates federal leadership ignores these important lessons. And, if states failed to meet the need when the federal government footed the entire bill, the pressure to slash benefits for children would be even worse under a block grant that reduced federal funding and left states to pick up the slack.

3) **Without assurance that all who meet the standards in the law will obtain the benefits offered, there will be long waiting lists for equally needy families when funds run out.** The safety net programs promise that children can get subsistence benefits so long as they meet stringent legislatively-defined tests. Block grant proposals would do away with this commitment, giving states little choice but to turn children away without help when fixed funds run out, even though the children meet all the stringent standards for help and would have been helped the week or month before. Waiting lists are standard for low-income children's programs that are not entitlements. Even successful and popular programs like Head Start and WIC are typically so squeezed for funds that they only serve one half or fewer of the eligible children. The specter of long waiting lists for help with food, shelter or health care is not mere speculation; indeed, one central provision of the AFDC and Medicaid laws -- that aid shall be furnished "with reasonable promptness to all eligible individuals" -- was enacted precisely because many states used to have such waiting lists for subsistence benefits. Especially in programs for the nation's neediest children, people who meet program rules should not be denied help because they applied too late in the year after money ran out, or live in the wrong state or county, or face some other arbitrary barrier unrelated to their need or the program's purposes.

4) **History shows that federal block grants tend to shrink over time.** Whether because their purposes become diluted, or because it is hard to sustain federal funds for a program in which states make all the decisions, block grants tend to shrink. From 1982 to 1995, for example, the Community Services, Title XX Social Services, Preventive Health, and Chapter II Education block grants shrank 49%, 28%, 7% and 53%, respectively, in inflation-adjusted dollars. Similar shrinkage in the decade ahead in safety net entitlement programs would mean <u>millions of children</u> without food, clothing, shelter and health care, or <u>tens of billions of dollars</u> of costs shifted to the states, or both.

5) **While states need more discretion in a variety of areas and programs, certain basic needs of children should be met in every state and every community. Children in this nation should not be penalized based on where they live.** We are one nation with a common commitment to humane treatment of each other. Just as we have made and kept national promises to provide basic help to the elderly and veterans, we should keep our national promise to children. Whether a child's most basic subsistence or health needs are met must not depend on the state of her residence or the month of her destitution. Making sure that children are healthy and not hungry and not abused or neglected must be as much a national priority in Mississippi as in Minnesota, in New Mexico as in New York. When the federal government is providing one half or more of the funds, moreover, there is additional reason that states should be held accountable to these national commitments.

6) **While most states will act responsibly, not all will at all times.** Before federal standards were applied, state and local governments often denied aid to poor families because they were black or had Eastern European origins. While such denials would be far less common today, other forms of arbitrary decision-making persist, denying aid to penniless families and leaving children hungry, homeless, and without health care. When states had the option to extend Medicaid to children in <u>working</u> poor families as well as in welfare families, only about one third did so. And even though all evidence shows that denying AFDC to two-parent families fosters family dissolution (as well as leaving the children with no safety net benefits), half of the states had no two-parent AFDC program before Congress acted in 1988 to require it. Another example is child support enforcement: until federal standards took effect, many states did not allow children born out of wedlock to pursue support from their fathers, or put other major roadblocks in the way of child support enforcement.

7) **Investments in children often have payoffs that, because they are long-term, help the nation more than they help individual states, and therefore are harder to get states to make.** There are important pay-offs from preventive health care, sound nutrition, and services that strengthen families and protect children. But in fiscal terms, some of the savings are reaped 5, 10 and 20 years after the initial investment. States know that huge numbers of families move out of their jurisdictions over such a 5, 10 or 20 year period, reducing significantly the return to the states of their investment. It is the nation that gains the most from and must make the commitment to the investment. It is also the nation that loses the most if these investments are not made at adequate levels and to all children in need.

Why safety net entitlements must not be converted into block grants

Transforming certain key means-tested "entitlement" programs (food stamps, school lunches and other child nutrition programs, Medicaid, AFDC, and Foster Care and Adoption Assistance, among others) into block grants would do incalculable damage to America's children and families, states' finances, and the nation's future.

These entitlement programs exist to make sure that eligible children are served; that emergencies can be responded to flexibly; and that the nation fulfills its commitment to children and families facing hard times. They are ill-suited to treatment as block grants:

1) **If safety net programs are funded as block grants, children and states will suffer when recessions or emergencies create increased demand for services or assistance.** States will have to choose whether to turn away tens of thousands of needy applicants, many of them children, or to dramatically reduce benefits for everyone, or to pay billions of dollars for the rapid growth of the program out of their own declining revenues. Recessions could be prolonged and deepened in individual states.

2) **The block grant proposals would dismantle programs that have proven records of success in helping reduce hunger, malnutrition, infant mortality and ill health among children and that were made into federal guarantees because children suffered when the federal government provided funds but no leadership or standards.**

3) **Without assurance that all who meet the standards in the law will obtain the benefits of the program, there will be long waiting lists for equally needy families when funds run out.** Even successful and popular programs like Head Start and WIC, when not entitlements, are typically so squeezed for funds that they only serve one half or fewer of eligible children and have long waiting lists.

4) **History shows that block grants tend to shrink over time, since Congressional interest in them wanes.** From 1982 to 1995, for example, the Community Services, Title XX Social Services, Preventive Health and Chapter II Education block grants shrank 49%, 28%, 7% and 53%, respectively, in inflation-adjusted dollars.

5) **While states need more discretion in a variety of areas and programs, certain basic needs of children should be met in every state and every community. Children in this nation should not be penalized based on where they live.**

6) **While most states will act responsibly, not all will at all times.** Some states, for example, in the past have denied aid on the basis of race or national origin; others have denied aid in recent times to working poor families or two-parent families or have erected huge barriers to child support enforcement services for children born out of wedlock.

7) **Investments in children often have payoffs that, because they are long-term, help the nation more than they help individual states, and therefore are harder to get states to make.**

MEDICAID AND CHILDREN:
HOLDING THE LINE ON COVERAGE FOR CHILDREN

Medicaid's role in improving access to health care for low-income children has been profound. Now covering nearly 80% of poor pregnant women and children, it has guaranteed millions of children a healthy start. Because children from poor and moderate income working families have been losing employer-provided health insurance so rapidly, states have successfully targeted further expansions to near-poor children. Coverage of children is relatively cheap, so states have been able to do this despite growing cost pressures, but without the expected relief from national health reform, and with renewed interest in cutting entitlements, children now face the worst insurance crisis ever.

ACCESS: Medicaid is the single biggest publicly funded health program for children.

* Today, 19.6 million children are covered by Medicaid, more than one out of every four children.

* Medicaid covers 80% of poor pregnant women and children and one-quarter of children in families with income between 100% and 200% of poverty.

* By the year 2001, upon completion of phasing-in Medicaid eligibility for all children up to age 19 with income below the poverty level, an additional 1.8 million children will be covered by the program.

* Thirty-four states have opted to expand coverage of pregnant women and infants above 133% of poverty. Eighteen states have opted to expand coverage for children over age one (with three going as high as 200%, 225% and 300% of poverty for all children).

* Medicaid has made an enormous difference in securing health services for poor children. For example, among those who had a doctor visit during the year, poor Medicaid beneficiaries had twice as many visits as the uninsured poor. This represents essential utilization, not over-utilization.

COST: While Medicaid costs over the years have skyrocketed, children's coverage is not the primary cause of these increases.

* Despite the fact that children represent half of all Medicaid beneficiaries, **they consume less than one-quarter (22.7%) of the total spending**.

* Medicaid spends only 23 cents of every dollar on children, compared to 43 cents on care for adults ages 21-64, many of whom are disabled, and 34 cents for adults age 65 and older.

* Medicaid per capita costs for children are $1,285 per year compared to $5,095 per year for adults (which includes disabled adults).

* Expanded coverage for children is not the cause of rising Medicaid costs. According to a 1993 Kaiser Commission study, half of the 4.8 million new Medicaid enrollees from 1988 - 1991 were pregnant women and children, but the costs associated with covering these groups accounted for only 11 percent of the spending growth.

INSURANCE CRISIS: Pressure to cover the growing number of uninsured continues, and states are restructuring the Medicaid program to reform coverage of current beneficiaries while providing new coverage for others.

* Medicaid has filled the critical gap created by declining levels of private insurance. Employer-based coverage for children has been declining at the rate of one percent annually. If current trends are allowed to continue, less than half of the children will be covered by employer-based coverage by the year 2000.

* In 1993 there were 806,000 more children without private insurance than in 1992, representing the overwhelming majority -- 79% -- of the total number of newly uninsured.

OPPORTUNITIES FOR REFORM: Investing in children's health matters a great deal -- in health status, in access to services, and in reducing long-term and catastrophic costs. The Medicaid program has been the vehicle for insuring poor and near poor children. Given current trends, it is needed more than ever. Proposals to cut or cap federal spending on Medicaid would significantly erode children's access to health care by threatening current benefit levels (e.g., EPSDT) and eligibility.

Protecting children will require two strategies:

(1) **Maintaining current levels of coverage**:

* Opposing the Balanced Budget Amendment that could force as much as a 25% cut in domestic spending.

* Opposing any cuts in Medicaid specifically that will erode coverage for currently insured children or the

poverty-level children to be phased in over the next seven years, or significantly cut back the EPSDT benefit package for children.

(2) **Attaining incremental expansion of insurance for children through either:**

* Expanding Medicaid coverage to bring in, at a minimum, the six million uninsured children below 200% of poverty (essentially two-thirds of uninsured children), perhaps framing this as one step toward making sure all children are covered. Medicaid programs could purchase managed car or private insurance for the children.

* Expanding coverage to a targeted number of uninsured children with a system of subsidies to allow families to purchase health insurance coverage through the private market (through an organized system of care such as FEHBP or state employee benefit plans, for example).

Medicaid Block Grant Methods

1. **Overall Federal Fiscal Effects:**
This exercise uses the President's FY 1996 baseline. We estimated the savings resulting from various block grant options assuming introduction in FY 1996. All of the estimates come from OAct with two exceptions. Recipient growth projections and CPI projections end in the year 2000; we assumed that the growth rates in the outyears are the same as those in 2000.

Using these data, alternative growth rates for the Medicaid block were chosen and applied to FY 1996 expenditures to yield the proposals' expenditures and savings.

2. **Capped Payments to States: Potential Reductions**
These estimates were be calculated for specified years and for the combined period, 1996-2002. The 1996 to 2002 period was chosen for illustration since the Republican proposals have stated a set of savings estimates using this time period. For each period, the amount of savings that could be achieved from specified program reductions (e.g., eliminating certain services or eligibility categories) are shown. The estimates illustrate the magnitude of program reductions necessary to offset the reduction in federal payments.

Services:

These estimates are from OAct's projected expenditures by service categories for the President's FY 1996 budget. Expenditures represent both state and federal share. They were chosen for display because their expenditures are large enough to potentially offset the cuts due to the block grant.

Recipients:

These estimates are from OAct's projected expenditures by recipient groups for the President's FY 1996 budget. Expenditures represent both state and federal share. They were chosen for display because their expenditures are large enough to potentially offset the cuts due to the block grant.

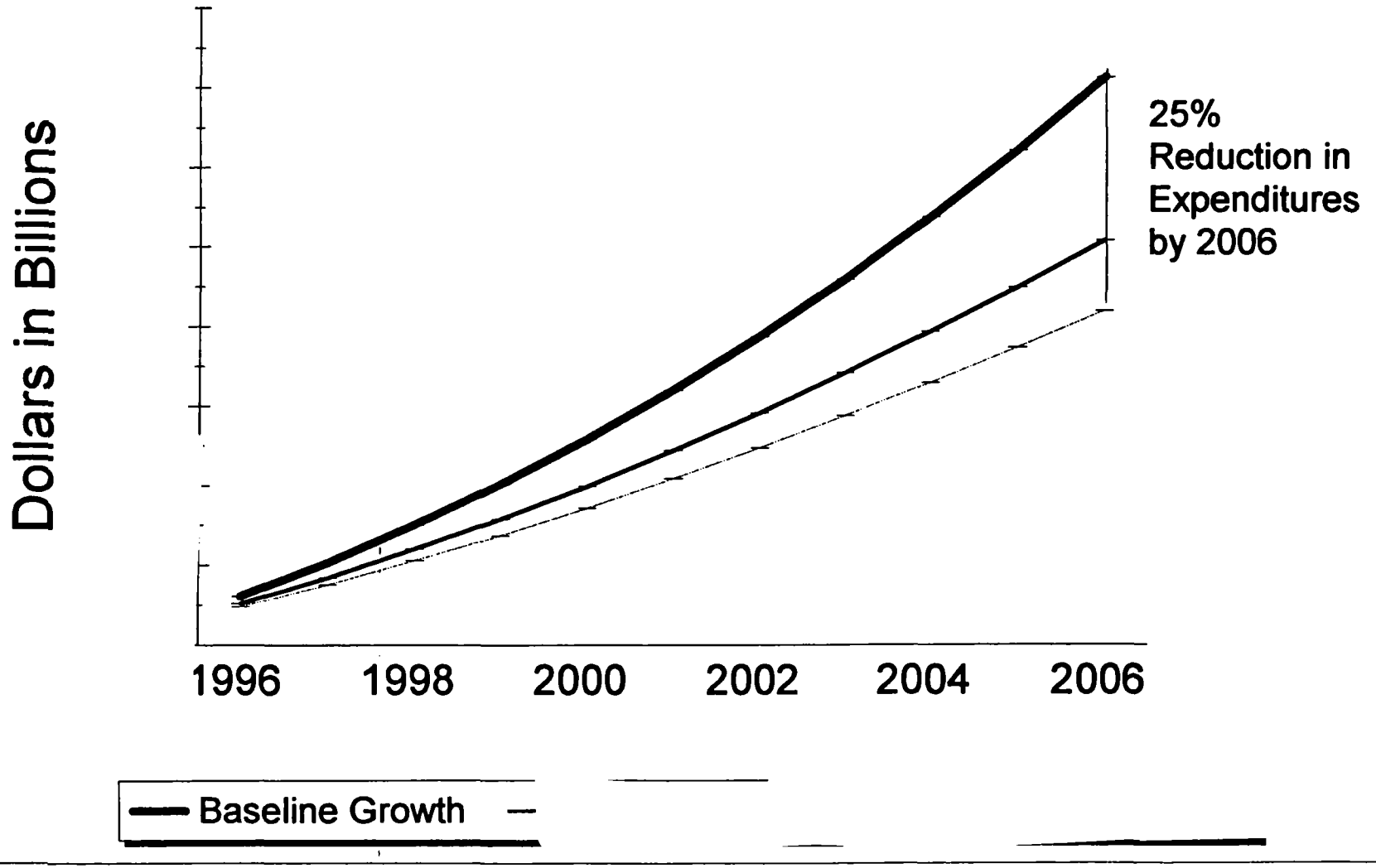
3. **State Effects:**

a. State average annual per capita growth rates, 1990-1993: Data from the Urban Institute. These data exclude DSH and recipient growth, both of which were high during this period. The Urban Institute data were used since they exclude 1990 DSH expenditures (note: prior to 1992 , HCFA does not have 64 form data that separately reports DSH).

b. State per capita expenditures 1993: Data from the Urban Institute (note: these data were chosen because they are consistent with the data used for the other state effects estimates). These expenditures exclude DSH.

Medicaid Expenditure Growth 1996-2002

Capped Expenditures to States



	1997 $ in billions	2005 $ in billions
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	1.9	3.9
Drugs	9.3	17.6
EPSDT	1.1	4.0
Home Health & Hospice	2.5	5.8
Medicare Premiums & Cost Sharing	4.7	10.8
Personal Care Services	3.8	7.1
Cost of Services for Recipients		
AFDC Adults	12.0	24.4
NonCash Kids (OBRA Expansion)	4.3	9.5
QMBs/SLMBs (1)	4.7	10.8
Medically Needy	22.1	38.8

Potential Federal Budget Savings Under Alternative Block Grant Proposals
Acute Care Medicaid Only
(Fiscal Years, Dollars in Billions)

DRAFT

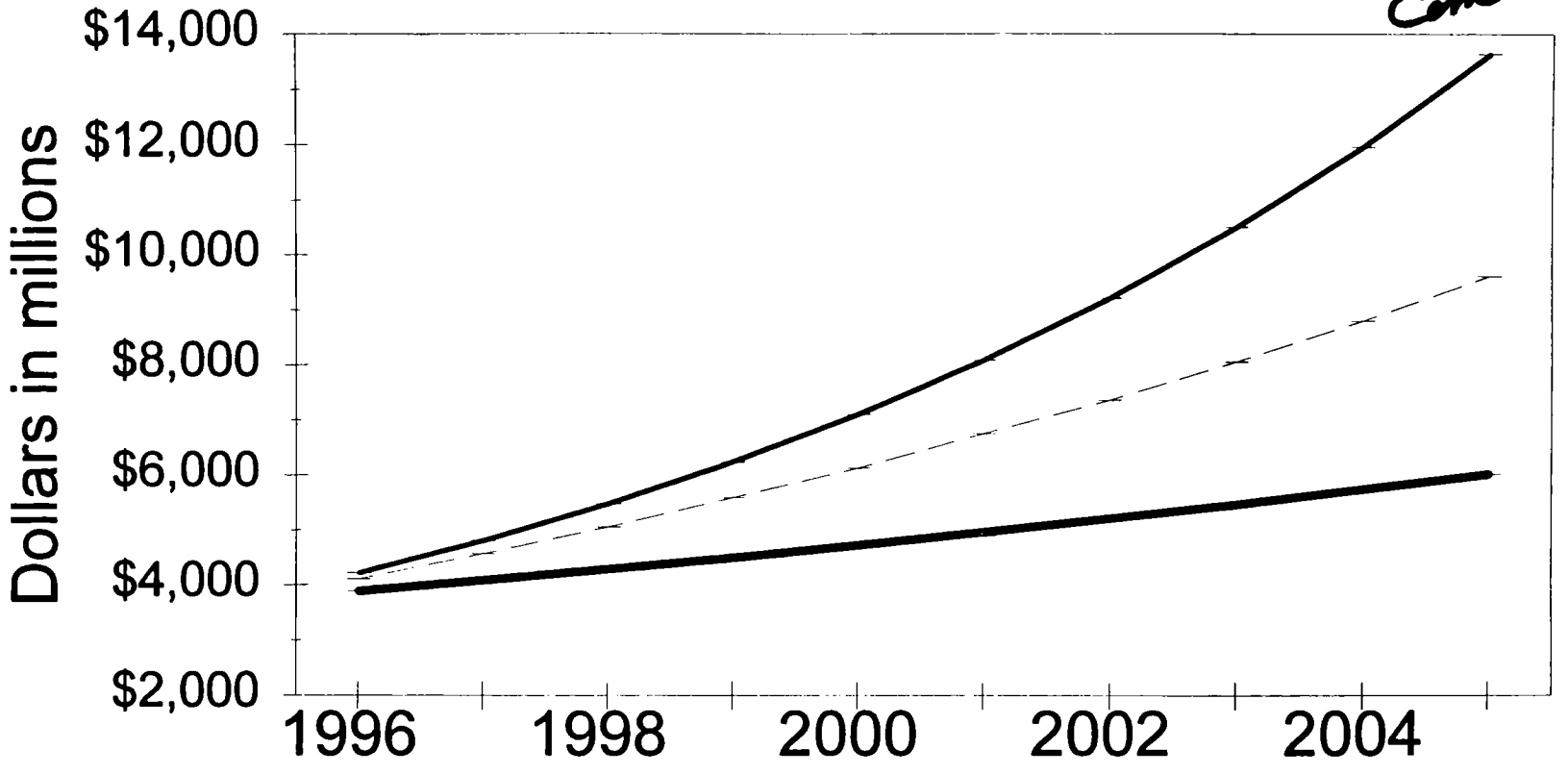
OPTION	1996-2000	1996-2002	1996-2005
MEDICAID			
Administration: Total Acute Care			
Growth at 5%	$46	$95	$217
Growth at 3%	$61	$125	$282
Administration: Aged & Disabled Acute Care			
Growth at 5%	$25	$52	$121
Growth at 3%	$33	$68	$154
Administration: Adult & Child Acute Care			
Growth at 5%	$20	$42	$95
Growth at 3%	$28	$57	$127

Medicaid State by State

There are three steps to the analysis of Medicaid block grants state by state. First, a base year was chosen: FY 1995. The data for the base year come from the states' estimates submitted to HCFA in November, 1994. Second, state baseline total spending was estimated. This was done using two methods. First, the CBO Medicaid baseline growth rates were applied to state spending in FY 1995. Second, the states' estimated rate of growth between FY 1993 and FY 1996 were applied to state spending in FY 1995. Third, the Federal expenditures under the block grant were calculated for each state. This was done by increasing the base year, and then each subsequent year's expenditures by 5%.

Effect of Capped Medicaid Payments on Florida: 5% Growth Cap

SAMPLE - Comments?



Medicare Spending Cap Impact Analysis 2/14/95

Attachment 1 describes the assumptions of the Medicare spending cap analysis.

Attachment 2 outlines the impact analyses to be done.

- Table 1 would show year-by-year as well as 7-year and 10-year figures between FY 1996 and FY 2005, the current baseline and the impact of 3 percent and 5 percent caps. The only specific savings proposal used here would be an income-related premium beginning at $80,000. National aggregate impacts as well as impacts per beneficiary would be shown.

- Table 2 would the net Federal savings from table 1 for each state, allocated in proportion to each state's share of total Medicare spending.

- Tables 3 and 4 would replicate tables 1 and 2 for Medicare inpatient hospital spending. Table 4 is contingent on the availability of data on Medicare inpatient hospital spending by state.

An attempt will be made to consider impacts of Medicare spending caps on academic health centers, public hospitals, rural hospitals and nursing homes.

Assumptions

(1) The CBO December preliminary baseline is used. The analysis may have to be adjusted after the CBO February baseline is set.

(2) The cap policy would begin in FY 1996. There would be no phase-in; rather, Medicare spending would immediately be brought to the cap growth rate.

(3) The cap would apply on a total expenditure basis (rather than on a per capita basis). Medicare population growth averages 1.5 percent per year and aging is 0.1 percent per year between FY 1996 and FY 2005.

To account for both population and aging, the actual growth rate in Medicare expenditures would be reduced by 1.6 percent per year. For example, a 5 percent Medicare total expenditure cap would translate into 3.4 percent growth for both prices and volume.

(4) The policy assumes no slippage, loss of savings due to increases in volume as a response to price cuts.

In the past, CBO has applied "effectiveness ratings" to growth target policies. For example, in the out-years, CBO assumed that 25 percent of the Gephardt Medicare growth target would be lost due to slippage. The effective growth rate is the sum of 75 percent of the target and 25 percent of the baseline growth rate.

If slippage were assumed, then the actual cap growth rate would be to be lowered in order to achieve a desired target growth rate.

Table 1: National Impacts Year-by-Year, 7-Year, 10-Year Impacts

Columns: (a)-(j) Each year between FY 1996 and FY 2005;
(k) the 7-year period FY 1995-FY 2005; and
(l) the 10-year period FY 1996-FY 2005.

Rows:

Aggregate Figures

(a) Spending Baseline: National Medicare Spending (Parts A and B benefits combined)
(b) Spending Cap Baseline: National Medicare Spending at Cap Growth Rate
(c) Specific Proposal Savings (Income-Related Premium at $80,000)
(d) Total Net Cap Savings
(e) Total Net Federal Savings (After Part B Premium Offset)

Per Beneficiary Figures

(f) Spending Baseline: National Per Capita Medicare Spending (Parts A and B benefits combined)
(g) Spending Cap Baseline Per Capita: National Per Capita Medicare Spending at Cap Growth Rate
(h) Total Federal Savings Per Capita (After Part B Premium Offset)

Table 1A would be for a 5 percent Medicare cap.
Table 1B would be for a 3 percent Medicare cap.

Table 2: State-by-State Impacts, Year-by-Year, 7-Year, 10-Year

Columns: (a)-(j) Each year between FY 1996 and FY 2005;
(k) the 7-year period FY 1995-FY 2005; and
(l) the 10-year period FY 1996-FY 2005.

Rows: (a) Total Net Federal Savings (Net of Premium Offset) (row (e) from table 1) allocated to each state on the basis of each state's proportion of total Medicare spending in the most recent year available (probably FY 1993).

Table 2A would be for a 5 percent Medicare cap.
Table 2B would be for a 3 percent Medicare cap.

Table 3: National Impacts on Hospital Services, Year-by-Year, 7-Year, 10-Year Impacts

Columns: (a)-(j) Each year between FY 1996 and FY 2005;
(k) the 7-year period FY 1995-FY 2005; and
(l) the 10-year period FY 1996-FY 2005.

Rows:

Aggregate Figures

(a) Spending Baseline: National Medicare Inpatient Hospital Spending
(b) Spending Cap Baseline: National Medicare Inpatient Hospital Spending at Cap Growth Rate
(c) Total Federal Inpatient Hospital Savings

Per Beneficiary Figures

(d) Spending Baseline: National Per Capita Medicare Inpatient Hospital Spending
(g) Spending Cap Baseline Per Capita: National Per Capita Medicare Inpatient Hospital Spending at Cap Growth Rate
(h) Total Federal Inpatient Hospital Savings Per Capita

Table 3A would be for a 5 percent Medicare cap.
Table 3B would be for a 3 percent Medicare cap.

Table 4: State-by-State Impacts on Medicare Inpatient Hospital Spending, Year-by-Year, 7-Year, 10-Year

Columns: (a)-(j) Each year between FY 1996 and FY 2005;
(k) the 7-year period FY 1995-FY 2005; and
(l) the 10-year period FY 1996-FY 2005.

Rows: (a) Total Federal Inpatient Hospital Savings (row (c) from table 3) allocated to each state on the basis of each state's proportion of total Medicare spending in the most recent year available (probably FY 1993).

Table 4A would be for a 5 percent Medicare cap.
Table 4B would be for a 3 percent Medicare cap.

Cost Shifting

1. Hospitals and physicians have traditionally charged, and payers have paid, different prices for medical care services. With respect to hospitals, these differentials have increased over time. For instance, private payers paid 120% of hospital costs in 1980 and paid 131% of costs in 1992.

2. Traditionally, Medicare ,and until the late 1980s Medicaid, have increased their payments to hospitals at rates slower than the growth in hospital expenditures (costs). As a result, hospitals have, on average, continued to "lose" money on Medicare patients (as well as Medicaid).

3. Hospitals (and physicians) also lose money treating patients without health insurance. These costs have risen over time faster than public subsidies designed to compensate for them and have increased faster than the overall growth in hospital expenses. As a result, uncompensated care comprises a larger share of hospital spending today than in the past.

4. Hospital could respond to lower profits on Medicare (and Medicaid patients) and rising levels of uncompensated care in at least three ways:
 a. Reduce their expenditures, and maintain a constant level of profits from treating privately insured patients.
 b. Treat fewer uninsured patients.
 c. Maintain their expenditures at (real) historic levels, and increase revenues (profits) from treating privately insured patients.

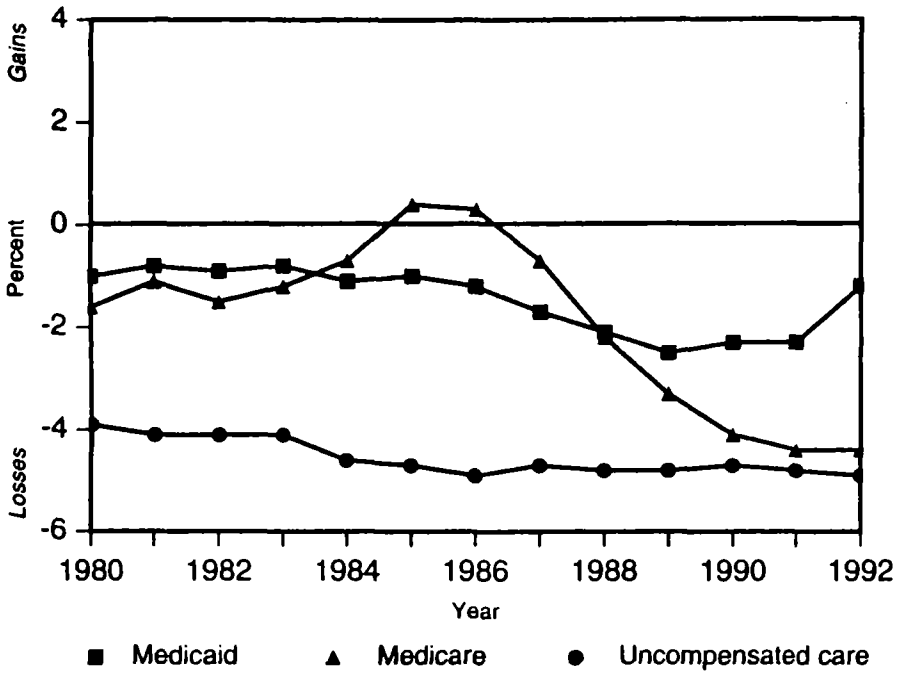
5. Historically (through 1992 at least) hospitals have responded by increasing their profits from treating privately insured patients. Indeed,despite increased losses from public patients and growing levels of uncompensated care, total hospital profits have risen over time (coincident with the decline in Medicare margins).

6. Congressional proposals to slow the growth in Medicare and Medicaid , as well as failure to broadly expand health insurance coverage, has raised fears that hospitals will respond by offsetting these losses by even higher levels of profits raised from those with private insurance. However, private payers have, apparently, intensified their effects to reduce the growth in their payments to providers. These efforts have, it appears, have forced hospitals to rely on reducing the growth in their spending to remain solvent.

7. At issue is how providers will respond to continued reductions in the growth in public revenues: will they (and can they) increase revenues from private patients, or will they be forced to maintain very low rates of growth in real hospital spending? The answer is likely a combination of both.

8. In areas where private purchasers are less able to negotiate prices with providers, they will face substantial increases in their charges from providers. In other cases, hospitals will have to push continued productivity improvements, lower wage increases,changes in the intensity of services provided patients, or all the above.

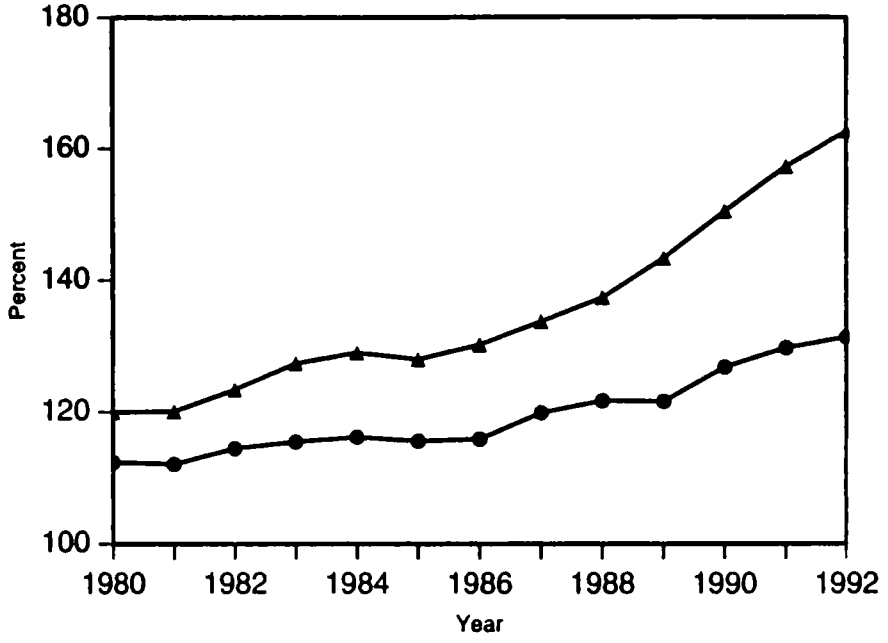
Figure 1-2. Losses as a Percentage of Total Hospital Costs for Medicaid, Medicare, and Uncompensated Care, 1980-1992



Note: For each payment source, losses are the difference between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Due to reporting inconsistencies related to Medicaid disproportionate share hospital payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Figure 1-3. Hospital Charges and Private Payer Payments as a Percentage of Costs, 1980-1992



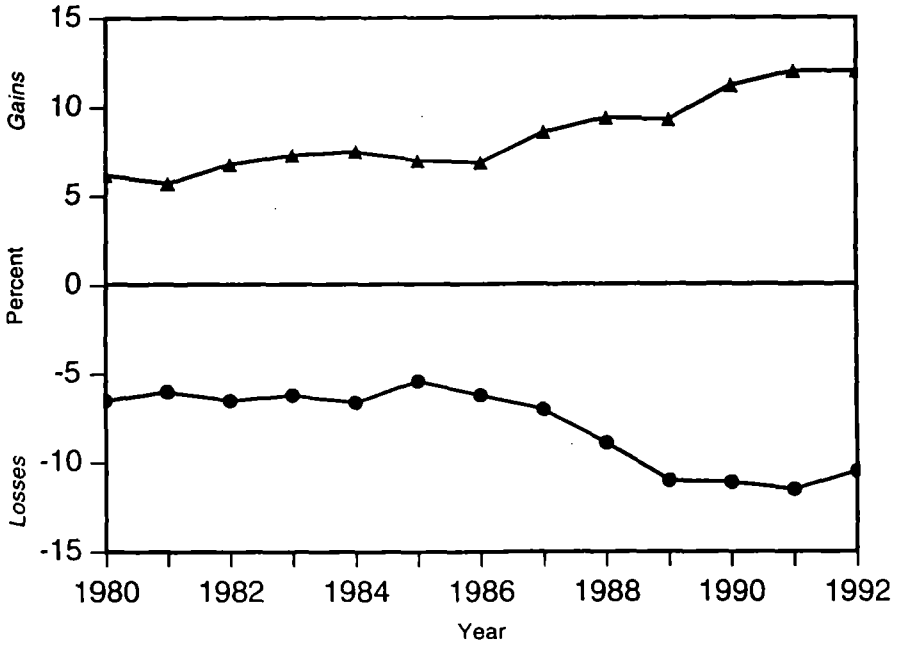
▲ Hospital charges as a percentage of total patient care costs

● Private payer payments as a percentage of private payer costs

Note: Due to reporting inconsistencies related to Medicaid disproportionate share hospital payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Figure 1-4. Total Gains and Total Losses as a Percentage of Hospital Costs, 1980-1992



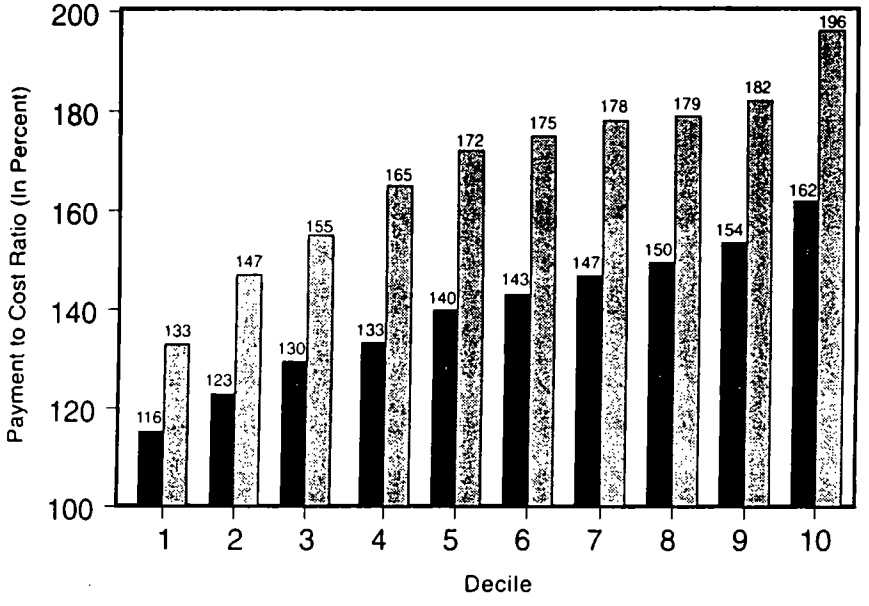
▲ Total gains (from private payers and operating subsidies above uncompensated care costs)

● Total losses (from Medicare, Medicaid, other government payers, and uncompensated care)

Note: Gains and losses are the difference between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Excludes non-patient care income. Due to reporting inconsistencies related to Medicaid disproportionate share hospital payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Figure 1-17. Distribution of Hospital Inpatient and Outpatient Payments as a Percentage of Costs for 69 Large Employers, 1991



Note: Each decile represents 10 percent of the total payments for services made in 1991 by employers in the study. The values shown are the ratio of the payments received to the cost of care for the patients in each decile.

SOURCE: MEDSTAT Systems, Inc., under contract to ProPAC and using hospital-specific cost to charge ratios calculated by ProPAC.

Evidence of Cost Shifting

Table 1. Medicare and Total Hospital Margins

Year	Total Margin	Medicare Margin
1990	3.5%	1.4%
1991	3.8%	-0.7%
1992	4.3%	-2.5%
1993	4.1%	-2.6%

.SOURCE: ProPAC

Table 2. Hospital Payment to Cost Ratios By Payer

Year	Medicare	Medicaid	Private (MEDSTAT)	Private (AHA)
1990	89.6%	80.1%	135%	127.6%
1992	89%	91%	154%	131%

SOURCE: ProPAC

Table 3. Increase in Hospital Cost and Payment Per Medicare Admission

Year	Increase in PPS Costs Per Case	Increase in PPS Payments Per Case
1987	9.2%	5.3%
1990	8.6%	6.2%
1992	4.9%	5.1%

Table 4. Ratio of Private to Medicare Physician Payment Rates

	1989	1990	1991	1992	1993	1994*	1995*
% Change in Medicare Fees		2%	-3.9%	-3.1%	1%	3.1%	6.1%
% Change in Private Fees		3.5%	2.7%	2.7%	0.6%	0%	0%
Ratio of Private to Medicare Payments	1.41	1.43	1.54	1.64	1.61	1.56	1.47

SOURCE: PPRC

* Projected

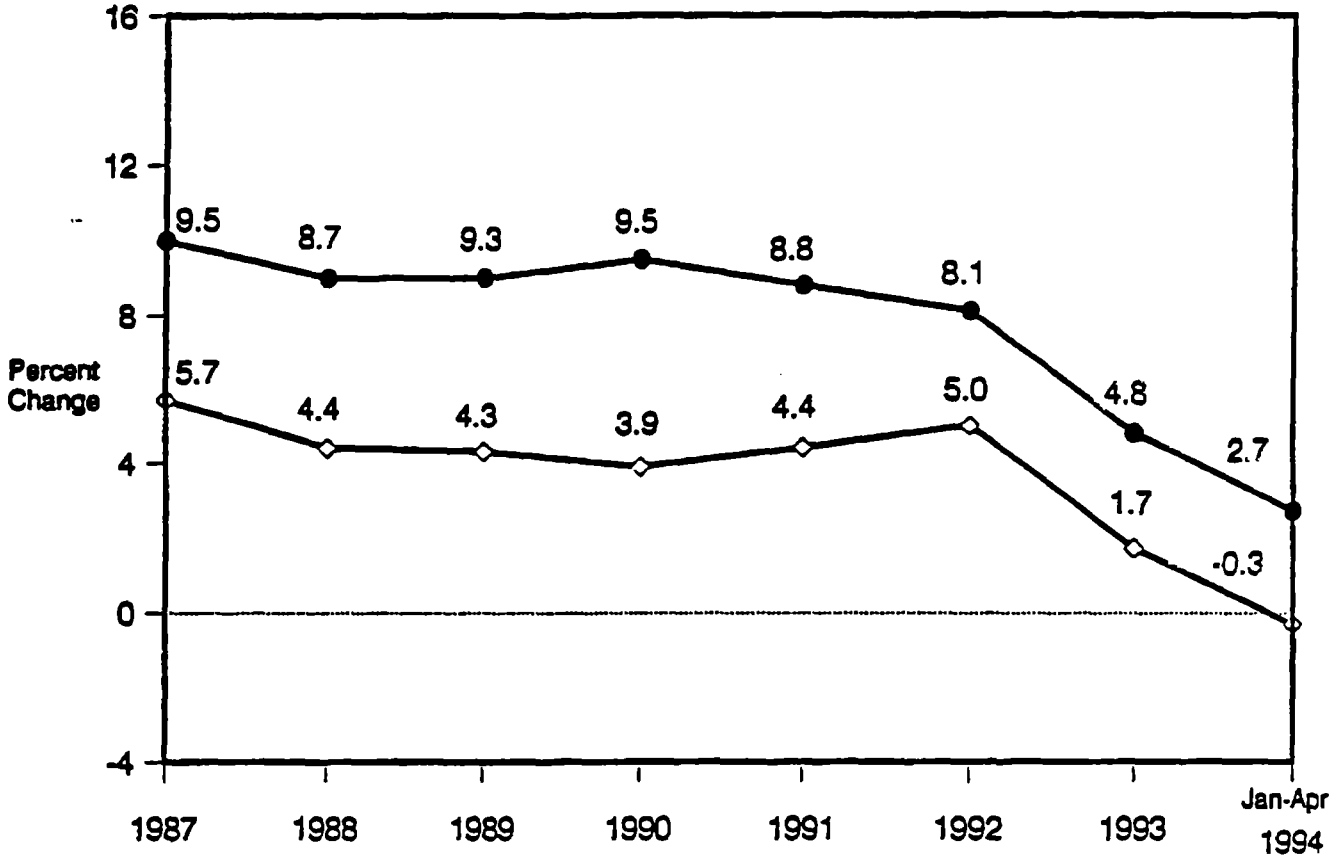
Table 5. Payment to Cost Ratio As Function of Hospital Operating Losses From Medicare, Medicaid and Uncompensated Care, 1992

State Payment to Cost Quartile	Average Ratio of Private Payments to Costs	Average Losses as Percent of Hospital Costs
Lowest (1)	120.7%	8%
2	132.8%	9.4%
3	140.8%	12.9%
Highest (4)	148.9%	12.6%

SOURCE: ProPAC

Figure 1-5

Annual Change in Hospital Cost Per Adjusted Admission



SOURCE: AHA Panel Survey, Bureau of Labor Statistics (CPI-U)

Table 6.

Percent Change in Health Benefit Costs, 1992-94

Firm Size	1993-1994	1992-1993
Under 500	6.5%	5.9%
Over 500	-1.9%	9.1%

SOURCE: Foster Higgins

Percent Change in Cost By Source of Insurance, 1993-1994

Plan Type	Firms Under 500	Firms Over 500
Total Benefit Costs	6.5%	-1.9%
Indemnity	15.7%	10.2%
PPO	4.1%	-2.6%
POS	NA	13.1%
HMO	6.2%	9.7%

SOURCE: Foster Higgins