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S. Hrg. 103–937

MEDICAID ISSUES UNDER HEALTH CARE REFORM

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Medicaid Issues Under Health Care R...

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MARCH 24, 1994

Printed for the use of the Committee on Finance

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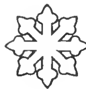

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MEDICAID ISSUES UNDER HEALTH CARE REFORM

THURSDAY, MARCH 24, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:25 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Riegle, Rockefeller, Daschle, Breaux, Conrad, Packwood, Roth, Danforth, Chafee, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H-27, April 21, 1994]

FINANCE COMMITTEE SETS HEARING ON TAX TREATMENT OF EMPLOYER-BASED HEALTH INSURANCE

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on tax treatment of employer-based health insurance.

The hearing will begin at *10:00 A.M. on Tuesday, April 26, 1994* in room SD-215 of the Dirksen Senate Office Building.

"Many of the health care reform proposals before the Committee would limit the tax-favored treatment of employment-based insurance," Senator Moynihan said in announcing the hearing. "The Committee will hear testimony discussing the advantages and disadvantages of these proposals and other alternatives for increasing the cost-consciousness of health care consumers."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. And now we have the very special opportunity of having four authorities on the subject of Medicaid which is a matter of large interest to our committee and to those who are interested in the whole subject of health care.

I will ask our guests who are departing to allow our panel to get underway.

Senator Packwood has an opening statement he would like to make on this or any other subject he so chooses. I really must ask that everybody pay attention. Senator Packwood has the floor.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, when we get onto Medicaid I have to brag a bit about my home State. We are the first State to really undertake an effort to rationalize, in my judgment, Medic-

aid. We have raised coverage to the poverty level. Most States do not cover people to that level.

We started this program only in February 1994. We waited for two-and-a-half years to get a waiver from the Federal Government and more than 120,000 Oregonians who were below the poverty level have become eligible for Medicaid coverage and the sign-up is coming infinitely faster than anyone expected. We are not disappointed.

It is working and in exchange for covering everybody Oregon had to attempt to, in a rational order, list on a priority list Medicaid services from one to over 700 and then say how many we could pay for. We have decided we are not going to pay for a treatment that does not work. We are not going to treat the common cold anymore. We do not know how to cure it, so we are not going to treat it. Nor are we going to treat absolutely incurable illnesses that cannot be treated.

Will we try to ease suffering? Yes. Ease pain? Yes. But we are not going to try to cure the incurable. It has had overwhelming support in the State of Oregon from the philosophical left, from the philosophical right, from business, from labor, from the Republicans and Democrats in the legislature and Republicans and Democrats holding statewide offices. And I would hope that it would be a model for what we might eventually consider at the national level.

Thank you, Mr. Chairman.

The CHAIRMAN. It certainly commends itself. That is what federalism is supposed to be about and occasionally is. So let us begin on that subject with Mr. Raymond Scheppach. Do you say it Scheppach, sir?

Mr. SCHEPPACH. Scheppach, Mr. Chairman.

The CHAIRMAN. Scheppach. Is that Dutch or German?

Mr. SCHEPPACH. It is German.

The CHAIRMAN. It is German. And you are executive director, of course, of the National Governors' Association. We welcome you, sir, and we will put all statements as written in the record. Proceed exactly as you would like.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION, WASHINGTON, DC

Mr. SCHEPPACH. Thank you, Mr. Chairman. Good morning, members of the committee. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the impact of health care reform on low-income population in the Medicaid program.

There are few issues of greater importance to Governors than how the Medicaid program is integrated into the new health care system. I am just going to summarize very quickly three basic issues, Mr. Chairman.

Number one, some interim changes that the Governors would like to have. Second, the Governors' position with respect to the three major bills that are before the committee. And third, some general guidelines that we would like you to be aware of as you put your final package together.

In terms of the interim changes that we would like to have, the first has to do with the Medicaid managed care waivers. Currently, we need to have these renewed every 2 years. What we would like to do is to move toward having an initial three-year waiver with a five-year renewal without a lot of the paperwork burdens that are required at this particular time.

A second area of waiver concern is that we are only able to get one nonrenewable 3-year waiver to have beneficiaries served in health maintenance organizations where more than 75 percent of the enrollees are Medicaid beneficiaries. We would like to have that provision eliminated or at least allow renewability.

Regarding the comprehensive waivers, the so-called 1115(a), research and demonstration waivers, these are nonrenewable and they go from three to 5 years. We would like to have those renewable as well. One of the problems is that once you have demonstrated, successfully, an innovation, even if it is cost effective in delivering quality care, a state may not continue its operation. We would like that changed.

Finally, we seek some relief from the Boren Amendment. The Governors support a proposal to develop a series of safe harbors which would give States some certainty in setting reimbursement rates while protecting the financial integrity of providers.

Now, Mr. Chairman, I would like to move on and talk about the Governors' position on the three major bills. First, on the Health Security Act. As you are probably aware, we were privileged to have a State team working with the administration on a number of the federal/state components.

Therefore, we tend to be relatively supportive of a lot of the Medicaid changes that the administration has recommended. Let me just summarize those very, very quickly.

First, in the administration's proposal, Medicaid acute care services are integrated into the same delivery system used by all Americans. Second, States will have much more financial certainty in the growth of their Medicaid programs. Third, the so-called maintenance of effort, although we probably would ask for some technical changes, the concept there is one that the Governors tend to support.

We also support the fact that there are problems with the Medicaid matching formula. The administration has proposed that a commission look at the formula within the next 3 to 5 years and make a recommendation back to the Congress. And although we do not have a formal proposal or policy on this strategy, I do tend to think Governors could support it.

And finally, in terms of support, we tend to support the new home or community-based care program. It gives States a fair amount of flexibility. Moreover, the legislation is currently written as an entitlement to States as opposed to an entitlement to individuals. Governors support this concept.

There are, however, three areas where we differ with the President's plan and believe that it could be modified. First, the Health Security Act maintains the link between cash assistance programs and Medicaid. Governors are forced into the position that if they are going to make any changes in their SSI or AFDC, they are automatically going to have some cost implications on Medicaid.

The Governors would rather see a delinking of health care for the poor from cash assistance programs. They prefer to see the acute care portion of Medicaid folding into a new low-income program, one in which the various Medicaid categories are eliminated.

The Governors' second concern has to do with the qualified Medicare beneficiaries or related programs. The so-called QMBs programs are very complicated. The Governors support federalization of that particular program rather than continuing it the way it is under current law.

And finally the Health Security Act reduces the hospital program to about $800 million annually. This may be insufficient to provide coverage to these who remain without coverage under the President's proposal. Governors remain concerned about who will provide and pay for care to undocumented immigrants.

In terms of Senator Chafee's proposal, there are a number of components that we support there. Number one, States will be able to establish managed care systems under Medicaid without the need for waivers. The Governors are very supportive of that particular component.

Second, Medicaid beneficiaries will be able to use the same health care delivery system as other Americans. The Governors are very supportive of that component as well.

And third, they are very supportive of the creation of a new broad-based low-income program. Despite these areas of support, Governors strongly oppose the cap on the Federal share of Medicaid expenditures. This is a direct cost shift to States.

We also have a problem with the Chafee proposal that reduces the disproportionate share program to zero. This is probably a bigger problem than even under the administration's plan because the low-income program is phased in over time and, therefore, we would probably require a higher level of disproportionate share to continue defraying the costs of uncompensated care.

Finally, with respect to Senator Breaux's approach as Governors testified somewhat previously on that issue, we have longstanding policy that is in opposition to the type of swap that the Senator is recommending, which is essentially for the States to take the long-term care program in exchange for the acute care. We prefer the reverse of that swap if, in fact, we got into discussions on that.

Finally, I want to say, Mr. Chairman, from the States' perspective we would like you to be guided by a number of principles. First, eligibility for a low-income subsidy program must be relatively simple and uniformly applied.

We need to abolish the complex, categorical eligibility structure used in Medicaid.

Second, individuals who receive low-income subsidies for the health care must have access to the same health care delivery system as those that receive no subsidies. They need to be fully integrated into the system.

Third, managed care must be an important component of the health care delivery system. Forty percent of the population of the United States now is in some type of a network, and yet we have only about 10 percent of the current Medicaid population in networks.

Fourth, States must be assured the stability and predictability in their contributions toward the funding of the new national low-income subsidy program.

And finally, any Federal cost containment strategy that limits the financial exposure of the Federal Government for public funded entitlement programs must also limit the financial exposure of States.

One of the big problems I think we have in restructuring Medicaid, Mr. Chairman, is how do we handle the so-called supplemental benefit programs—benefits beyond a national care benefits package. We have been exploring a number of options to add on this issue. One of those options, of course, is to maintain the entitlement nature of those.

A second option which we are probably less enamored with would be to have a block grant of flexible money that the States could use for supplemental benefit package across all low-income recipients.

The third option that we are beginning to look at is, could you do an entitlement to the State for flexible moneys that could be used for the supplemental programs. That would mean that the Medicaid population will have the same basic benefit packages as everybody else, but there would be a pot of money as in a State entitlement of flexible money that could be used to fill in around the various supplemental packages.

Mr. Chairman, members of the committee, on behalf of the National Governors' Association leadership, I would like to propose a bipartisan meeting with Governors in the very near future, so that they could sit down with this committee and discuss perspectives on national health care.

Thank you, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement of Mr. Scheppach appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Scheppach.

The committee, Senator Packwood and I will very much look forward to a meeting of that kind.

Senator PACKWOOD. I recall when they were here before they were very, very good and I would like to see them again.

The CHAIRMAN. We will schedule that.

We will hear the whole panel, as is our practice. Good morning, Mr. Merlis. On behalf of the Congressional Research Service you are going to speak about some recent trends in the Medicaid program.

STATEMENT OF MARK MERLIS, SPECIALIST IN SOCIAL LEGISLATION, EDUCATION AND PUBLIC WELFARE DIVISION, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Mr. MERLIS. Thank you, Mr. Chairman. I have just been asked to give a little bit of background. My written statement has a number of tables attached to it and I thought I would just point up a few highlights in those.

Beginning with Table 1., which shows overall spending growth from 1988 through 1999, Medicaid since 1988 has gone from 3 percent to 6 percent of total Federal outlays. It now accounts for al-

most half of Federal spending on programs targeted to the low-income population.

Senator PACKWOOD. You said half of all low-income programs?

Mr. MERLIS. It is 45 percent of low-income programs. It is a little over a third of total Federal health spending now.

Much of the growth, as the table indicates, happened over just a few years, between 1988 and 1992. The program doubled in that period. Growth since then has slowed down a little bit. Costs are still projected to grow in constant dollars 50 percent by 1999.

Although there are other factors I am going to get to, a lot of this spending growth has been fueled by growth in program enrollment.

If you can turn to Table 2., the number of Medicaid recipients has grown by more than 50 percent between 1988 and this year. Spending per recipient has not gone up so sharply, as column two indicates. Except in 1991 and 1992 the per capita cost increases really were not very different from what you saw in Medicare or in private insurance.

The Kaiser Commission estimates that 34 percent of the total Medicaid spending growth between 1987 and 1991 was directly related to population.

The CHAIRMAN. Say that once again.

Mr. MERLIS. The Kaiser Commission tried to break down the components of spending growth between 1987 and 1991 and found that 34 percent of the growth was related to population growth.

The CHAIRMAN. By population growth you mean growth in number of persons in the program?

Mr. MERLIS. Right.

The CHAIRMAN. As against the population of the States.

Mr. MERLIS. Right.

Using the same method between 1991 and 1995 growth in program enrollment accounts for 41 percent of spending increases. So this is clearly the major single factor driving spending.

Table 3. breaks out the population growth by cash assistance or welfare status. There is one typo on this table, the column headed "Blind and Disabled" should read "Aged, Blind and Disabled."

As you can see, the largest growth has been in the column labeled "Noncash." This is the pregnant women and kids added by the statutory expansions of the 1980's. It is the QMBs and various other noncash groups.

There has been growth, however, in the welfare categories as well, particularly the jump in AFDC participation in 1991 and 1992 that I am sure you are aware of.

In addition, moving on to Table 4., which goes out a few years——

The CHAIRMAN. Could I just ask once again, you say in AFDC participation. Are you suggesting that the universe of eligible persons remains the same but their participation rose, or do you mean there is just more of them, the population?

Mr. MERLIS. I cannot say that. I only know that the number of persons receiving AFDC and receiving Medicaid benefits rose during that period.

The CHAIRMAN. True.

Mr. MERLIS. Table 4. carries numbers out to 1995 and this time breaks people out by demographics. You can see in that table the

sharp recent increase in SSI disabled enrollment. Nevertheless, over the entire period, it is still basically pregnant women and kids who are accounting for the bulk of the growth.

Medicaid has had a significant effect on the rate of uninsurance among children. In 1988 about one in five kids in the United States was without insurance. The figure for 1992 is down to one in eight kids. But if you turn to the next table, Table 5., you will see that the overall impact of Medicaid expansion has not even kept pace with the drop in employer-based coverage during that period.

Medicaid went from covering about 6 percent of the nonelderly population to 9 percent, but employer coverage dropped. So the proportion of the population with no coverage increased during that period.

Finally, Table 6——

The CHAIRMAN. That is not the same population, Mr. Merlis. The Medicaid population and the employer-based population are not the same people.

Mr. MERLIS. No, I am not saying Medicaid picked up people losing employer-based coverage. I am saying that the gains,. the inroads into the uninsured made by Medicaid were offset by increases in other classes of the uninsured because of lost employer coverage——

The CHAIRMAN. Your principal interest is a number called proportion of uninsured.

Mr. MERLIS. I am sorry?

The CHAIRMAN. If your principal interest is just that percentage of uninsured.

Mr. MERLIS. Yes.

The CHAIRMAN. Which is not in itself very helpful. You have to disaggregate it.

Mr. MERLIS. Yes, sir.

Finally, Table 6. breaks out spending growth by type of service. In the first part of the period there is the conspicuous growth in inpatient spending, which is very largely fueled by the growth in DSH payments' which went from under a billion in 1989 to $18 billion last year.

As you know, some of this funding was recaptured by States through various mechanisms. But some of it did, in fact, go to hospitals and the Prospective Payment Assessment Commission found a significant increase in the payment to cost ratio in hospitals as a result of DSH payments.

Overall, acute care grew much faster than long-term care in the period ending 1992. In 1988 the acute and long-term care sides of the program were roughly equal. Now long-term care is down to about 36 percent. Since 1992 though the growth in the two sectors has been roughly parallel.

Finally, one last category on the table I want to point to, that is "Other Insurance Payments." That includes premiums paid to capitated managed care programs. Overall Medicaid enrollment in Medicare has grown from about $1.5 million in 1988 to almost $5 million last year. There is continued growth shown on the table for coming years. Thank you, Mr. Chairman.

[The prepared statement of Mr. Merlis appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Merlis. And as always, the Congressional Research Service is indispensable to our groping our way through.

We would like to get your supplemental statement on the disproportionate share regarding where that money actually went.

[The statement appears in the appendix.]

The CHAIRMAN. And now, Mr. Stan Dorn, who is Managing Attorney of the Washington Office of the National Health Law Program. Good morning, Mr. Dorn. I do not think you have been before the committee before.

Mr. DORN. No, I have not. It is an honor to be here today, Chairman Moynihan.

The CHAIRMAN. It is a great pleasure to have you.

STATEMENT OF STAN DORN, MANAGING ATTORNEY, WASHINGTON OFFICE, NATIONAL HEALTH LAW PROGRAM, WASHINGTON, DC

Mr. DORN. The National Health Law Program is the legal services national backup center that specializes in health issues affecting low-income people. We work with over 1,200 legal services offices across the country to try to help their low-income clients receive necessary health care.

And before getting into the substance of my testimony, I would like to take a second to thank the members of this committee for all your hard work down through the years to make sure that the Medicaid program improves and better serves the 30 million people who depend on it for their health care coverage.

The three issues I would like to discuss today are universal coverage, cost sharing and mainstreaming low-income people into the same programs that serve others. And because of limits of time I am going to focus my initial remarks on the three bills with principle sponsors who are members of this committee—the administration's bill, the Managed Competition Act and the Heart Act.

But during the question period I know there are other bills of interest to members of the committee such as Senator Nickle's bill and I would be delighted to discuss those or any other questions the committee might have.

The issue of universal coverage is obviously fundamental. The administration's bill provides universal coverage for all but certain immigrants. Unfortunately, the Managed Competition Act does not. It does make important steps forward for people below the poverty line. However, because of the bill's subsidy structure, people with incomes above poverty will often go uninsured, even including the 6.2 million Medicaid beneficiaries with incomes above poverty.

Here is an example. Pregnant women with incomes up to 185 percent of poverty are covered today under the Medicaid program in most States. Under the Managed Competition Act, if their employer did not choose to provide coverage, they would have to pay 85 percent of the cost of the health insurance policy, which obviously very, very few of those women could afford. They would lose the Medicaid coverage they have now because the bill would abolish acute care Medicaid and they would not have coverage.

A second problem with the bill is that low-wage workers at large companies with over 100 employees as we understand the bill could

not get low-income subsidies no matter how poor they were. That obviously leaves a gaping hole, including many Medicaid beneficiaries today, and it also makes it more difficult for low-income people to work their way off welfare. If the job that they want is with a large company, they may not have health coverage. That is certainly not the direction that we want to go.

The third bill that I am going to discuss is the Heart Act, sponsored by Senator Chafee. The individual mandate approach obviously has the potential of providing universal coverage, but some of the details are troubling from our perspective as advocates for low-income people.

The caps on Federal Medicaid dollars which were mentioned by my friend from the National Governors' Association are very troubling. After the first year Federal dollars go up by 6 percent per year regardless of what is happening with health care inflation.

If health care costs are expanding at a rate of 10 or 11 percent per year in the private sector, those Federal dollars will buy fewer and fewer health care resources, forcing States to choose between putting in additional dollars of their own or making large cutbacks. And if they do make cutbacks, people who lose Medicaid coverage may or may not get low-income subsidies under the bill because the subsidies phase-in depends on the certification by the Office of Management and Budget that there is enough money to pay for the subsidies. So, unfortunately, the Heart Act does not ensure universal coverage.

On the second issue, cost sharing, the bills flip around. The administration's bill has some significant problems in this area because it makes everything depend on whether you receive cash assistance. If you get AFDC or SSI your cost sharing is reduced to $2 every time you go see a doctor.

If you are any other kind of a poor person, it is $10 whenever you go see the doctor. Now $10 does not sound like much to those of us sitting in this room, but to the one in 20 households in this country with incomes below $5,000 a year, that $10 copayment is the equivalent for an average household of a $75 copayment.

So it is not surprising that many public health studies show subjected to copayments low-income people defer seeking care until their illness degenerates, they suffer harm and costs are increased.

Now 40 percent of Medicaid beneficiaries today do not receive cash assistance and most commonly they pay no copayments. Unfortunately, this provision of the administration's bill would erect a new financial barrier to access for these people. And also, it would once again make it more difficult for people to move from AFDC to employment because when you do, you have to pay more for your health care.

This is one of the most important details in the administration's bill, that from our perspective must be fixed for the bill to accomplish its objectives with respect to low-income people.

By contrast, the Managed Competition Act says that everyone with incomes below 200 percent of poverty pays no more than nominal copayments, which is a sensible direction, roughly defined with reference to the Medicaid Act.

And the Heart Act in some ways goes even farther and incorporates the full range of Medicaid cost-sharing protections for Med-

icaid beneficiaries. There are some areas where these provisions need improvement as outlined in my testimony, but in terms of a basic direction, this is a more sensible way to go.

Low-income people should have cost sharing scaled down to fit low-income budgets regardless of whether they receive cash assistance or not.

The third issue is mainstreaming and we support the position of the National Governors' Association that it is critical for low-income people, including Medicaid beneficiaries to have access to the same health plans that serve their neighbors. We do not want a health care system that is segregated on the basis of income, among other reasons, because in much of the country that would mean segregation on the basis of race. We do not want discreet racially identifiable health care systems in this country.

Furthermore, we do want a system where low-income people can vote with their feet and health care plans know if they do a bad job their customers will leave. It is critical to harness competitive pressures to promote quality. The administration's bill does quite well on this score.

Reimbursement is equalized for all consumers, rich or poor, because of regional health alliances. Low-income people can enroll in any plan up to the average price. It is a very important, positive feature of the administration's bill.

The Managed Competition Act unfortunately in operation would limit low-income people for the most part to the lowest cost plan in the area, giving rise to the problems I outlined.

And the Heart Act, among other things, would permit States to enroll Medicaid recipients into health plans for poor people only.

As you can see, our suggestion would be for this committee to combine the strongest elements of all these various proposals to come up with an approach to low-income people, including Medicaid beneficiaries that would really work and we would be delighted to work with the committee toward that end.

Thank you.

[The prepared statement of Mr. Dorn appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Dorn. That was admirably explicit.

And now the last of our panelists, representing the Health Insurance Plan of Greater New York, Karen Wintringham, Senior Vice President.

Ms. WINTRINGHAM. Good morning. Thank you, Mr. Chairman.

The CHAIRMAN. It seems to me I was enrolled in HIP some 45 years ago.

Ms. WINTRINGHAM. And look at how well you have done.

The CHAIRMAN. I am still here.

Ms. WINTRINGHAM. We must have succeeded. [Laughter.]

STATEMENT OF KAREN WINTRINGHAM, SENIOR VICE PRESIDENT, CORPORATE DEVELOPMENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK, NEW YORK, NY

Ms. WINTRINGHAM. Mr. Chairman, and members of the committee, I am pleased to be here. I obviously represent the Health Insurance Plan of Greater New York, but I may refer to it as HIP because it is much briefer.

HIP today serves nearly 1.2 million members in the New York City metropolitan area, in New Jersey, and not surprisingly in Florida. We would like to share with this committee some of our experience in the past 30 years of serving Medicaid members. In addition to some 80,000 Medicaid members in New York we also serve other groups requiring special consideration including small businesses, uninsured employed individuals and uninsured children.

We will also provide the committee with some recommendations on what Congress, the States and health plans should really consider when mainstreaming Medicaid recipients into private sector and managed care organizations.

I would also like to commend you, Mr. Chairman, for your support of Medicaid managed care. Your dedicated efforts on behalf of Medicaid reform have contributed greatly to the larger discussion about national health reform.

HIP was established nearly 50 years ago. This is not a new organization. And our mission was really to provide affordable health care to everyone in our community. Unfortunately, now 50 years later we still find that there are still barriers to access.

The CHAIRMAN. HIP was quite an adventurous idea when it began.

Ms. WINTRINGHAM. It certainly was.

The CHAIRMAN. It now is very much mainstream, if I can use that word.

Ms. WINTRINGHAM. Yes.

Controlling Medicaid costs and ensuring access to comprehensive care rather than episodic acute care has also been at the heart of New York State's efforts to integrate its Medicaid population into managed care. The New York statewide Managed Care Act passed in 1991 will shift half of the State's Medicaid population into managed care plans.

Several proposals for national reform, including the President's plan and bills that have been introduced by Senators Breaux and Chafee, would also mainstream the Medicaid population into private plans. The consequences of these proposals are considerable and caution should be exercised.

But the proven success of the prepaid group practice model HMO upon which these proposals are based results from factors very different from fee-for-service medicine. These include use of a selective network of providers who have been credentialed, designation of a primary care physician who knows everything that is happening to their patients, intensive quality review, emphasis on early access and preventive services and care that is prepaid with limited out-of-pocket expenses.

We and other HMOs have also found ways to meet the special needs of our Medicaid members while providing their health services with the same physicians, the same providers and the same medical centers as all of our other members.

For example, we assign a Medicaid program officer to every new Medicaid member. These patient advocates encourage the patients and the members to use preventive services, like screening, routine examinations and prenatal care. They assist the member in obtaining appointments, they arrange transportation, they help the mem-

ber understand how to use a complicated system, and they assist in any other way the member needs.

Every teenage mother in our plan, many of whom are AFDC population, have a case manager assigned to them who assures that they receive all the prenatal services that they need. And we have found that programs such as these are absolutely vital in our organization, and others that have tried them, to treat and care for a Medicaid population in a managed care setting.

Even with these extra services, we have achieved significant savings for the State, the Federal and in the case of New York, the city governments. Our premium for Medicaid, including additional services such as dental, drugs, optical, transportation, methadone maintenance are approximately $147 per member per month. When compared to projected costs in the fee-for-service community, these are about 16 percent lower in our community, which translates into an annual savings for our plan of approximately $18 million for the Federal, State and city governments.

So based on our experience, we recommend that health reform proposals mainstream Medicaid and other uninsured populations and that they consider the following elements. First of all, the proposals must recognize that the elements of managed care that are fundamental to their success must be preserved and to avoid changes which would jeopardize or undermine those basic elements.

Any willing provider laws should be preempted. Point-of-service products should be voluntary. And mandated contracts with all essential community providers need to be reconsidered.

Clearly, funding for providers that have traditionally served low-income populations must be assured; however, requiring health plans to contract with every one of these providers threatens the very success of closed-panel HMOs which already provide comprehensive health services.

Just last week the Ways and Means subcommittee adopted an amendment which would require all health plans to contract with a broadly defined universe of essential community providers. While well-intentioned, such an amendment guts our basic ability to assure continuity of care, appropriate use of services, cost containment, maintaining a complete medical record so that we can look at outcomes, and providing comprehensive services in one convenient setting.

The government must assure there is an adequate choice, as has been said earlier, among health plans for all populations. To help ensure greater choice in underserved areas, we would suggest that Congress allow health plans to reimburse part or all of the educational expenses of primary care physicians without those payments being taxable income to the physicians.

I view this proposal as a positive incentive to try to attract primary care physicians into professional shortage areas.

And finally, oversight and accountability are vital. However, we would suggest that health plans that demonstrate expertise and consistent, good performance be subject to less intrusive oversight and that health plans that achieve independent accreditation, such as NCQA certification, should be deemed to have met some elements of oversight and review process.

Mr. Chairman, my written testimony elaborates on other recommendations which I would be happy to discuss. But our experience as a provider of comprehensive services to Medicaid recipients has been very positive for us, for our physicians, certainly for our members and for government. Our experience, along with that of other plans around the country, indicates that reform of the health system should mainstream Medicaid and uninsured low-income populations into integrated health plans.

With appropriate attention to the lessons we have all learned, some of them painful, we believe that Medicaid recipients, like the nearly 50 million members in HMOs nationwide, can also benefit from improved quality, access and cost effective medical care.

Mr. Chairman, thank you for giving us the opportunity to testify. I would be happy to answer any questions.

[The prepared statement of Ms. Wintringham appears in the appendix.]

The CHAIRMAN. We thank you, Ms. Wintringham. You skipped over in your written statement that it was Fiorello LaGuardia as Mayor of New York and Dr. George Baehr, a public health doctor, who conceived the idea of a group health service and a health insurance plan. And not the least of things we owe Fiorello LaGuardia.

I would like to ask Mr. Scheppach as regards—and this is obviously a self-interested query—the Medicaid formula, which is a source of great agitation in New York State at least. You have stated that "with a major restructuring of health care financing the President's plan includes a strategy for reviewing the State financial obligations under the new system toward resolving possible inequities among States."

I compliment you on the term "strategy" which is a form for not addressing it in the next century. And the term "possible inequities," do you want to expand on that? I do not want to press you. But we are dealing with a formula which reimburses States in accordance with the square of the differences of their income.

I mean, 18 years ago I proposed square root, just to make the point of the absurdity of it. And surely it comes from another generation in American social policy. But do I understand the basic problem is that by a slight margin there are more States who come out better in this arrangement than—and you vote one State at a time, something like that? I do not think you have to answer that. [Laughter.]

You have constitutional rights that we may be abolishing here.

Mr. SCHEPPACH. Let me just say, Mr. Chairman, those issues are tough, obviously, for the Association because there are winners and losers.

The CHAIRMAN. Yes.

Mr. SCHEPPACH. I think there is a feeling on some States' parts that neither the underlying fiscal capacity of the States nor the extent of vulnerable populations is reflected in the current medical formula.

Because of its volatile nature, it seemed to make sense that one would not want to combine a relook at the Medicaid formula one would at the same time one is doing health care reform. It may well be better to first address reform and then address the formula.

One option that has been discussed is to have an independent commission make recommendations to Congress on changes to the formula.

The CHAIRMAN. The thing that did hurt, however, was when we found that as you are reading through the 1,300 pages and you get to long-term health care, and there was that square of the differences again as if everything we had said for 18 years was a matter of no significance. There are costs to that.

I wonder if I could ask Mr. Merlis if we could not get a history of that, the present formula, from the CRS. Would you just give us a two or three page?

Mr. MERLIS. Sure.

The CHAIRMAN. I think it really is Hill-Burton, adapted to Medicaid in 1965, something like that.

Mr. MERLIS. We have a report on this subject. I will get it over to you.

The CHAIRMAN. Would you do that?

Mr. MERLIS. Yes.

The CHAIRMAN. Fine. Thank you.

Senator Packwood?

Senator PACKWOOD. Ms. Wintringham, I want to make sure I understand how the HIP works. The Medicaid people do not have to join. This is voluntary. They can continue to go to the emergency rooms and their fee-for—service if the doctors will take them if they want.

Ms. WINTRINGHAM. Well, since 1966 when Medicaid was passed, HIP has had a voluntary Medicaid program.

Senator PACKWOOD. Right.

Ms. WINTRINGHAM. In 1991 the State of New York passed a law which will move half of the Medicaid population into managed care plans.

Senator PACKWOOD. But how do you get the——

Ms. WINTRINGHAM. There is a choice among managed care plans.

Senator PACKWOOD. How do you get them in? Half can be out, I guess, but how do you get them in? You do not compel them in, I take it.

Ms. WINTRINGHAM. Everyone in that community has to join a managed care plan, like in southwest Brooklyn.

Senator PACKWOOD. Oh, they do?

Ms. WINTRINGHAM. So half of the State's population will be in managed care.

Senator PACKWOOD. Oh, I see.

The CHAIRMAN. Yes.

Senator PACKWOOD. Do you operate principally in New York City, in the State of York, principally New York City?

Ms. WINTRINGHAM. The New York City metropolitan area, yes.

Senator PACKWOOD. So half of them have to be in.

Ms. WINTRINGHAM. And the way they are phasing that in is by community, by area.

Senator PACKWOOD. I understand what you are saying. Everybody in an area must be in it and I assume you are in all the areas.

Ms. WINTRINGHAM. Right. Correct.

Senator PACKWOOD. Do you have a fair number of competitors?

Ms. WINTRINGHAM. Well, in the Medicaid area you would not be surprised to know that we have had no competition until recent years. There has been an effort in the State of New York to encourage plans that wanted to contract with the largest contractor, the City of New York, to sign a Medicaid contract.

It has only been as recent as about a year ago that any of our competitors have elected to enroll Medicaid members in their plans.

Senator PACKWOOD. But you are breaking even on your Medicaid patients?

Ms. WINTRINGHAM. We are doing very well.

Senator PACKWOOD. You are making a profit on it?

Ms. WINTRINGHAM. We are a nonprofit organization.

Senator PACKWOOD. I understand the totality of your bottom line is zero.

Ms. WINTRINGHAM. We are covering our costs and maintaining new facilities, yes. We are operating the program and are recovering our costs.

Senator PACKWOOD. I am very impressed that you are able to do it at the cost that you are doing and you will have in those neighborhoods. We do not any longer use 100 percent as universal because I am sure there are people that just are not going to join no matter what, even if they live in the neighborhood and they will go off to the emergency room on occasion when they break their leg.

But you have come very close to universal coverage in those neighborhoods.

Ms. WINTRINGHAM. And the neighborhoods are all of the neighborhoods as the Chairman knows.

Senator PACKWOOD. I went to NYU Law School and I am somewhat familiar with the subway system and used to ride out to Brooklyn and Queens and I have some familiarity with the area. I am very impressed with your success.

Let me ask each of the panelists this. We are going back and forth over the issue of mandates. There is nothing to Medicaid in this, now individuals and employees above the poverty level. And even if we have an employer mandate we are going to have to have some kind of an individual mandate also.

What would be in your judgment the most effective method of enforcement? So that if we say to Suzy Smith or Johnny Jones you must have a health plan policy and it will provide the following benefits and now you go out and buy it, and he can buy it from you if you want or he can buy it from Blue Cross or buy it from Aetna or MetLife. What would be the most effective method of making sure it is done?

Ms. WINTRINGHAM. That is certainly beyond our expertise. We provide service once people join us. I think the major concern we have had over the years is that without adequate insurance reform that the choices that an individual who wanted to receive coverage had were very limited.

And so in the State of New York there have been great efforts, particularly for individual members and small businesses to try to reform insurance law so that individuals could get access to any one of those insurance companies or health plans.

Senator PACKWOOD. Well, I am not asking the question right, because I am presuming——

Ms. WINTRINGHAM. No, you asked it right. It is just not our area of expertise to know that.

Senator PACKWOOD. I am presuming in the bill we pass we will have insurance reform and we will prohibit exclusion on preexisting illnesses and will have some modified form of community rating. I do not think it is going to be nationwide like Social Security.

So that the access well within reason will be there.

Ms. WINTRINGHAM. Right.

Senator PACKWOOD. What is the method of making sure that people buy? And again, if it is not your experience, I will go down the line. Just give us your judgment on how we should do it.

Mr. DORN. Senator Packwood, as far as the enforcement mechanisms go, that is also outside our area of expertise. But I can make one or two comments about how to make sure that low-income populations learn about this program and actually obtain the benefits that they need.

One suggestion would be—well, outreach and assistance is absolutely critical. Many low-income people do not read very well or do not speak English. They may not know about benefits programs. Every benefit program we have has substantial under enrollment. There are lots of folks who are eligible who do not know about it, do not come onto the program.

So some suggestions would be to subcontract with—to have some kind of a system where you could contract or subcontract with community agencies in low-income communities that know those communities, that know how to do outreach to those communities, community action agencies or others, and have them do some outreach and education.

A second suggestion would be that when you develop the low-income subsidy system, use as at least interim proxies for eligibility determinations the determinations that have been made on other low-income programs. In other words, if food stamps or WIC has found that a given individual has an income below whatever the income threshold is, you can at least on an interim basis use that as automatic interim certification of eligibility for low-income subsidies.

That way folks who know about existing programs will automatically be enrolled in this new one. I guess the only point about enforcement specifically that I would make is that whatever enforcement mechanisms you use, you do not want to take withdrawal of health care coverage. You do not want to have that be part of the picture. You may want to have financial penalties, et cetera, but it is important to make sure that people are assured health care coverage even if they do not do what they are supposed to do.

Senator PACKWOOD. What they do in Germany is a payroll deduction. You have to join and you cannot work if you do not join. That is a reasonable method of enforcement for those who are at least in the employment pool.

Mr. DORN. Well, payroll deductions would be one approach where you could still keep your insurance if you are working and the money is taken out, in extra payroll deductions, for example, if you

do not pay in during an earlier period. That is something worth considering.

But if the committee does go along that line, I would caution it to have special provisions for low-income people to make sure that the monthly adjustments that take place are affordable. Most public benefits programs have such provisions today where, for example, if you receive excess AFDC or excess food stamps, you have a prospective reduction in your benefits over time, but there are caps built into the program. You cannot lose more than a certain percentage of your subsidy.

Because obviously we do not want low-income people to have to choose between health care and other necessities of life.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

Senator Riegle, I must, if I may, excuse myself. I have to get to the floor where we are voting, whether we realize it or not, on the future of the President's health care plan by taking all the Medicaid—$20 billion in Medicaid expenditures that we were going to use for health care—and transfering them to the military.

Senator PACKWOOD. That is not quite the way it reads, Mr. Chairman. [Laughter.]

The CHAIRMAN. It is not quite, but that is our argument. [Laughter.]

Senator RIEGLE. Well, it is very close to the truth and that is an important service for the Chairman to render, to go to the floor and illuminate that issue, because it is tough enough to find a way to pay for our health care reform—I am talking obviously about the Medicaid part today—if we are not mindful of how it fits into the overall direction of which other Federal money is going.

I would like to make just a few observations that touch on some of the points you have made and then I would like to pose a general question to all of you. I think it is clear to anybody that has studied Medicaid, your experience notwithstanding in terms of how well you are doing in New York right now, that inadequate Medicaid payments to providers is a key problem in the Medicaid program when you look at it across the country.

There are some estimates that the Medicaid rates run somewhere in the range of 60 percent, only 60 percent of private rates. That is really, I do not think, workable over time. I think it gives you two-tier medicine. In fact, we see that in the fact that many doctors do not want to serve Medicaid patients. That by itself creates a kind of cast system in the country and I have a hard time reconciling that with everything we say we mean to stand for as a country in our founding documents.

I do not think when we all arrive here by divine help presumably that we are really consigned to different kinds of health care treatment throughout what may be our life times because of the way the system is geared.

I also see the cost shifting that is going on across into the private sector and I see it being loaded up in the areas where good insurance coverage is being offered and the cost shift that is taking place that lands there, and also the hospitals that sort of end up being caught in the middle with costs that they are not finally able to cost shift and just have to eat a lot of that cost. It is up in the

hundreds of millions of dollars a year, for example, just in my home State of Michigan, just the uncompensated care that hospitals themselves are having to eat and cannot effectively cost shift.

I think most people view Medicaid as a second-class health care system and option in our country. It can be painted a different way. But I think that is the essential reality of the situation.

For all those reasons and more, it seems to me that we have to figure out how to integrate as wisely as we can Medicaid into this health care reform picture, where we end up with some kind of an integrated changed system in that we do not have, in fact, a two-tiered system.

Each of the plans that is now before the Finance Committee here treat the Medicaid program differently. The Clinton plan obviously undertakes to integrate it. We did that earlier in a plan that Senator Mitchell and Rockefeller and Kennedy and I put together prior to the Clinton Administration.

Senator Chafee's plan gives the States options. The Breaux plan appears to do this but it is not exactly clear how that is done. It gets a little fuzzy.

I would like each of you to comment on which plan in your view does the best job of accomplishing a sensible integration and assurance that we are going to end up with some kind of a wisely homogenized system here. So let me just go right down the table and start with you if I may.

Ms. WINTRINGHAM. Senator, we have been very careful not to take positions on individual bills, in part because they are changing so quickly. We have really tended to comment——

Senator RIEGLE. If you take the names off, and let us talk about the mechanics, I mean, because we have to get past that or we will never get to the end of the game here.

Ms. WINTRINGHAM. Sure. And we have really talked more about the elements that are critical. If you want to take advantage of the success that has been proven in HMOs, then you have to make sure that some of those elements that led to that success survive. And although we will have to change as every other health provider in the community will, we want to make sure that those elements that I spoke to earlier have to survive.

If you look across the three unnamed bills, the real difference from the perspective of the provider is relatively small, that it is really more a matter of where the funding source would be coming from and how quickly that population could be incorporated into managed care.

We certainly have been long supporters of providing the full continuum of care for any individual member for all of their needs. And if you look at the Breaux bill where you are really separating long-term care in Medicaid, obvious concerns from the provider standpoint that we tend to provide all those services. We have not yet gotten into the business of providing true custodial long-term care services.

But as our population has aged, it is very clear we are going to have to look at that as well, as some other States, such as the State of Oregon and the Kaiser Plan have done very effectively.

So if we are talking from the perspective of providing health care, we want to make sure that whatever the needs of the population are, we are in a position to provide them. And again, the bills all make this possible with differences about how quickly or who is going to be paying us the money. From our perspective, there is not much difference across those approaches.

Mr. DORN. Senator Riegle, I am delighted to hear your concern about this issue. From our perspective there is no bigger access problem affecting the Medicaid program today than the lack of access that comes about as a result of the reimbursement.

The 60 percent figure from the Kaiser Commission that you mentioned is just an average. That includes hospital rates that are much closer to the private sector. So when you are dealing with out-patient services the gap is much greater.

In California, for example, until the State was sued, their Medicaid reimbursement rates for obstetricians were so low that about one in five women could not find an obstetrician when they were pregnant. I mean, all across this country people have Medicaid cards. They cannot find pediatricians to treat their kids. They cannot find people to set their broken arms. It is a horrendous problem.

And we see significant differences among the bills. The administration's bill makes an enormous step forward by using regional health alliances to equalize reimbursement rates for all consumers regardless of income. And in our judgment, this step alone, even aside from the issues of universal coverage, would be the biggest step forward for low-income people's health care since the adoption of the Medicaid Act.

It also promotes mainstreaming by permitting low-income people to enroll in any plan up to the regional average. The one concern we have in terms of choice is, we think it is important for people, low-income consumers, to have a meaningful, affordable choice between managed care and fee-for-service. Some managed care plans do a wonderful job, some do not. Some people are well-served in managed care, some are not.

We think it is critical to leave that choice to the individual family to figure out how best to meet the needs of the people in that family. But overall the administration's bill really does a remarkable job of mainstreaming low-income people.

Unfortunately, I have to report that the Managed Competition Act does not do as good a job. Low-income subsidies are pegged to the lowest cost plan in each area. If a low-income person wishes to enroll in a more expensive plan, they have to pay a percentage of the difference in price.

Some people with grave needs for health care that cannot be served in the cheapest plan in their area may pay that. But for most people, that means that takes food off your table. That means you cannot pay your utility bills. So the reality is that most low-income people under the Managed Competition Act would have no choice but to enroll in the lowest cost plan, which means segregation. It means no competitive pressure to promote quality because the health plan knows that they are dealing to a fair degree with a captive audience.

And it also means potential fragmented care, where year by year the lowest cost plan changes. So this is one of the gravest concerns that we have about the Managed Competitive Act.

The Heart Act is in some ways better than the Managed Competition Act, but it is also problematic. The Medicaid caps, the caps on Federal Medicaid dollars, we fear could force States to make cutbacks, to respond to potentially decreasing real Federal dollars coming into their States.

One way to make cutbacks is to cut reimbursement rates, further increasing the differential between Medicaid and the private sector. The Heart Act also gives States increased freedom to enroll Medicaid recipients in mandatory managed care plans for poor people only, no obligation to serve others who are not poor, and that is a very troublesome segregated two-tier system.

I mean the quality of care protections in that part of the bill are positive. There are improvements that could be made. But they are helpful. But there also needs to be competitive pressure to promote quality where the health plan knows the low-income person can meaningfully vote with their feet and then there is an incentive to provide care.

Many HMOs do a wonderful job but some respond to the financial incentive to underserve by denying people necessary care. There are some populations that are not well served in managed care programs. Disabled people, for example, who may need lots of different specialists who are not part of a particular plan. So we think choice is really critical.

But overall between the three bills on the point you asked, Senator Riegle, it is very clear that the administration's bill does a really wonderful job and the others need some improvement.

Senator RIEGLE. Mr. Merlis?

Mr. MERLIS. I am from CRS and, of course, I cannot take any position on what the most effective plan is.

Senator RIEGLE. No, no, forget the names. Let us talk mechanics. I do not want to get off into that. But if we get boxed by that then we cannot—I mean, we might as well just fold up and go home. So do the best you can.

Mr. MERLIS. There are a few key issues and one has been alluded to by you and by a couple of the witnesses. That is the shortfall in Medicaid payments per unit of service. Some managed care plans dealing with Medicaid have been able to make up for that by reducing utilization, shifting people out of emergency rooms, improving coordination of care. But the ability to do that is going to vary a lot in different States. It is not necessarily going to be the case that you can make sufficient cuts in Medicaid utilization through management of care to make up for that shortfall in payment rates. So it is not certain that it is going to work everywhere.

A second issue is that managed care in Medicaid has had very little experience in dealing with the SSI, the disabled population, who are the most costly beneficiaries. Most of the State managed care programs up until now have dealt only with AFDC beneficiaries who much more closely resemble the kind of patients they treat in the private sector.

And the ability to achieve the savings that are necessary to integrate Medicaid patients in the private sector and private sector

rates is going to depend on the ability of these managed care entities to move into management of chronic problems, special populations such as the chronically mentally ill, people with HIV, that not all HMOs in the private sector have had very much experience with.

Senator RIEGLE. You know, let me just stop you for a minute. It seems to me that if we did not have to worry about the money, if we had enough money to pay to cover the health needs across the board and to get these underserved persons with particular problems dealt with properly, we could get just the mechanics of delivery done right. Assume that for the moment, and the money was there to pay for it.

I think, you know, our task would not be nearly so difficult. I mean we would figure out a way to do it and we would pick one way or the other and we would do it and then we would see how it worked. And if it needed adjustment, we would adjust it.

I am concerned that as we come down toward the home stretch in this debate that there may not be the national will to spend the money to do the job right. I mean, the problem may be in effect coughing up the money to do what has to be done here.

Even if you can make a strong economic argument that over 10 or 15 or 20 years you will actually spend less money, that the Hawaii experience of 20 years of universal coverage where the cost is a percentage of the total economy has now dropped way below the national average, good preventive care and good monitored high quality care over time saves you money that you otherwise will spend.

But that is sort of a subtle argument and it is future versus now and there is a lot of skepticism. I am concerned that when it comes right down to it, people who have some semblance of health care, feel pressed financially, may not feel all that charitable in their hearts about wanting to cough up the additional money that is needed through whatever taxing, revenue raising measures to get this job done right for the whole country.

Then if your economic system is not working right, so you have a growing underclass that cannot escape by a sort of upward mobility through the economic system, and therefore cannot solve their own problem, you are really caught in a terrible dilemma because you have a growing number of people who need health care services and who cannot pay for them. And the question is, can we get everybody else who might have some extra money to help in that regard and in the process get the system changed and then get ourselves a healthier population over time.

I mean that is sort of the terrible quandary we are in. I can sort of feel as this debate sort of comes down to the end here, that the issue of facing the need to raise an adequate amount of money to do this and to sort of make the change, assuming we can make wise decisions about the different mechanics of delivery and quality into one system, I feel a great pain about it.

Because I think we have finessed that issue. I have never been convinced that the cost estimates that we have been working with are solid enough. I do not think they are really earning public confidence.

The other thing is that the question of just off loading this on the States and telling each one of the 50 States, well, look, why do you not figure out how you want to do it. These are the parameters. But in a sense that is kind of a finesse, too, because then the responsibility for the delivery is out there and we kind of cut some corners at this end with respect to the responsibility and the measurement and the accountability.

It would be much better in my mind if we could have a uniform national system and everybody was in it, and it had the choice that you speak about. The quality was high and that we were willing to face up to what that costs, recognizing that there are efficiencies in economies that you can start to get on day one and that build up over time as you get a healthier profile in your people and you avoid future costs that you otherwise would spend.

I guess I am just sort of stating a concern that I have at this point in the discussion that I am not sure that we are really facing up to what has to be done here in terms of just stepping up to the plate and saying, look, to do this involves spending this much money. And if we do it right, it will be a bargain and we all ought to feel better about ourselves and about our country, and about looking after one another and caring about one another.

I hope we will have the courage to do that. I think the President has tried, and the First Lady, with their plan to put these issues out and to try to deal with it in that kind of encompassing way. But whether or not we are ready to really step up to the plate and do what is needed I think is very problematical at this point, and it is a great concern to me.

Let me just have your comment and then we have two other colleagues and I will yield to them.

Mr. SCHEPPACH. Let me just say that I think both the administration's plan and the Chafee plan will get the low-income populations into managed care. So I really do not see any difference there. But both of them also maintain the categorical nature of Medicaid. So you continue to have Medicaid and then you create another low-income program.

We think it is a real opportunity to take the acute care portion of Medicaid and sunset it and fold that into the new low-income program. Assuring that everyone gets the same benefit package.

And if, in fact, we need some supplemental benefits for those population broadly defined from low-income populations, then we need to set up a separate financing mechanism to do that.

The Medicaid program, as you know, continues to be very, very inflexible and we are very concerned that if we maintain the categorical nature of that program we will not get the savings, we will not get the care that we really desire.

Senator RIEGLE. Thank you very much.

Senator Rockefeller, I must go to the floor, too. I am sitting in for Senator Moynihan. Let me not only recognize you, but invite you, if you would, to come on over and do the chairing through yourself and Senator Grassley.

Senator ROCKEFELLER. Can I do it from here?

Senator RIEGLE. You sure can. I will bring the gavel down.

Senator ROCKEFELLER. I do not need the gavel. I never use a gavel.

Senator RIEGLE. All right.

Senator ROCKEFELLER. Senator Grassley and I have both been on the floor trying to protect any semblance of the future of health care.

Senator RIEGLE. Good.

Senator ROCKEFELLER. We apologize to the panel members that we were late. But it is very interesting what is going on there, because they—the Senator from New Mexico and the Senator from Nebraska, one Republican and one Democrat—voted for a budget cut in the Budget Committee. Then they suddenly realized that half of that money might come out of Defense.

Since they are not very happy about that. They then ignored what they did and offered another amendment which would eliminate all the Defense cuts, but would take all the cuts out of Medicare. This is not a Medicare hearing, but it is really quite something. The feeling on the floor is that the amendment may carry.

Otherwise, I disagreed with what I heard about what Senator Riegle said. I have a more optimistic feeling about the future of health care reform, if he was implying otherwise, and I am not sure that he was, because I was reading and talking, too.

But I do think that what the President's plan does for the Medicaid population is stunning. I think most people do not know about it. Most people do not know about a lot of things in the President's plan because we cannot get through the airwaves and Harry and Louise and all the other matters that are less important to our lives, but claim more of our attention than important things in our lives.

I think what the President's plan does and I think Senator Grassley can speak for the Chafee plan, when you take an entire population and put it inside a general health care system is that you suddenly present the possibility that doctors will see Medicaid patients. In West Virginia, in fact, doctors do see most people who come to them, they are much more generous in that respect than doctors from other States. They do accept Medicaid patients at a much higher rate. But they are, of course, underpaid.

Now the chances of that happening are much less good. In other words, much more favorable in the President's health care plan. It is very difficult to take a Medicaid population and put it inside a health care plan. It costs money. That is one of the reasons that Chuck Grassley and I were down there fighting this amendment because they are going to take $20 billion out of health care money, on a quiet Thursday morning.

Obviously, that would have repercussions for Medicaid. It would have repercussions for everything. It would have repercussions for veterans who are a very big part of the President's health care program. I do not really have so much a question to ask, although I guess I ought to because it is kind of silly for me to be sitting here with four panelists.

I used to work for Ray Scheppach and he understands these matters. It just makes me very angry, I guess, Senator Grassley, and I think you would share this because I think you want the same things out of health care that I do. There may be some places where we approach it differently. But I think in our gut, so to speak, we start from the same place. I think basically that is what

counts. If your gut is right, things tend to sort themselves out later on.

It is really annoying when all the good things that can be done in health care and for the Medicaid population are simply side tracked so that the public cannot get an understanding.

On the other hand, I will have to say that the health care retreat that we had this weekend, just the members of the—as I keep saying, the 20 white males on the Senate Finance Committee, was a very successful one. It was interesting to me that it was really the first time—we have these hearings, but Chuck Grassley and I do not talk at these hearings. We ask you questions. Well, I am not doing that. I am sort of talking to Chuck. But we do not talk to each other.

If you are going to come out with a bill there has to be a human relations component. You have to understand where other people are, and what their requirements are, what their beliefs are so that you can adjust your own beliefs and hold onto your own beliefs, but try to get something that works.

I felt, Senator Grassley, that it was a very good weekend in that respect. We were very honest with each other. There was, I think, a good deal of optimism that came out of that weekend. Senator Moynihan was on the Today Show Monday morning and was very optimistic.

We had an odd instance. I spoke to the League of Lobbyists yesterday right after Senator Chafee did. We did not hear each other speak, but I am told we both gave the same speeches and that they were basically optimistic. They were upbeat. The feeling that Pete Stark has now done what he is going to do; Bill Ford will do what he is going to do; John Dingell is going to do what he is going to do; Ted Kennedy is going to do what he is going to do.

But it going to end up in this Chamber, Senator Grassley. It will be ourselves kind of working this thing out, which is the way I think it ought to work because I think we are a more representative group of Senators. Representing the Senate in a more moderate fashion perhaps than some other committees.

Senator GRASSLEY. We are like a partisanship in this case.

Senator ROCKEFELLER. Yes. I mean we have from time to time, I divulged myself a little bit of it on the floor this morning and was not very happy about it, but I was just angry enough that I went ahead and did it anyway. But I think we are going to do it here.

What I guess I want to say to all of you who care so much about these things and fight so hard for them, is I think we will get health care reform. I think we will get it this year. I think we will get it with most of the basic principles that are required and I think that the Medicaid population will be taken into the general program and in a very interesting symbolism will be no different than the President of the U.S. or any U.S. Senator.

Everyone will belong to alliances, you know. Bill Clinton will belong to an alliance and Sara Jones from somewhere in West Virginia who is on AFDC will belong to an alliance. Everyone will be on equal terms. Chuck Grassley and I will belong to an alliance somewhere and we will all be doing this the same way, just kind of a one—tier approach which appeals to me.

Senator Grassley, I just kind of thought I would say those things and now you have better things to say. So let me turn to you.

Senator GRASSLEY. I do not have better things to say. I have questions to ask. Thank you very much for your participation and yielding the floor to me.

First of all, because I am late, and if any of these were discussed with any other members, you would not make me feel bad if you said read what I said to so and so, so we do not keep you here needlessly.

Ms. Wintringham, you stated that point-of-service options should be optional but not mandated. If I remember correctly, the Clinton Administration required a point-of-service option in managed health plans because they wanted to retain a greater degree of consumer choice and thought that having a point-of-service option would be the best way to do it.

I would like to have your comment on it. But before you comment, why should we not require such an option if the enrollee had to pay some for it? That is a question, for instance, the Medicaid beneficiaries, that extra amount that they might have to pay would not be large but it could be sufficient to discourage some sort of routine out-of-plan utilization.

Ms. WINTRINGHAM. We, as many other HMOs around the country, have been very strong supporters of choice in the sense of letting every citizen exercise their vote and their right to a vote based on their experience with a particular plan. So we, as other members of this panel, have said whatever model is adopted there should be a way for each individual member to say I do not like the way the plan is taking care of me and if that is not resolved to leave and go to another plan.

Choice should be exercised at the health plan level. As we said earlier, if you want to take advantage of the success of HMOs, and if you want to then apply that to larger populations and theoretically solve the health care problem in the United States, we have to make sure that any element that is fundamental to their success in the first place does not go away.

We believe in a system, a panel such as ours, where you have a wide range of providers to choose from, but they are all taking care of only our members. And in order to let those members seek care outside anytime they wanted to will undermine the ability for us to succeed in a couple of ways.

One is that if you want to hold us accountable, as I believe you should, for the full range of services provided to our members, if you want us to look at the care and make sure it is appropriate, if you want us to look at outcomes based on that care, if you want us to coordinate everything that is happening to that member and achieve cost efficiencies, you have to let us be in a position to be accountable.

And every time someone can go outside the system that we have created through credentialing, quality assurance reviews, a single medical record, we lose the ability to be accountable for that service.

Another concern that was raised earlier is, what would happen if there are even modest copays, out-of-pocket expenses for a Medicaid population if they had a choice to use a point-of-service option?

I agree with what was said earlier that even at a very modest level, people will not go for the preventive and up front services they need. They will withhold care and withhold paying that small amount until they become very sick. And you have just undermined the whole process you have tried to put in place, of encouraging people to come in, to get preventive services, to have screenings, to get the care up front instead of waiting until they are very sick.

Senator GRASSLEY. Well, let me ask you this. From the title of your organization, for Greater New York, do you take in any of the rural areas of up-state New York? What I am getting at here is what you just said, and you feel strongly about it, that there should not be any option outside of choosing a plan——

Ms. WINTRINGHAM. It should not be a mandatory option, right.

Senator GRASSLEY. Will that then work in rural areas?

Ms. WINTRINGHAM. Well, our recommendation is that it not be a mandatory option, that plans have the option of offering a point-of-service product. I believe as you go community by community, you will find communities where it will make sense to create some sort of network or joint arrangement with local community providers will do so.

You can still do that through the same sort of mechanisms we have now, if oversight credentialing and quality assurance, if we have the option of making those arrangements. We are obviously not in rural areas in central New York City, although we are in underserved areas.

Senator GRASSLEY. You are strictly an urban organization?

Ms. WINTRINGHAM. We are also in New Jersey and in Florida. And in parts of New Jersey we obviously have rural circumstances to deal with. In those neighborhoods we have not installed beautiful $10 million medical centers where all of the care and all of the specialists are in one site. We have made arrangements with local community providers to provide care to our members and they agree in turn to go through our processes of credentialing, having a unified medical record, going through quality assurance.

So our recommendation is that it be voluntary based on the local market and the local community.

Senator GRASSLEY. I think you wanted to offer something.

Mr. DORN. Thank you, Senator Grassley. Unfortunately, after this gracious agreement with our issue about cost sharing I hate to disagree on the point-of-service option, but I must. We see the point-of-service requirement in the administration's bill as being a very positive feature.

It assures consumers choice. If you are enrolled in an HMO and someone in your family needs to go outside that HMO for care, you can make that choice. You pay more, but you can make that choice.

And in addition, it promotes quality. If an HMO starts to see lots of people using the point-of-service option, then they have to ask themselves, why are all these people finding our network inadequate. Is there some problem that we need to correct here? So we see this as being something that promotes accountability rather than undermines it.

The idea about letting people choose plans as opposed to point-of-service options is problematic. Because perhaps, you know, three or four people in your family may be served perfectly well in an

HMO but you have one child with a special health need that cannot be adequately met by providers who happen to belong to that HMO and you may need your child to go out of the network and you are willing to pay a little extra for it.

So we see this as a positive measure, promoting choice and promoting accountability. And in recent years, the HMO with point-of-service option, far from being a problem for the HMOs has expanded greatly in the market. I do not happen to have materials with me right now, but I would be delighted to provide them to you, Senator, after the hearing if you would find that of interest.

And I think the suggestion that you made that low income people, including Medicaid beneficiaries as well should have this choice with some increased cost sharing. I think that makes a great deal of sense. Medicaid beneficiaries may find themselves in a position where one member of their family needs to go out of plan, perhaps somebody with disabilities, perhaps a senior citizen.

Of course, the point was well made that that increase cannot be the same as that which middle income people would face, but some kind of modest increase in copayments so that the family has some financial incentive to stay in the plan. But if they really need to, they can get out.

So unfortunately I need to disagree, but I wanted to heartily second your sentiment, Senator Grassley.

Senator GRASSLEY. Senator Rockefeller, thank you.

Thank you all very much.

Senator ROCKEFELLER. Thank you, Senator Grassley.

Let me just ask a final question. The President is coming here at noon to meet with some of us on health care reform. I think I might drop in. [Laughter.]

I would like to have—Ray, I understand you talked on this before and, Mr. Dorn, you might have and I would like to get comments again. Because there is a distinction, a very strong distinction, between the Chafee bill and the President's bill as I see it in the way the Medicaid population is treated.

One of those is the so-called cap on Medicaid that is in the Chafee bill, which is at what, 6 percent growth per year when Medicaid probably grows last year—what was the increase last year?

Mr. SCHEPPACH. Last year it was only about 12 percent, but for the 5 years before it averaged 20 percent annually.

Senator ROCKEFELLER. Okay. And some of that is more people and some of that is health care inflation. But I would just like to get a sense from you what a 6 percent cap statutory would mean for health care for Medicaid patients.

Mr. DORN. Senator Rockefeller, we are very worried about it, as you can imagine. If real health care inflation goes up at 10, 11 percent per year and Federal dollars flowing into the States are going up at 6 percent per year and then 5 percent per year ultimately under the Chafee bill, that means that the dollars will buy fewer real health care resources in the States and the States will have to choose between investing more of their resources to maintain the status quo or making cutbacks—knocking people off Medicaid, lowering the scope of services, cutting provider reimbursement rates to make access even more difficult. We are very worried about this provision of the bill.

Senator ROCKEFELLER. That is fascinating.

Mr. DORN. I am sorry?

Senator ROCKEFELLER. That you do not hear this aspect discussed in the press. I mean I bet there are 30 people in the United States of America that know about this. That is an obvious exaggeration. But, in effect, it is the case. I have not heard this discussed. I have not read about it.

Mr. DORN. It is a very serious problem.

Senator ROCKEFELLER. I interrupted you. Go ahead, please.

Mr. DORN. If I could just take the liberty of raising one other issue with you, Senator Rockefeller, given that you are soon going to be meeting with the President, we agree that in many, many respects that the administration's bill does a wonderful job with Medicaid recipients. It mainstreams our clients, not just into managed care plans, but into the same plans that serve middle class people.

If there is one major concern that we would have, it would be in the area of cost sharing, where under the administration's bill if you get cash assistance you pay $2 when you go see the doctor; if you do not get cash assistance, for whatever reason, you pay $10.

That may not sound like much to many of us, but for a very low-income family, a couple kids get sick, that is half the family's food budget for the week.

If you have somebody with disabilities, HIV, ongoing health needs, $10 copays can quickly mean you cannot pay your utility bills. So we fear that people who do not get cash assistance will have a new barrier to access in their way.

Forty percent of Medicaid recipients do not get cash aid today and most commonly they pay no copayments. So there would be a new barrier. It would also make it more difficult for people to move from AFDC to employment because you would get punished with increased costs when you make the right choice.

So if there is one issue where we could improve the administration's bill, it would be to make sure that all low-income people have cost sharing scaled down to fit low-income budgets and in appropriate cases eliminate it entirely.

Senator ROCKEFELLER. I totally agree with you on that. I am sort of surprised by that in the President's budget. In the President's plan, there are a couple areas where I do not agree and that is natural. Most of them I do. But I think your point is extremely well taken.

You know, thinking back to my Vista days in Emmons, West Virginia, $10 is a lot of money.

Mr. DORN. Right.

Senator ROCKEFELLER. It was then and it is a lot today. Are there any other points that any of you want to respond to? Are there any other points anybody wants to make?

[No audible response.]

Senator ROCKEFELLER. If not, you are all free to go have lunch.

Mr. DORN. Thank you.

Mr. SCHEPPACH. Thank you very much.

Mr. MERLIS. Thank you.

Ms. WINTRINGHAM. Thank you.

[Whereupon, at 12:47 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF STAN DORN

Good morning, Mr. Chairman and members of the committee. It is an honor to participate in these historic hearings.

I am Stan Dorn, managing attorney of the Washington office of the National Health Law Program. Our program is the legal services national back-up center specializing in health issues affecting low-income people. We work with over 1,200 legal services offices across the country to help their indigent clients receive necessary health care, including through Medicaid. I would like to take this opportunity to thank the members of the Finance Committee for the Committee's leadership in improving Medicaid through the years.

Long ago, I learned one of the cardinal rules of public speaking: never give a speech with more than three main points. Apparently this rule has origins in Christian theology. At my peril, I hope to discuss four topics today: universal coverage; cost-sharing; supplemental services; and mainstreaming low-income people into the same health care delivery systems that serve those with higher incomes. In each area, I will describe the issue and compare the three proposals likely to be of greatest interest to this Committee: the Administration's bill; the Managed Competition Act of 1993, sponsored by Senator Breaux; and the Health Equity and Access Reform Today ("HEART") Act of 1993, sponsored by Senator Chafee.

Although the remainder of my testimony will not focus on Senator Wellstone's "single payer" proposal, I would be remiss not to note that it would provide universal coverage, without cost-sharing, through a single system of care, providing comprehensive benefits to all. Medicaid beneficiaries and many other consumers would be well-served by such a system.

1. UNIVERSAL COVERAGE

The issue of universal coverage is obviously fundamental. Without health care coverage, consumers' health and well-being are at risk. According to studies in the New England Journal of Medicine and the Journal of the American Medical Association:

- Within six months of losing Medicaid coverage, low-income hypertensive patients suffered an average increase in blood pressure associated with a four-fold increased risk of death.
- Compared to the insured, uninsured women with breast cancer are 50% more likely to die.
- After controlling for factors identified by Congress' Office of Technology Assessment (e.g., income, sex and race), lack of insurance increases risk of death by 25%.

In the context of the Medicaid program, the issue of universal coverage has two sides: ensuring that coverage is not endangered for America's over 30 million Medicaid recipients; and extending coverage to other low-income people, including the one in three families with incomes below poverty who today are uninsured, often despite employment

The Administration's bill. The Administration's bill provides coverage to all, except certain immigrants. Both current Medicaid recipients and low-income people without Medicaid coverage would receive health insurance under the Administration's bill. Some Medicaid beneficiaries would lose health coverage—namely, immigrants who now receive full Medicaid benefits as permanent residents under color of law but would not qualify as legal permanent residents under the definition in the Administration's bill.

The Managed Competition Act. For people with incomes below the poverty line, this bill provides subsidies permitting enrollment in the lowest-cost local plans. This would extend coverage to many currently uninsured people who live below poverty.

For many families with incomes above poverty, however, this bill will provide little coverage. Because it abolishes Medicaid, the bill may actually take away health insurance from many of the 6.2 million Medicaid beneficiaries who, in 1992, had incomes above the poverty line. Such beneficiaries include the following groups:

- In most states, pregnant women with incomes up to 185% of poverty;
- Families that left AFDC because of eamings;
- In many states, infants with incomes up to 185% of poverty, and in all states, some young children up to 133% of poverty, depending on age;
- People with disabilities who lost SSI because of earnings;
- Certain seniors and people with disabilities who lost SSI due to receipt of Social Security, including COLAs, survivors' benefits, and special widow's or widower's benefits; and
- In most states, the "medically needy," who qualify for Medicaid because of their medical expenses.

Here are some examples of how this bill would work for people between poverty and 200% of poverty:

- Pregnant women with incomes of 185% of poverty today receive Medicaid coverage in most states. Under the Managed Competition Act, these women would lose coverage unless they paid 85% of the full cost of an insurance policy, which few such women could afford. Without health insurance, low-income pregnant women would receive less prenatal care, increasing the odds of bad birth outcomes. Such outcomes entail potential tragedy for the family and preventable costs for the taxpayers.
- Households who work their way off AFDC today receive continued Medicaid coverage for a year, smoothing the transition from welfare to wages. Such a household with an income at 150% of the poverty level would lose coverage under the Managed Competition Act unless it could pay 50% of the cost of an insurance policy, which few such families could afford. The Managed Competition Act would create new barriers to employment for such households seeking to leave welfare.

Moreover, the bill apparently denies low-income subsidies to people, regardless of income, who work 25 hours a week or more at companies with over 100 employees. Under this provision, identically needy households would receive radically different levels of assistance, based purely on the size of their employer. For example, someone working 40 hours a week at $5 an hour has annual earnings below the poverty line for a family of three. If employed at a small company, such a family would have its premium fully subsidized for a low-cost plan, and, as described below, would receive substantial assistance with cost-sharing. If employed at a larger company, such a family would be entirely without assistance. Without employer contributions, such a family almost certainly could not afford coverage. This provision would erect a sizable obstacle to employment for low-income families seeking to leave public assistance to work at large or medium-sized companies.

The HEART Act. Potentially, the HEART Act could achieve universal coverage. Medicaid would remain intact. By the year 2005, low-income subsidies would reach households with incomes up to 240% of the federal poverty line.

This potential may not be achieved, unfortunately. The bill would limit annual increases in federal Medicaid funds to a fixed percentage—18.8% during fiscal year 1996, 6% for each of the next four fiscal years, and 5% thereafter. If these increases are outpaced by general health care inflation, federal dollars would buy fewer and fewer health care resources. States would be forced to choose between increasing their investment in Medicaid or cutting Medicaid eligibility, benefits or reimbursement. Many Medicaid beneficiaries could lose current coverage.

This is a serious danger. From 1986 through 1991, for example, private health insurance premium costs increased at an average annual rate of 11%.

If the bill's low-income subsidies were firmly in place, loss of Medicaid would not entail a complete loss of coverage, since people losing Medicaid coverage could obtain private insurance. Unfortunately, the availability of low-income subsidies depends on certification by the Office of Management and Budget that the HEART bill's revenues are sufficient to pay for subsidies. If such certification is not forthcoming, low-income people, including those who may lose Medicaid coverage, would not receive necessary subsidies and could go uninsured.

2. COST-SHARING

Health care coverage will be a mirage for the poor unless it is affordable. Cost-sharing that sounds modest to middle-income people is prohibitive to the poor. For example, for the more than one in twenty American households with annual incomes below $5,000, a mere $10 copayment is the equivalent, for a household with average income, of a $75 copayment. If several children get sick, or one chronically ill patient needs several services within a short period, $5 or $10 copayments could consume the family's weekly food budget. As the late Senator Claude Pepper once explained, "For the [elderly] poor, a fifty cent co-payment which seems insignificant to most of us can mean the difference between a needed prescription and a quart of milk or a loaf of bread."

Public health studies confirm that low-income people may suffer great harm with substantial cost-sharing. For example:

- One Rand Corporation analysis found that, when California's Medicaid program imposed a $1 co-payment on the first two physician visits per month in 1972, physician visits declined by 8%; inpatient hospital utilization rose by 17%; and overall program costs increased by 3–8%.
- Another Rand Corporation study found that, when low-income people with heart problems were exposed to a range of co-payments, the resulting hypertension increases were associated with a 10% average increased risk of death within a year. Congress' Office of Technology Assessment (OTA–BP–H–112, p. 11) recently concluded:

" . . . Congress should be cautious about the extent to which cost-sharing is relied on to control costs, especially for sick, low-income individuals. These individuals are the most likely to benefit from receiving health care services at no out-of-pocket cost and the most likely to be harmed by patient cost-sharing requirements. Policymakers should also be aware that there is no evidence to suggest that cost-sharing's greater deterrent effect on those with lower incomes ceases at a rigid dollar threshold."

Decisions by state Medicaid programs confirm the wisdom of avoiding substantial cost-sharing for the poor. Under federal law, such programs may charge up to $3 per service, depending on the dollar value of the service. But as the chart attached to my testimony indicates, the most common policy is to charge no copayments for services like physician visits and prescription drugs. These programs, which have experience working with low-income beneficiaries, have found that it is generally not helpful to charge copayments. To work effectively with low-income populations, health care reform should avoid cost-sharing for low-income populations, and at most charge no more than the nominal copayments used under Medicaid.

Medicaid provides other crucial protections that should be incorporated into health care reform legislation. Providers may not deny care to those unable to pay copayments in advance. Certain groups of beneficiaries (e.g., children) and services (e.g., family planning) are exempt from copayments. States may place caps on copayments, preventing those with chronic illness requiring multiple services from being forced to choose between paying for necessary health care and paying for other necessities, such as utility or grocery bills.

The Administration's bill. For recipients of AFDC or SSI, the Administration's bill would provide copayments of $2 per doctor visit, $1 per prescription, and $5 per outpatient psychotherapy visit.

Unfortunately, the picture is very different for low-income people not receiving cash assistance. They include households whose unemployment insurance has run out, people with disabilities lasting less than one year, and the working poor. Such low-income people must pay $10 per doctor visit, $5 per prescription and $25 per outpatient psychotherapy visit.

These copayments would be prohibitive for families with little or no discretionary income. They would force dangerous and costly deferral of care until health problems degenerate into emergencies, contradicting the President's goal that health problems should receive prompt attention.

Moreover, making receipt of cash assistance the basis for significant help with cost sharing has the following consequences:

- It punishes poor families who leave AFDC for employment.
- It perpetuates irrational interstate disparities. Families with identical need would receive very different levels of assistance based purely on the cash assistance rules in their state of residence. (For example, AFDC eligibility for a family of three ends at $964 a month in Arizona but at $288 a month in Indiana.)

This approach would also create a new health access barrier for many current Medicaid beneficiaries. The vast majority would face some increased copayments under the Administration's bill. This increase would be particularly large, however,

for the nearly 40% of Medicaid beneficiaries who do not receive cash assistance. In 1992, the latter group included over 2 million seniors, over 1 million people with disabilities and over 5 million children.

For a narrow category of preventive services, including tests, examinations and prenatal care, cost-sharing is waived under the President's proposal. However, much primary care remains subject to copayments that are not scaled down to fit low-income budgets and thus will cause dangerous and costly deferral of essential care.

The Managed Competition Act. This bill limits cost-sharing to nominal amounts for low-income people with incomes below 200% of poverty. Not only does this approach promote access to care, it avoids the adverse consequences, described above, of making cost-sharing subsidies depend on receipt of cash assistance.

Unfortunately, the bill leaves it to federal administrative authorities to define "nominal" copayments. Last year's managed competition bill sponsored by the Conservative Democratic Forum provided more assurance of access to care, since it cross-referenced the Medicaid statute in defining nominal copayments. Neither version of the bill incorporates Medicaid's other cost-sharing safeguards.

The HEART Act. Under this bill, Medicaid consumers receive the Medicaid program's full cost-sharing protections, described above. Cost sharing is undefined for other consumers, however, including those with low incomes. The bill directs federal administrative authorities to develop appropriate standards. While continuation of Medicaid protections is an important, positive feature of the bill, access to care for other low-income consumers will not be secure without express cost-sharing protections, including the protections available under Medicaid.

3. SUPPLEMENTAL SERVICES

In most states, Medicaid benefits exceed those offered by typical private plans, in several ways. First, Medicaid often covers services such as transportation or case management, which are needed to ensure that low-income beneficiaries actually receive health care, not just a health insurance card.

Second, Medicaid covers services that address the above-average health care needs of much of the Medicaid population, including people with disabilities and senior citizens. Poverty is associated with risk factors that increase the incidence of such conditions as breast cancer, hypertension and developmental disability. Moreover, many people are poor precisely because they suffer from significant illness that precludes substantial employment. Accordingly, most Medicaid programs cover services such as rehabilitation or therapy to maintain function; and ongoing mental health services, particularly for seriously ill children and senior citizens.

Third, Medicaid covers essential services that poor people usually cannot purchase. For example, nearly 90% of state Medicaid programs cover adult dental care and eyeglasses, which many low-income adults need for work. Missing or disfigured teeth reduce employment prospects, and inability to see properly can greatly impede job performance.

At a minimum, health care reform should not deprive these beneficiaries of essential supplemental services now covered by Medicaid. Coverage of these services should also extend to other low-income people not covered by Medicaid today.

Before describing the differences between the bills on this issue, I should note that many of them authorize increased appropriations for supplemental services. Increased funding for community health centers, for example, is part of these bills. The Administration's bill also funds "enabling services," such as transportation and translation, to help low-income people actually receive care. Unfortunately, there is no assurance that these newly authorized funds in fact would be spent. A more secure approach would (a) direct the expenditure of funds and (b) establish a supplemental benefits package reimbursing supplemental services either through fee-for-service payments or as part of a capitated rate.

The Administration's bill. The Administration's bill would continue Medicaid supplemental services for low-income children, cash assistance recipients and Medicare beneficiaries. Adults receiving neither AFDC, SSI nor Medicare, on the other hand, could not receive federally-funded Medicaid supplemental services. These adults include many people with disabilities who would suffer great harm without such services as ongoing mental health care, or rehabilitation and therapy services to prevent deterioration in function. Federal financial participation would end for these adults, forcing states to choose between continuing to provide these benefits entirely at state expense or making cutbacks in these critical services.

The Managed Competition Act. People with incomes below the poverty line would receive all services commonly covered by state Medicaid programs. This would provide supplemental services both to many current Medicaid beneficiaries and to millions of others with incomes below poverty.

By contrast, low-income people with incomes above the poverty line would receive no supplemental services. Their coverage would include only the standard package of benefits, which is not defined in the bill but is left to a federal administrative agency to determine. As noted above, 6.2 million Medicaid beneficiaries have incomes above poverty. Almost certainly, they would lose current, essential supplemental services under the Managed Competition Act.

The HEART Act. Under this bill, the Medicaid program would continue offering supplemental benefits. However, the dimensions of this coverage would depend on state decisions about optional benefits and eligibility. As noted above, the bill's absolute dollar caps on federal Medicaid funding may put great pressure on states to make significant cuts in benefits and eligibility. This could substantially reduce Medicaid beneficiaries' receipt of necessary supplemental services.

4. MAINSTREAMING VS. SEGREGATION

Today, low-income families often receive care from a different health care delivery system than that serving people with higher incomes. Often, these systems are both separate and unequal. Medicaid reimbursement, for example, averages 60% of private reimbursement, according to the Kaiser Commission. These substantially lower reimbursement rates have serious consequences:

- Many Medicaid beneficiaries cannot find a doctor willing to see them. For example, until California's Medicaid program was sued, it paid so little to obstetricians that over 20% of pregnant women with Medicaid could not find a maternity care provider.
- Many Medicaid beneficiaries receive inferior quality care. A recent New England Journal of Medicine study of one state's Medicaid hospital program found that, when reimbursement fell to 70% of private sector rates, Medicaid patients with heart disease were less than half as likely, compared to private fee-for-service patients, to receive potentially life-saving treatment of heart disease.

Even beyond the critical issue of reimbursement, mainstreaming is an important concern for low-income people. Low-income families should have a meaningful opportunity to enroll in the same health plans that serve their middle-class neighbors. People with disabilities, for example, often need a full range of specialists, who might not affiliate with health plans targeting low-income people. Moreover, such freedom of choice provides competitive pressure that promotes quality of care. If health plans instead know that their low-income consumers lack the ability to "vote with their feet," they are more likely to provide poor care to their captive clientele.

This issue is also important because, often, health care delivery systems segregated on the basis of income are thereby segregated on the basis of race. In much of the country, low income people are disproportionately likely to be people of color. Under health care reform, we should strenuously avoid the promotion of discrete health care delivery systems that are racially identifiable.

The Administration's bill. Through the use of regional health alliances, the Administration's bill equalizes basic reimbursement for all consumers, regardless of income. The bill also gears premium subsidies to permit low-income people, defined as cash assistance recipients and people with incomes at or below 150% of poverty, to enroll in any plan up to the regional average price. If plans at or below that price are all at capacity, the subsidy expands to permit enrollment in other plans. In short, the Administration's plan provides low-income consumers with a broad range of options, expanding access to care, helping prevent segregation and incorporating competitive mechanisms to promote quality.

The Managed Competition Act. Under this proposal, low-income premium subsidies would be based on the lowest-priced local plan. Low-income consumers wishing to enroll in other plans would be required to pay part of the difference in price. For most low-income families, these additional payments would require sacrificing other necessities of life. Only a small proportion would have the ability to choose any but the least-cost plan. Not only might this result in the problems described above, it could cause harmful fragmentation of care, as the lowest cost plan could change from year to year.

Moreover, under this bill, all health plans except the lowest-cost plan in a region would receive less initial reimbursement for low-income consumers than for others. This shortfall would be greatest for the lowest-income consumers and the highest-priced plans. This is because the federal low-income premium subsidy is based on the cost of the lowest-priced plan. Low-income consumers would pay only a percentage of the difference in price between the lowest-priced plan and the plan actually chosen. The health plan chosen by the consumer would "eat" the difference.

Such reimbursement gaps would increase if the bill's funding mechanisms produce too little revenue to pay for the bill's contemplated subsidies. If shortfalls occur, low-

income premium subsidies would be reduced across the board, causing all health plans to lose money by accepting low-income customers.

Obviously, these reimbursement gaps would create great incentives for health plans to do whatever they can to avoid enrolling low-income consumers. Such discrimination can be accomplished through many subtle means: choice of stations on which to advertise; choice of doctors and hospitals with which to affiliate; etc.

Fortunately, the bill contains a mechanism to equalize health plans' losses on low-income consumers. In effect, health plans seeing less than their fair share of low-income consumers would reimburse plans seeing more than their fair share, using purchasing cooperatives as intermediaries. If this Committee does not choose to accept regional health alliances as proposed by the President, a mechanism along these general lines could be critical to reducing financial incentives for discrimination. However, the bill's language should make clear that such a mechanism would prevent the enrollment of low-income consumers from affecting a health plan's gross income (aside from risk adjustments). More fundamentally, the bill's redistribution mechanism apparently applies only to plans offered by small employers with relationships to purchasing cooperatives. Large employers as well should participate in this mechanism to "share the burden."

The HEART Act. Under this bill, low-income premium subsidies would be based on the average of the lower-priced local plans (those at or below the average price). Low-income consumers wishing to enroll in more expensive plans would be required to pay the full difference in price. While this proposal may provide greater choice than does the Managed Competition Act, consumer choice remains limited to one-fourth of health plans. This may pose a particularly serious problem for people with special health care needs whose providers may not participate in the lowest tier of health plans.

This subsidy scheme applies to low-income people not on Medicaid. For Medicaid beneficiaries, the HEART Act presents several problems. First, Medicaid reimbursement shortfalls may worsen in response to caps in federal funding, as explained above. Second, the bill makes it easier for states to end beneficiary freedom of choice; it permits states to limit Medicaid beneficiaries' choice to two managed care plans, which need not serve anyone but Medicaid beneficiaries. Special federal approval would no longer be required to waive Medicaid consumers' right to freedom of choice.

This bill contains important and positive quality and access protections that would apply under such Medicaid managed care systems. We support strong quality and access standards. Such standards should be in place to benefit all consumers, and they should be enforceable. However, they are not enough. Obviously, they do not prevent the development of segregated health care systems. Moreover, the history of Medicaid is filled with examples of wonderful Congressional enactments that are not always observed or enforced. Competitive mechanisms to promote quality care are also essential. Low-income consumers will be at grave risk of receiving inadequate care unless they have the ability to take their business elsewhere.

CONCLUSION

If this Committee were required to choose between these three plans as currently written, we would recommend the Administration's bill as providing the greatest protection to the most vulnerable consumers. Fortunately, you have an opportunity to combine the best elements of all these bills, as follows:

Assure universal coverage, along the general lines proposed by the Administration.[1]

- For all consumers with incomes below 200% of poverty, limit cost-sharing to no more than the nominal amounts permitted under the Medicaid program, along the general lines proposed by the Managed Competition Act, while providing these low-income consumers with additional Medicaid cost-sharing protections, as proposed by the HEART bill for Medicaid beneficiaries.[2]

Furnish the supplemental benefits offered by a majority of state Medicaid programs to all low-income people below a set income threshold, along the general lines proposed by the Managed Competition Act, with continuing Medicaid coverage for

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[1] We would recommend modify the Administration's proposal by eliminating or modify the statutory caps it would impose on subsidies for low-income people and small business.

[2] In addition, we would recommend eliminating cost-sharing for the lowest-income consumers, including those with incomes below poverty.

other Medicaid beneficiaries, along the general lines proposed by the HEART Act (but without rigid caps on federal Medicaid dollars) and the Administration's bill.[3]

Permit low-income consumers to enroll in any plan up to the regional average price, without reducing reimbursement rates for low-income consumers, along the general lines proposed by the Administration.

I wish you the best of luck in your historic task. If we can provide any assistance, please do not hesitate to call upon us.

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[3] Given the likely greater federal role in administering overall low-income subsidies under health care reform, we would recommend federal administration of such supplemental benefits, with state responsibility limited to "maintenance of effort" payments.

STATE MEDICAID COPAYMENT PROVISIONS
October 1993

Physician Office Visits	States
No copayment	**31 & DC:** AK, CT, DC, DE, GA, HI, IA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, ND, NE, NJ, NH, NM, NV, OH, OR, RI, SC, TN, TX, UT, VT, WV
$1	**9:** AL, KS, MS, MT, OK, PA, VA, WA, WY
$2	**3:** CO, FL, ND
$3	**1:** NC
$5	**1:** AZ
Varies	**6:** AR, CA, IL, NY, SD, WI

Prescriptions	States
No copayments	**21:** AK, AZ, CT, DE, GA, HI, ID, IN, KY, LA, MN, NE, ND, NJ, NM, NV, OH, OR, RI, TN, UT
$.50	**3 & DC:** DC, MA, MD, PA
$1	**11:** FL, IA, KS, MI, MS, MT, NC, VA, WA, WI, WY
$1.50	**1:** SC
Varies	**14:** AL, AR, CA, CO, IL, ME, MO, NH, NY, OK, SD, TX, WV

Mental Health Visits	States
No copayment	**39 & DC:** AL, AK, AZ, CT, DE, DC, FL, GA, HI, ID, IN, KY, LA, MA, ME, MD, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NY, NV, OH, OK, OR, RI, SC, TN, TX, UT, VT, WA, WV, WY
$1	**2:** MT, PA
$2	**3:** CO, IA, KS
$3	**1:** VA
Varies	**5:** AR, CA, IL, SD, WI

Prepared by National Health Law Program (202/887-5310) with data from <u>Medicaid Source Book: Background Data and Analysis</u> and various sources for updates.

Prepared Statement of Senator Orrin G. Hatch

Thank you Mr. Chairman.

I appreciate the opportunity to hear from our panel of witnesses today regarding the Medicaid program and how it will fit into the overall context of health care reform.

As my colleagues on this Committee well know, Medicaid has been one of the fastest growing programs in the Federal budget, and is expected to reach a combined Federal and state total of nearly $152 billion in expenditures in Fiscal Year 1994.

I was interested to see in the testimony from the Congressional Research Service that the Office of Management and Budget estimates this figure will increase to $266 billion in 1999.

It seems to me that even without health care reform, we need to take a careful look at the rising costs of Medicaid to determine the problems areas as well as appropriate legislative action.

Accordingly, I certainly welcome our witnesses who will provide us with both a Federal and state perspective, and I look forward to their recommendations on how we can address the is sue of escalating costs as well as improve the level of quality and services provided.

Once Again, Mr. Chairman, thank you for scheduling this important hearing.

Prepared Statement of Mark Merlis

RECENT TRENDS IN THE MEDICAID PROGRAM

Thank you, Mr. Chairman. I am Mark Merlis, a specialist in social legislation in the Education and Public Welfare Division of the Congressional Research Service. I am pleased to be here today to provide information on recent trends in the Medicaid program. At your request, I will be reviewing overall spending, changes in program enrollment, and spending for particular services.

OVERALL SPENDING

In recent years, Medicaid has been among the fastest growing Federal programs. The Federal share of program spending is expected to reach $85.8 billion in FY 1994, accounting for 5.9 percent total Federal outlays, compared to 2.9 percent as recently as FY 1988. The program now accounts for 45 percent of all Federal assistance specifically targeted to low-income persons (compared to a combined 22 percent for family support payments and supplemental security income, or SSI), and 32 percent of Federal health outlays (compared to 53 percent for Medicare).

Much of the growth in Medicaid spending occurred over a very short period in the late 1980s and early 1990s. Table 1 shows combined Federal and State spending for each year since FY 1988, along with current services projections through FY 1999. As the table indicates, spending rose sharply beginning in FY 1988 and more than doubled between that year and FY 1992. A variety of factors contributed to this explosive growth, of which the most important were rapid increases in program enrollment and changes in provider reimbursement, particularly for inpatient hospital services.

Since then, spending growth has been more moderate. Still, the Office of Management and Budget (OMB) projects that Federal outlays under current law would reach $152.2 billion in FY 1999. In constant dollars, that would mean a 50 percent increase over the next 5 years. Much of this projected increase is attributable to continued growth in program enrollment.

The Kaiser Commission on the Future of Medicaid has estimated that 34 percent of the spending growth in FYs 1988–1991 was attributable to growth in the number of recipients. Applying the same methodology to the figures for the next several years, it may be estimated that 41 percent of spending increases in the period FYs 1991–1995 will be attributable to enrollment growth.

Table 2 shows the increases in Medicaid recipients since 1988 and the changes in outlays per recipient. (Recipients are persons on whose behalf Medicaid has paid a claim during a year; the figures therefore exclude enroliees who have made no use of their Medicaid benefits.) As the table indicates, once one factors out population growth and considers per capita spending, outlay increases appear much more moderate. Only in 1991 and 1992 were per capita payment increases very much above those experienced in other health sectors, such as Medicare or private insurance. It should be noted that the 1994 and 1995 figures are based on State estimates, with some Federal adjustments, and may therefore be optimistic. Still, it is clear that population growth is a central factor in Medicaid spending.

PROGRAM PARTICIPATION

Tables 3 and 4 show changes in the number of Medicaid recipients in recent years. Table 3 classes recipients by basis of eligibility, while table 4 shows demographic characteristics.

As table 3 indicates, most of the growth has not been in the categories traditionally eligible for Medicaid, recipients of Aid to Families with Dependent Children (AFDC) and SSI and the medically needy. The categories labeled "non-cash" have grown much more rapidly. The 5.3 million new recipients in these categories between 1988 and 1992 account for 64 percent of the growth in the number of recipients. Most of these recipients have been enrolled as a result of the statutory expansions in Medicaid eligibility in the late 1980s: coverage of low-income pregnant women and young children who do not meet welfare standards, the ongoing phase-in of comparable coverage for older children, and supplemental assistance for low-income qualified Medicare beneficiaries (QMBs). At the same time, there has been some growth in the welfare rolls. In particular, there was a jump in AFDC enrollment in 1991 and 1992. A variety of explanations have been advanced for this, but at least one factor reported by some States has been that families applying just for Medicaid have also been found to qualify for cash assistance.

Table 4 shows that the largest growth in number of recipients has been among children. The number of children receiving Medicaid has grown by two-thirds since 1988. Again, this is largely but not entirely attributable to the statutory extensions of Medicaid to non-welfare children. As the phase-in of coverage for older children in poverty continues, this population is likely to account for much of the growth in the remainder of the decade.

Medicaid has made a significant difference in the number of children without health coverage. The percentage of children under 18 with no health coverage has dropped from 19.6 percent in 1988 to 12.4 percent in 1992. Overall, however, the growth in Medicaid enrollment has not meant a reduction in the proportion of Americans without health insurance. Table 5 shows the percent of nonelderly Americans receiving coverage from different sources, and the percent uninsured, in 1987 and 1992. Medicaid was the primary source of coverage for 9.0 percent of the population in 1992, compared to 6.6 percent 5 years earlier. However, this growth was more than offset by a drop in the percentage of the population receiving employer-based coverage, while the percentage receiving other forms of coverage went unchanged. As a result, the portion of the population without coverage rose nearly as fast as the percent with Medicaid.

Medicaid coverage is still subject to categorical exclusions. For example, single adults and childless couples who are not aged, blind, or disabled remain ineligible, regardless of income. In 1992, Medicaid covered 47.2 percent of persons with family income below the Federal poverty level, while 28.5 percent of persons in poverty were uninsured.

SPENDING BY SERVICE CATEGORY

Factors other than population growth, such as changes in service utilization and reimbursement, account for the remainder of Medicaid spending increases. The Kaiser Commission estimated that 31 percent of spending growth in the 1988–1991 period was due to general medical price inflation, while 28 percent was due to price and utilization factors unique to Medicaid. While a case can be made for factoring out general medical price inflation in this way, Medicaid agencies do not necessarily consider inflation in setting provider payment rates, and those rates do not always rise in tandem with increases in charges to private patients. It may therefore be difficult to separate the relative roles of general inflation and Medicaid policy decisions in fueling spending growth.

Table 6 shows spending growth by service category. All the figures represent only the Federal share of spending, about 57 percent through most of this period. (Note that the totals differ from the Federal payment figures in table 1, which include the Federal share of State administrative expenses and other adjustments.)

The largest increases have been in hospital spending. Payments for inpatient and outpatient hospital services rose by more than $16 billion between FY 1988 and FY 1992, accounting for 45 percent of total spending growth. Two key factors contributed to these increases. The first was State responses to litigation or potential litigation under the Boren amendments of 1980 and 1981, which required that State hospital and nursing facility payment rates be "reasonable and adequate." A number of courts have found that State systems failed to meet this test and have compelled payment increases.

The second factor was growth in Medicaid payment adjustments to disproportionate share hospitals (DSHs), those serving large numbers of Medicaid and uninsured

patients. DSH payments grew from an estimated $831 million in 1989 to $18.0 billion in 1993. The Federal share of DSH payments in FY 1994 is projected to be $10.5 billion. This amounts to 36 percent of Federal Medicaid payments for inpatient general and mental hospital services, and 13 percent of all service payments. While some share of the DSH payments has been recaptured by States through such mechanisms as provider donations, provider-specific taxes and intergovernmental transfers, hospitals have also benefited. The Prospective Payment Assessment Commission has estimated that Medicaid hospital payments rose from 83 percent of actual cost in 1991 to 89 percent in 1992; for the hospitals treating the largest share of low-income patients, Medicaid paid 94 percent of costs. Congress has acted, in 1991 and 1993, to restrict the use of provider donations and taxes and to limit growth in DSH payments. The result has been the much more modest growth in hospital payments in the 1992–1995 period.

Other acute care payments have also shown large increases. Many States have raised physician payments, especially for pediatric and obstetric services. Prices for pharmaceuticals have risen; this is one area in which Medicaid payments do track private prices, despite the drug rebates mandated in 1990. Finally, the growth in "other" acute care spending reflects the improvement in payments to community health centers, rural health clinics, and federally qualified health centers (FQHCs), as well as expanded coverage of optional services such as targeted case management and hospice care.

Between FY 1988 and FY 1992, growth in acute care significantly outpaced growth in long-term care spending. While the two types of services accounted for roughly equal shares of Medicaid spending in FY 1988, only 36 percent of spending in FY 1995 is projected to go for long-term care services. Still, there has been significant growth in this area. Nursing facility payments, like hospital payments, have increased in part as a result of Boren amendment litigation. There have also been dramatic increases in payments to institutions for mental diseases (IMDs). This service category has been treated here as long-term care because legislative proposals to split Medicaid, federalizing acute care and leaving long-term care to the States, generally include IMDs among the State service responsibilities. IMD payments have nearly quadrupled. DSH payments account for 70 percent of this growth, as some States have increased payments to State facilities and recaptured the increases through budgetary transfers. Again, this trend is expected to moderate as a result of recent legislation. The "other" long-term care area shows the expansion of Medicaid home and community-based services programs and increased spending for personal care services.

The expansion of eligibility for QMBs is seen in the payment increases for Medicare premiums and cost-sharing. Finally, there has been dramatic growth in the category labeled "other insurance payments." This includes State capitated managed care programs and such initiatives as the TennCare program, under which beneficiaries in Tennessee will be shifted to prepaid systems. This category of spending is projected to increase by 30 percent in FY 1995 alone. Overall, Medicaid enrollment in some form of managed care has grown from 1.5 million in 1987 to 4.8 million in 1993.

Mr. Chairman, I would be happy to answer any questions.

TABLE 1. Growth in Federal and State Medicaid Spending, FYs 1988-1999
(outlays in billions)

Fiscal year	Federal outlays	State outlays[a]	Total	Annual percent change
1988	30.5	23.7	54.1	-------
1989	34.6	26.6	61.2	13.2%
1990	41.1	31.0	72.1	17.8%
1991	52.5	41.9	94.5	30.9%
1992	67.8	50.3	118.2	25.1%
1993	75.8	56.2	132.0	11.7%
OMB current services estimates:				
1994	87.2	64.9	152.1	15.0%
1995	96.4	72.1	168.5	10.6%
1996	108.2	81.0	189.1	12.2%
1997	121.5	90.9	212.4	12.3%
1998	136.3	102.0	238.4	12.2%
1999	152.2	113.9	266.1	11.7%

[a]State outlays for FYs 1992-1999 based on percentage estimates furnished by Health Care Financing Administration, Office of the Actuary.

Sources: FYs 1988-1993, OMB, Budget of the United States; FY 1994, OMB current services estimates.

TABLE 2. Growth in Medicaid Recipients and Outlays Per Recipient, FYs 1988-1995

Fiscal year	Recipients (thousands)	Outlays per recipient	Annual per capita percentage increase
1988	22,907	$2,362	----------
1989	23,511	$2,605	10.3%
1990	25,255	$2,857	9.7%
1991	28,280	$3,341	16.9%
1992	31,150	$3,793	13.6%
1993 (est.)	32,961	$4,005	5.6%
1994 (est.)	34,578	$4,399	9.8%
1995 (est.)	35,979	$4,684	6.5%

Source: CRS analysis of data from HCFA-2002 reports; HCFA Justification of Appropriation Estimates and HCFA-64 reports.

TABLE 3. Trends in Medicaid Recipients by Cash Assistance Status, FYs 1988-1992

		Cash Welfare Recipients			
Fiscal year	Total	Needy adults & children	Blind & disabled	Medically needy	Non-cash
1988	22,907	12,150	4,442	3,605	3,305
1989	23,511	12,022	4,331	3,431	4,135
1990	25,255	12,125	4,342	3,392	5,280
1991	28,280	12,803	4,563	3,466	7,353
1992	31,150	13,928	4,875	3,656	8,597
Average annual rate of growth:					
1988-92	8.0%	3.5%	2.4%	0.3%	27.0%

NOTE: Totals for 1988-1990 represent beneficiaries in 49 States, the District of Columbia, Puerto Rico and the Virgin Islands. Totals for 1991-1995 represent benficiaries in 50 States, the District of Columbia, Puerto Rico and the Virgin Islands. Detail of recipient totals between 1988 and 1990 do not sum to total because a number of recipients who may be classified in more than one catgory during the year. During this period, the "other" category is composed primarily of children. Due to these definitional changes numbers are not always strictly comparable.

TABLE 4. Trends in Medicaid Recipients by Demographic Category, FYs 1988-1995

Fiscal year	Total	Aged 65 and over	Blind & disabled	Needy adults	Needy children	Other
1988	22,907	3,159	3,487	5,503	10,037	1,343
1989	23,511	3,132	3,591	5,717	10,318	1,175
1990	25,255	3,202	3,718	6,010	11,220	960
1991	28,280	3,359	4,069	6,778	13,415	658
1992	31,150	3,749	4,487	7,040	15,200	674
1993	32,961	3,904	4,961	7,369	16,060	667
1994	34,578	4,077	5,542	7,630	16,657	672
1995	35,979	4,238	6,107	7,868	17,089	677
Average annual rate of growth:						
1988-92	8.0%	4.4%	6.5%	6.4%	10.9%	-15.8%
1992-95	3.7%	3.1%	8.0%	2.8%	3.0%	0.1%

NOTE: Totals for 1988-1990 represent beneficiaries in 49 States, the District of Columbia, Puerto Rico and the Virgin Islands. Totals for 1991-1995 represent benficiaries in 50 States, the District of Columbia, Puerto Rico and the Virgin Islands. Detail of recipient totals between 1988 and 1990 do not sum to total because a number of recipients who may be classified in more than one catgory during the year. During this period, the "other" category is composed primarily of children. Due to these definitional changes numbers are not always strictly comparable.

TABLE 5. Percentage of Nonelderly Population Receiving Primary Health Coverage from Different Sources, 1987 and 1992

	1987	1992
Employer-based	67.6%	63.0%
Medicaid	6.6%	9.0%
Other insurance[a]	11.4%	11.4%
Uninsured	14.5%	16.6%

[a]Includes Medicare, veterans' and military coverage, and private nongroup insurance.

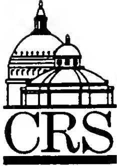
NOTE: Persons reporting multiple sources of coverage are assigned to a primary source according to coordination of benefits rules under Federal law or typical private insurance practice.

Source: Congressional Research Service analysis of data from the March 1988 and March 1993 Current Population Surveys.

TABLE 6. Federal Medical Assistance Payments by Category of Service Fiscal Years 1988, 1992, and 1995
(dollars in millions)

	FY 1988	FY 1992	FY 1995	Annual rate of change FYs 1988-92	Annual rate of change FYs 1992-95
Acute care					
Inpatient hospital	6,848	21,506	26,156	33.1%	6.7%
Outpatient hospital	1,394	3,195	4,330	23.0	10.7
Physician	1,848	4,036	5,071	21.6	7.9
Prescription drugs (less rebates)	1,989	3,664	5,228	16.5	12.6
All other	2,046	5,254	8,725	26.6	18.4
Subtotal, acute care	14,126	37,655	49,510	27.8	9.6
Long-term care					
Nursing facility	8,225	13,928	17,540	14.1	8.0
Intermediate care facility/mentally retarded	3,339	5,013	5,949	10.7	5.9
Inpatient mental health	804	2,695	3,483	35.3	8.9
Other long-term care	1,32	3,210	5,629	24.7	20.6
Subtotal, long-term care	13,675	24,846	32,601	16.1	9.5
Medicare premiums and cost-sharing	546	1,382	2,332	25.9	19.1
Other insurance payments	686	1,927	6,209	29.4	47.7
	29,054	65,808	90,652	22.7%	11.3%

Source: CRS analysis of data from HCFA-64 reports (1988 and 1992); Health Care Financing Administration, Justification of Appropriations Estimates (1995).



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April 22, 1994

TO : Honorable Daniel Patrick Moynihan

FROM : Mark Merlis
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Medicaid Funding Formula**

During the Finance Committee's March 24, 1994, hearing on the Medicaid program, you requested information about the history of the formula for establishing the State and Federal shares of Medicaid payments to medical care providers.

The formula is as follows:

$$\text{State share} = \left(\frac{\text{State per capita income}}{\text{National per capita income}}\right)^2 x \; 45 \text{ percent}$$

$$\text{Federal share} = 100 \text{ percent} - \text{State share}$$

The Federal share may not be lower than 50 percent or higher than 83 percent.

The attached excerpt from a 1982 Congressional Research Report describes in detail the formulas for Medicaid and for State allocations under the Hill-Burton Act (the Hospital Survey and Construction Act of 1946), as well as the formula once used to establish the Federal share of benefit payments under Aid to Families with Dependent Children (AFDC).[1] As the report indicates, there is no legislative history to provide a rationale for the AFDC formula enacted in 1958 or the Medicaid formula enacted in 1965. However, both follow the precedent of the Hill-Burton formula in using State per capita income as a measure of need, and in squaring the ratio of State to national per capita income.

The Hill-Burton Act used per capita income as a proxy to measure States' relative need for hospital beds, because there was an observed correlation between low per capita income and a low bed-to-population ratio. Squaring the ratio of State to national per

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[1]All States have now elected to use the Medicaid formula for AFDC, instead of the alternative AFDC formula.

capita income had the effect of increasing allocations to lower income States. Again, there is no history to indicate why a similar formula was adopted for Medicaid. Per capita income might be regarded as a measure either of need or of a State's capacity to fund the program. However, the General Accounting Office and others have suggested that per capita income is an inadequate measure for either purpose, and that it might be preferable to use alternate measures of need (such as the percentage of a State's population in poverty) and fiscal capacity (such as total taxable resources).[2]

Please contact me if you require any additional information.

Attachment

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[2]See U.S. General Accounting Office. *Medicaid: Alternatives for Improving the Distribution of Funds.* Fact sheet for the Honorable Dale Bumpers. GAO/HRD-91-66FS, May 20, 1991. Washington, 1991.

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ANALYSIS OF FEDERAL-STATE COST-SHARING IN THE
AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM

Education and Public Welfare Division
March 22, 1982

I. CURRENT SYSTEM

Description of Current Formulas

The share of Federal funds available to States for Aid to Families with Dependent Children (AFDC) varies from State to State, depending in part, on per capita income. The Federal share (matching rate) of AFDC payments is determined by either the "regular" formula specified in title IV of the Social Security Act or, if the State has a medical assistance (Medicaid) program under title XIX of the Act, an alternate formula specified in title XIX of the Act. States with Medicaid programs may choose either the regular AFDC formula or the alternate Medicaid formula as a basis for receiving Federal matching funds for the AFDC program. Currently, only two States use the AFDC formula.

AFDC Formula

The AFDC formula can be broken down into two parts. The first part of the formula is uniform for all States, with Federal funds representing 5/6 of the first $18 per month of the average payment per recipient made by the State multiplied by the total number of recipients. The second part of the formula provides for a specified percentage (50 to 65 percent, based on relative per capita income) of the next $14 per month of the average payment multiplied by the number of recipients. The maximum amount paid with Federal dollars is $24.10 per recipient

[(5/6 x 18) + (.65 x 14)]. Average payments above $32 are financed from State and local funds. 5/

The formula used in determining the State and Federal share of payments between $18 and $32 is as follows:

$$\text{State share} = \left(\frac{\text{State per capita income}}{\text{National per capita income}}\right)^2 \text{ X 50 percent}$$

Federal share = 100 percent - State share (with Federal minimum of 50 percent and maximum of 65 percent)

As of late 1981, only Texas and Arizona used this formula, which places a ceiling on average benefits eligible for Federal matching. Texas found the AFDC formula advantageous because of its low average benefits (in Fiscal Year (FY) 1980 average monthly benefits per recipient in Texas amounted to $35.54), and Arizona was ineligible to use the Medicaid formula because it had no Medicaid program.

Medicaid Formula

As applied to AFDC benefits, the Medicaid formula is simpler and sometimes more generous than the AFDC formula. It offers Federal matching dollars for all AFDC benefit payments, no matter how high they are in the aggregate or per recipient. The Federal share is determined by applying the Federal medical assistance percentage to the total amount spent by a State for AFDC benefits. The law sets lower and upper limits to the Federal medical assistance percentage (from 50 to 83 percent), but no State now has sufficiently low per capita income to receive the 83 percent maximum share.

5/ Under the AFDC foster care program the ceiling is $100 multiplied by the number of foster care recipients, instead of the $32 multiplied by the number of recipients which is applied under the AFDC program.

Under the Medicaid formula the Federal funding share of AFDC payments or of medical vendor payments is higher for States with low per capita incomes, and lower for States with higher per capita incomes. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share is 55 percent. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50 percent. A State qualifies only for the Federal minimum share of 50 percent if its per capita income exceeds the national average by 5.41 percent or more. If a State's per capita income is lower than the national average, the Federal share is increased. At the present time no State is entitled to receive a Federal share of more than 77.36 percent. For the outlying areas (Guam, Puerto Rico, and the Virgin Islands) the Federal Medicaid matching rate applicable to AFDC is 75 percent (contrasted with a 50 percent rate specified for Medicaid expenditures), but the law imposes a ceiling on total funding.

The formula used in determining the State and Federal share is as follows:

$$\text{State share} = \left(\frac{\text{State per capita income}}{\text{National per capita income}}\right)^2 \times 45 \text{ percent}$$

Federal share = 100 percent - State share (with a minimum of 50 percent and a maximum of 83 percent)

The law further provides that the Federal Government will pay half the costs of State and local administration of AFDC. States decide whether local governments must help pay for the non-Federal costs of the AFDC program, but only 11 States, including New York and California, require counties to help pay AFDC benefits.

Rationale and History of Funding Formulas for AFDC

The legislative histories of the AFDC formula and the Medicaid formula do not explain their construction or give rationales for their usage. The AFDC

program adopted the basic concept of relating a State's matching share to its relative per capita income in 1958, when the program was 23 years old. In doing so it used a mechanism earlier developed for allotment of hospital construction funds in the Hill-Burton Hospital Survey and Construction Act of 1946. The Hill-Burton formula, discussed below, regarded relative per capita income as a measure of both State need and State fiscal capacity.

AFDC: 1935-1958

Grants for State Aid to Dependent Children (ADC) were authorized in the original Social Security Act of 1935 "for the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy dependent children." The Act authorized the Secretary of the Treasury to reimburse each State with an approved ADC plan for one-third of its benefit payments, up to a maximum Federal payment of $6 per month for the first child in a family, plus $4 per month for each additional dependent child. Thus, in 1935, the Federal share of AFDC payments was directly related to each child's AFDC payment.

In 1946, the AFDC Federal matching formula was changed so that the Federal share of AFDC payments was related to the average expenditures per child up to an individual maximum.

In 1950, the AFDC matching formula was changed so that one needy relative could be included with the dependent child as a recipient for Federal matching purposes.

From 1956 to 1958 the Federal share of AFDC payments was 14/17 of the first $17 per month (average per recipient) multiplied by the total number of AFDC recipients plus one-half of the remaining amount up to individual ceilings of $32 for one needy relative, $32 for the first child, and $23 for each additional

child. (For full details of the history of the AFDC funding formula, see Appendix A.) Thus, from 1935 to 1958 the maximum amount that the Federal Government would pay a State for its AFDC benefit costs was directed related to each individual's AFDC payment, and the matching rate was the same for States that paid the same benefits.

During the period 1935-1958 the shifting of AFDC costs to the Federal Government was pronounced (see the table in Appendix A). The way in which the overall Federal share was increased, however, was considered inequitable by some critics. They maintained that any further expansion should be made in a manner that took into account the fiscal abilities and needs of the States.

The Hill-Burton Act

Both the National School Lunch Act of 1946 and the Hill-Burton Act (Hospital Survey and Construction Act) of 1946 employed an index of State fiscal ability derived from the ratio of State to national per capita income in determining the allotment of Federal aid. In addition, the Hill-Burton Act adopted a squaring mechanism as a means of assuring an even larger Federal funding share to those States with per capita incomes below the national average.

In 1946 there was no acceptable measurement of need for hospital beds. However, witnesses at Senate hearings 6/ noted a correlation between low per capita income and a small number of existing beds per 1,000 population. The Congress approved in the Hill-Burton Act a methodology for the distribution of hospital construction funds which in essence gave relatively poor States proportionately more money in relation to population than it gave to wealthy States.

6/ U.S. Congress. Senate. Hearings before a Subcommittee of the Committee on Education and Labor on S. 3230, 76th Cong., 2d Sess., 1940. Hearings before the Committee on Education and Labor on S. 191, 79th Cong., 1st Sess., 1945.

The methodology was incorporated into law and is expressed by the formula:

$$\text{State allotment} = \frac{\text{population of State} \times (\text{allotment percentage})^2}{\text{sum of (population of each State} \times \text{allotment percentage for each State)}}$$

$$\text{Allotment percentage} = 100 \text{ percent} - \frac{\text{State per capita income}}{\text{national per capita income}} \times 50 \text{ percent}$$

The statute provides that allotment percentages are to be computed between July 1 and September 30 of each even-numbered year on the basis of the average per capita income of each of the States and of the U.S. for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce.

The Hill-Burton allocation formula treated relative State personal per capita income as a surrogate for the need for hospital beds. Some students of the Federal role in health care concluded that State relative per capita income failed to be a valid indicator of need for general hospital beds. 7/

The 1958 Amendments to the Social Security Act

The 1958 formula increased the Federal Government's share in the cost of the AFDC program and adopted the principle of variable matching rates, inversely related to State relative per capita income, for a portion of reimbursements.

The formula under the 1958 amendments provided for a limit on the average monthly amount of State benefit payments eligible for Federal dollars. Formerly, the Federal maximum on money payments applied to each individual assistance payment. Any amounts paid in excess of the ceilings were excluded

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7/ Clark, Lawrence, et al. The Impact of Hill-Burton: An Analysis of Hospital Bed and Physician Distribution in the United States, 1950-1970. Medical Care, v. XVIII, no. 5, May 1980. Lave, Judith and Lester Lave. The Hospital Construction Act: An Evaluation of the Hill-Burton programs, 1948-1973. American Enterprise Institute. 1974.

from Federal financial participation. Under the 1958 amendments, Federal financial participation was not related to individual assistance payments but to total expenditures, all of which were matched within the specified average payment per recipient. This average amount included both money payments to recipients and medical care on their behalf.

The Federal share of these State expenditures in the 1958 amendments was 14/17 of the first $17 per recipient in the AFDC program. For payments in excess of that amount, but within the specified average maximums, the 1958 law provided for variable matching based on per capita income for the most recent 3-year period. 8/ The State percentage for this portion of the formula was derived by dividing the square of the State's per capita income by the square of the national per capita income and multiplying the result by 50 percent. For States with a per capita income equal to or greater than national per capita income, the Federal percentage was established at 50 percent. The Federal percentage for Alaska and Hawaii was also established at 50 percent. Where a State's per capita income was less than the average of the nation, the Federal percentage would have been more than 50 percent but no higher than 65 percent. If for example, the per capita income of a particular State for the base years was 90 percent of the corresponding figure for the country as a whole, then the State percentage would have been 40.5 (.90 x .90 x .50) and the Federal percentage 59.5.

One effect of the 1958 law was to increase the Federal share in State public assistance expenditures. The amount of the increase, if any, that reached individual recipients depended upon State decisions on use of the extra money.

8/ The 1958 amendments required that the Federal percentage be promulgated each even-numbered year by the Secretary of Health, Education, and Welfare (now Health and Human Services).

The 1958 formula allowed flexibility in meeting unusual needs of recipients, such as medical care, and probably minimized the tendency that may have existed for States to consider the maximum, established only as a limit on Federal cost-sharing, as a limit on the monthly payment to an individual recipient. Furthermore, administrative and fiscal procedures were simplified. The objective of the variable portion of the 1958 formula was to achieve a more equitable distribution of Federal funds in relation to the fiscal capacities of the States than was possible under the previous formula.

The proposal to change the AFDC formula to reflect State fiscal capacity was made by the Eisenhower Administration. The Administration later objected to the formula which was adopted by the Congress because it included features that resulted in an overall increase in the Federal matching share.

The 1965 Amendments to the Social Security Act

Title XIX of the Social Security Act was enacted to extend the Kerr-Mills medical assistance program for the aged to the AFDC program as well as to other needy persons. As part of the amendments creating the new Medicaid program, the Congress agreed to allow States to use, as an alternative financing formula for the AFDC program, the same formula that had been adopted for the Medicaid program.

The Federal share of AFDC expenditures under the Medicaid formula was based upon a uniform formula with no maximum on the amount of eligible expenditures. For the Federal share, which varied inversely to a State's relative per capita income, the law imposed a minimum of 50 percent and a maximum of 83 percent.

In a paper entitled "Regional Disparities in Federal Medicaid Assistance," 9/ Richard Weiss quoted Wilbur Cohen, then undersecretary of the Department of Health Education and Welfare, as saying that the Medicaid formula was appropriate on three grounds. First, it was asserted that the formula could not easily be manipulated by any particular State for its own gain. Second, the formula relied upon data—State per capita income statistics—which were published periodically, and could therefore be easily estimated with reasonable accuracy. Moreover, the formula would not have required the costly collection or processing of any additional statistics by the Federal or State governments. Finally, the per capita income proxy was thought to bear "reasonable relevance" to the concept—tax capacity--to which the reimbursement formula was supposed to be sensitive.

Procedures and Definitions

Sections 1101(a)(8) and 1905(b) of the Social Security Act require the Secretary of Health and Human Services (HHS) to publish the Federal percentages and the Federal medical assistance percentages (Medicaid percentages) between October 1 and November 30 of each even-numbered year. The Secretary is to determine the percentages, by the appropriate formulas, from the Bureau of Economic Analysis (BEA) statistics on average income per person in each State and in the nation as a whole for the three most recent calendar years for which satisfactory data are available.

An example may make this clearer. The following are Department of Commerce per capita personal income figures for Pennsylvania and the U.S. for years 1977, 1978, and 1979:

9/ Weiss, Richard. Regional Disparities in Federal Medicaid Assistance. Northeast-Midwest Research Institute. Nov. 28, 1977.

Pennsylvania .... \$6,969, \$7,669, and \$8,558

U.S. .... \$7,043, \$7,854, and \$8,773

The average per capita income figures for Pennsylvania and the U.S. are

([\$6,969 + \$7,669 + \$8,558] ÷ 3) = \$7,732

([\$7,043 + \$7,854 + \$8,773] ÷ 3) = \$7,890, respectively

To find the State percentage, square both numbers, divide the Pennsylvania figure by the U.S. figure and multiply by 50 percent.

Pennsylvania .... $(\$7,732)^2$ = \$59,783,824

U.S. .... $(\$7,890)^2$ = \$62,252,100

Federal percentage (AFDC formula)

State Share = .96 x .5 = .48

Federal Share = 1 - .48 = .52

Federal medical assistance percentage (Medicaid formula)

State Share = .96 x .45 = .43

Federal Share = 1 - .43 = .57

These percentage are effective October 1, 1981-September 30, 1983, fiscal years 1982 and 1983. The 1979, 1980, and 1981 per capita personal income data 10/ will be used to determine the Federal percentage and the Federal medical assistance percentage for fiscal years 1984 and 1985.

10/ The term per capita income is defined by the Department of Commerce as the total personal income of the residents of a given area divided by the resident population of the area. For example, the 1979 total personal income figure for Pennsylvania was \$100,398 million, the population of Pennsylvania in 1979 was 11,731,000, and thus, the 1979 per capita income of Pennsylvania was \$8,558. For this purpose, persons are defined as individuals, nonprofit institutions, private non-insured welfare funds, and private trust funds. The last three are referred to as "quasi-individuals."

Total personal income consists of private and government wage and salary payments in cash and in kind, other labor income, farm and nonfarm proprietors' income, personal interest income, rental income, dividends, and transfer payments, less payroll deductions for social security and unemployment compensation.

Per capita personal income serves as an indicator of the quality of consumer markets and of the economic well-being of the residents of an area. However, a high per capita income is not always representative of the standard of living in an area, and conversely a low per capita income is not necessarily indicative of the economic well-being of an area. For instance, an unusually high (or low) per capita income may result from unusual conditions, such as a major construction project such as the Alaska pipeline or a catastrophe such as widespread crop failures in an agricultural State.

In addition, population is measured at mid-year whereas income is measured as a flow over the year. Therefore, a significant change in population during the year, particularly around mid-year, can cause distortion in per capita figures.

It should be noted that the substantial differences between estimates of per capita income made by the Bureau of Economic Analysis (BEA) and the Census Bureau (both within the Department of Commerce) are due to differences in definition of income and collection and computation methods. For example, the Census Bureau computes 1976 per capita income by dividing 1976 total money income 11/ by April 1977 total population, whereas the BEA derives its 1976 per capita income by dividing 1976 total personal income by July 1976 total population.

11/ Money income differs from personal income as follows: money income excludes income in-kind, imputed income, and income of quasi-individuals—which are included in the personal income definition. Furthermore, it includes items that are excluded from the personal income definition—income from private pensions and annuities, cash benefits from private workmen's compensation insurance, regular contributions for support received from individuals not residing in the same living quarters, income received from roomers and boarders residing in households, and employee contributions for social insurance.

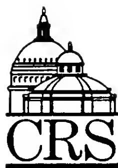
Congressional Proposals

Some view the current funding formulas for AFDC as inequitable. Some critics of the AFDC formula say that per capita income is only one gauge of a State's economic condition and that it generally fails to accurately measure a State's fiscal capacity. In his floor statement on S. 855 (April 1, 1981), the Medicaid Formula Modernization Act of 1981, Senator Daniel P. Moynihan noted that the current Medicaid formula ignores the cost-of-living differences among States, and he maintained that this meant unfair treatment of areas with higher living costs. He also objected to inclusion of cash transfer payments in calculating a State's per capita income, on grounds that this distorted a State's relative fiscal capacity. States paying relatively high benefits to a large caseload receive relatively less Federal support than States with smaller welfare burdens.

Further, some say that the spread between low- and high-income States should be reduced by dropping the squaring mechanism in the formula. These people maintain that there is no evidence that an unsquared ratio would not allocate Federal moneys in closer proportion to the true needs of the State. In 1978, because of the dissatisfaction with the squaring rule for per capita income Congress dropped it from the allotment formula for Federal vocational rehabilitation funds. The Senate Committee on Human Resources recommended the change for several reasons. Its report (Senate Report No. 95-899) said that per capita income was, "at best, an imprecise measurement of a State's relative ability to pay," and it complained that the squaring rule weighted allotments "so heavily" against higher per capita income States that it discriminated against the majority of handicapped persons, who lived in such States. It said, further, that State differences in ability to pay had narrowed greatly since allotments began in 1954, partly because the richer States had to contend with higher taxes, higher costs of living, and "massive public debts" caused by their provision of

social services, and that there no longer was a need to use the allotment formula as a way to encourage States to begin basic programs of rehabilitation services.

Over the last six years, a number of bills have been introduced in Congress to change the AFDC matching formula (see Appendix A). The bills have ranged from increasing the minimum Federal percentage and/or decreasing the maximum Federal percentage to requiring the Federal Government to pay 100 percent of all AFDC costs or 100 percent of a specified AFDC income floor. Some bills would change the AFDC program into a block grant and give States full responsibility for policy.



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April 22, 1994

TO : Honorable Daniel Patrick Moynihan

FROM : Mark Merlis
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Medicaid Payments to Disproportionate Share Hospitals**

During the Finance Committee's March 24, 1994, hearing on the Medicaid program, you requested additional information about trends in Medicaid payment adjustments for disproportionate share hospitals (DSHs), those serving high numbers of low-income patients.

States did not separately report the amount of DSH payments until FY 1992, and did not provide separate figures for DSH payments to general and mental hospitals until FY 1993. Table 1 shows actual payments for FY 1992 and FY 1993 and projected payments for FY 1994 and FY 1995. Under Medicaid law, the total amount States may spend on DSH payments is now subject to annual limits. As the table indicates, FY 1993 payments recorded to date do not equal the total allotment to States for that year. However, the totals are subject to change if States report additional retroactive adjustments or if any of the payments already recorded should be subject to Federal disallowances.

Table 2 shows DSH payments by State and by type of facility for FY 1993. The figures are current as of April 13, 1994.

Please contact me if you require any additional information.

TABLE 1. Combined Federal and State Medicaid Payment Adjustments to Disproportionate Share Hospitals, FY 1992-FY 1995
(amounts in millions)

	Inpatient hospital	Institutions for mental disease	Total
1992	n/a	n/a	$17,455
1993:			
Actual, 4/13/94	$13,907	$3,080	$16,987
Allotted	N/A	N/A	$17,952
1994 (est.)	$15,487	$3,952	$19,439
1995 (est.)	$15,033	$3,439	$18,472

NOTE: Projected Federal payments for FY 1994 and FY 1995 converted to total payments on assumption that Federal share remains at FY 1993 level of 54.2 percent. N/A = not available.

Source: FY 1992 and FY 1993, Health Care Financing Administration (HCFA), Office of Medicaid Management. FY 1994 and FY 1995, HCFA *Justification of Estimates for Appropriations Committees, Fiscal Year 1995.*

TABLE 2. Medicaid Payment Adjustments to Disproportionate Share Hospitals, by State and Provider Category, FY 1993
(amounts in thousands)

	Inpatient hospitals	Institutions for mental diseases	Total
Alabama	412,931	109	413,040
Alaska	0	14,146	14,146
Arizona	91,111	0	91,111
Arkansas	2,540	2	2,542
California	2,542,500	0	2,542,500
Colorado	128,737	922	129,659
Connecticut	257,606	168,607	426,213
Delaware	0	5,194	5,194
District of Columbia	23,991	14,009	38,000
Florida	175,715	63,978	239,693
Georgia	338,900	0	338,900
Hawaii	44,147	0	44,147
Idaho	979	0	979
Illinois	246,781	0	246,781
Indiana	21,263	7,399	28,661
Iowa	3,993	0	3,993
Kansas	4,411	180,007	184,418
Kentucky	136,763	0	136,763
Louisiana	1,046,182	17,805	1,063,986
Maine	108,984	42,865	151,849
Maryland	22,869	97,398	120,267
Massachusetts	324,083	160,400	484,483
Michigan	497,664	56,682	554,346
Minnesota	21,181	6,163	27,343
Mississippi	152,343	0	152,343
Missouri	564,044	139,045	703,089
Montana	70	469	539
Nebraska	2,100	1,160	3,260
Nevada	73,559	0	73,559
New Hampshire	0	37,652	37,652
New Jersey	764,652	316,113	1,080,765
New Mexico	8,678	0	8,678
New York	2,190,637	593,840	2,784,477
North Carolina	13,206	332,339	345,545

TABLE 2. Medicaid Payment Adjustments to Disproportionate Share Hospitals, by State and Provider Category, FY 1993–Continued (amounts in thousands)

	Inpatient hospitals	Institutions for mental diseases	Total
Ohio	449,020	0	449,020
Oklahoma	18,629	4,847	23,475
Oregon	7,911	10,301	18,212
Pennsylvania	330,680	712,969	1,043,649
Rhode Island	97,084	76	97,160
South Carolina	412,528	27,231	439,759
South Dakota	11	0	11
Tennessee	427,055	3,191	430,246
Texas	1,513,029	0	1,513,029
Utah	3,594	860	4,454
Vermont	9,500	9,092	18,592
Virginia	101,276	10,908	112,184
Washington	214,116	43,170	257,286
West Virginia	94,769	0	94,769
Wisconsin	5,447	1,124	6,571
Wyoming	0	0	0
U.S. Total	13,907,279	3,080,072	16,987,350

Source: Health Care Financing Administration (HCFA), Office of Medicaid Management.

PREPARED STATEMENT OF RAYMOND C. SCHEPPACH

Good morning Mr. Chairman and members of the committee. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the impact of health care reform on the low-income population and the Medicaid program. There are few issues of greater importance to Governors than how Medicaid is integrated in a new health care system.

GOVERNORS' MEDICAID AND LOW-INCOME SUBSIDY POLICIES

The Governors have adopted a two-paged approach in their policies toward reforming Medicaid and addressing the needs of the low-income population. First, even if comprehensive health care reform is enacted this year, states still need some interim changes to the Medicaid program. Second, the Governors support a major restructuring of low-income programs as part of national reform.

INTERIM REFORM

The Medicaid program, with its state/federal partnership, has contributed significantly to ensuring that a safety net exists for low-income individuals. Irrespective of its critics, it has been the only nationally organized system of care for many poor people for the last thirty years. For at least the last five years, however, the nation's Governors have been calling for changes in the Medicaid program. The administrative and financial burdens resulting from general medical inflation, Medicaid's individual entitlement nature, and the proliferation of unfunded federal mandates have created havoc with state budgets. Its impact has been so great that other state programs have suffered. The growth in Medicaid, particularly during 1991 and 1992, was a major reason why states increased taxes by $25.6 billion over this two-year period. It is no wonder that states have had to cut spending and raise taxes to keep up with other equally important needs such as education and economic development.

Medicaid Managed Care Waivers. The private sector has led a national trend in health care service delivery toward systems of care. These systems or networks have been shown to provide cost-efficient care while assuring the patient a medical home—a reliable place to seek primary care and from which specialty care can be directed. Yet, as the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all eases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. And while the Bush and Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must reapply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because under current law, states are permitted only one non-renewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed or at least modified to give states the opportunity to apply for renewable waivers. Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care and they support federal oversight through the regulatory process.

If the nation is serious about controlling health care costs, giving states the opportunity to enroll Medicaid beneficiaries in networks, including fully and partially capitated systems, through the regular plan amendment process is essential to achieve this goal.

Comprehensive Waivers. Many states have begun to look seriously at comprehensive systems of health care where the artificial categorical barriers of Medicaid are removed and where states can establish statewide networks of care for additional low-income individuals. These strategies are being developed in response to the fact that with efficient cost containment, states may be able to deliver health care to a greater number of poor people. Unfortunately, there are no provisions in the Social Security Act that give states any certainty that these networks, once established, can remain a part of the state's health care delivery structure.

Currently, states have been developing these more comprehensive networks through the research and demonstration provisions of the Social Security Act (Section 1115a). Because Section 1115a was designed for research purposes, it has some important limitations. States must demonstrate through the application process that they are testing an innovation. The law requires an evaluation that in some cases requires control groups. Projects approved under the 1115a process are approved for a limited time period, usually three to five years at the discretion of the administra-

tion, and require special statutory changes to go beyond the demonstration period. Finally, these projects must be cost neutral over the life of the project.

Section 1115a is essential to allow the testing of alternative health and social policies. However, the current statute falls short by requiring statutory changes if a state wants to continue its successful effort. In short, once a state has proven that its research project works, it cannot continue without congressional action. Governors support changes to the Social Security Act so that a state may apply through the executive branch of government for renewable waivers of their innovations. This waiver process should be consistent with the streamlined approaches used by the Clinton administration and states should have to reapply for these waivers no less than every five years.

Relief from the Boren Amendment. In 1981, Congress enacted the Boren Amendment to give states more certainty in setting institutional reimbursement rates in Medicaid. Since then, judicial interpretations have done just the opposite. The Governors believe something should be done regarding this amendment as part of health reform. They are aware that the administration is moving ahead to develop regulations. Although this effort should be commended, the administration is bound by the parameters of the statute and the statute appears to give states little flexibility. And a repeal of the Boren Amendment may be no help to either providers or states. The Governors support a proposal to develop a series of "safe harbors" that would give states some protection while protecting the industry. These or other equitable alternatives could be helpful to states.

NATIONAL REFORM

Regarding national reform, the Governors have called for a federal framework with state flexibility. NGA policy supports a national benefits package that is comprehensive and has a strong emphasis on primary and preventive care. While the policy does not identify specific benefits to be included, it calls for a package like one that would be found at an efficiently operated health maintenance organization. This state/federal reform system would be structured around a managed competition approach.

Governors believe that the acute care portion of Medicaid should be eliminated and folded into a broader low-income subsidy program. This new program might be defined solely by income and assets standards applied uniformly across the population. Moreover, the Governors believe that this new low-income subsidy program should be incorporated into the overall service delivery structure under managed competition so that the differences between acute care service delivery for low-income and the rest of the population disappears. Finally, the Governors believe that managed competition gives consumers the freedom to choose plans based on price and quality. Given such choice, people are likely to choose managed care systems and other integrated health care networks.

GOVERNORS' REACTION TO HEALTH REFORM PROPOSALS

Mr. Chairman, within the context of the Governors' policies, I would now like to briefly address the Medicaid and low-income subsidy program proposals in the President's health plan and those proposed by Senators Chafee and Breaux.

THE HEALTH SECURITY ACT

The President has chosen to establish a broad-based low-income subsidy program as part of his comprehensive reform. Governors' policy supports such a program. In establishing this program, the President has chosen to maintain the general Medicaid structure in his health reform package. While the Governors prefer a greater restructuring of the program, the President's proposals are generally consistent with the Governors' Medicaid policy. From a state perspective, the President's plan has the following advantages.

Medicaid acute care services will be integrated into the same service delivery system used by all Americans. The Governors support the integration of the cash and noncash categorical populations the new service delivery system. This unitary acute care service delivery structure should dramatically reduce the incentive for a two-tiered health system that results from our current Medicaid program. As we have seen in the Medicaid program, some education and outreach will be needed as Medicaid beneficiaries and others move from a fee-for-service environment into a network environment. Care must be taken that this change occurs as smoothly as possible without sacrificing quality and access to care.

States will have much more financial certainty in the growth of their Medicaid budgets. Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) beneficiaries will receive services in the guaranteed national bene-

fits package through regional alliances. With federal matching funds, states will be required to pay alliances a per capita amount for each beneficiary. That per capita payment will increase at a predetermined amount each year. This approach gives states significant stability in a part of their Medicaid budget and is supported by the Governors.

Maintenance of Effort Payments. States will be required to make lump sum payments for Medicaid services that previously had been provided to the noncash categorical populations. Like the cash categorical populations, the payment is based on expenditures for Medicaid services in the guaranteed national benefits package. This strategy holds states harmless from unpredictable changes that have been the hallmark of Medicaid in recent years.

While the Governors are generally supportive of this concept, they are concerned about some of the growth factors used in the President's plan during the transition period. During the transition period, both the cash and non-cash categorical expenditures will be "grown" by about 12 percent annually. For states that expect their Medicaid programs to grow at a slower rate, they can only appeal to the secretary for an adjustment for growth in the cash categorical population, but have no appeal rights for growth for the non-cash categorical population. As such, this decision may punish states for operating efficient programs.

With a major restructuring of health care financing, the President's plan includes a strategy for reviewing the state financial obligations under the new system toward resolving possible inequities among states. The President's plan requires states to make payments in support of national health reform based on current Medicaid spending patterns and using current federal Medicaid matching percentages. Because of the significant differences among states in Medicaid match and program characteristics, this strategy could punish states with more generous programs by requiring of them a greater financial maintenance of effort. The extent of this perceived inequity is complicated by real differences among states in their fiscal capacity to support health care. The issue requires reasoned study before changes are made. I believe that the Governors would support the President's decision to have a commission review the methodology used to calculate state financial obligations.

The President has enhanced institutional long-term care options and proposed a new community-based long-term care program that gives states significant flexibility to meet the individual needs of beneficiaries while protecting the financial exposure of both states and the federal government. In general, the Governors can support the incremental changes to Medicaid long-term care in the President's plan. They support the state option to increase the protected assets limit from $2,000 to $12,000. The requirement for establishing medically needy programs affects about fourteen or fifteen states, and because this is a new mandate, it may have significant fiscal impacts on these states. NGA policy opposes unfunded Medicaid mandates. As we get a better understanding of the impact of this mandate, we will keep the committee informed.

New Community-Based Care Program. The President's plan creates a new joint state and federally financed community-based long-term care program for persons with significant functional impairments. The Governors support community-based alternatives to institutional care, and the plan contains several provisions, including this one, consistent with their position. Not only does the plan increase the availability of community-based long-term care, but states have significant flexibility in the program's design to meet the needs of beneficiaries. Although this program requires state matching funds, the match rate is favorable to states. States should be able to expand some of their state-financed community-based initiatives through this program

Because of the limitations on federal spending, the President has tried to construct the program so that states' financial obligations are equally limited. The Governors strongly support this practice. Limitations on spending must be applied equally to states and the federal government. However, Governors are concerned that despite of drafting efforts, the courts might consider this program an individual entitlement to services.

Areas of Improvement. There are several aspects of Medicaid where the Governors would suggest program modifications.

Re-establishing the Link to Cash Assistance Programs. Since the mid-1980s, Congress has enacted Medicaid legislation that has delinked Medicaid from its historic ties to cash assistance programs. Delinking public health care programs from public cash assistance programs is good public policy. Unfortunately, by requiring per capita payments for each AFDC and SSI beneficiary, states would be required to consider health care costs when considering policy decisions in the AFDC and SSI programs. The Governors would support an approach that delinks these programs from Medicaid.

Qualified Medicare Beneficiaries and Related Programs. The President has chosen to continue the Qualified Medicare Beneficiary (QMB) program and related programs, including the program for individuals who are dually eligible for Medicaid and Medicare. The Governors believe that this decision requires further review. Members of Congress are well aware of enrollment problems with the QMB program. But enrollment problems are just the tip of the iceberg. The administrative complexity associated with reimbursement is nothing short of astounding for both providers and states. The Governors support the federalization of this program. If it is not federalized, they would like to work with subcommittee staff to explore other options.

Disproportionate Share Hospital Program. The President's plan substantially reduces the size of the nation's disproportionate share hospital program. Despite the nation's best efforts to provide universal coverage, the Governors believe that there is a small part of the population (at the very least, undocumented immigrants) who will seek care at hospitals, most likely public hospitals, for whom there will be little or no compensation. The President allocates about $800 million for this purpose. This may not be enough and without such additional support, the cycle of cost shifting to the paying population will continue.

As an aside Mr. Chairman, the Governors support a stronger federal financial response to the increasing health care burden on states resulting from undocumented immigrants. Immigration policy is federally developed and federally enforced. The need for publicly financed health care resulting from these policies and enforcement activities must also be a pure federal responsibility.

THE HEALTH EQUITY AND ACCESS TO REFORM TODAY ACT

The Chafee proposal takes an incremental approach both to providing health care to the low-income population and to modifying the Medicaid program. With some notable exceptions, the Governors can support parts of the Chafee proposals.

States will be able to establish managed care systems under Medicaid without the need of waivers. Governors believe that this type of flexibility gives states an important cost containment tool under proposals where the Medicaid program remains intact. Not only are the states given more flexibility in establishing this important service delivery approach, it moves this low-income program toward a system of care that will soon predominate health delivery in the nation. As the nation moves toward receiving care through health care networks, as long as there are strong quality and consumer protections, the low-income population should be a part of this trend.

Medicaid beneficiaries will be able to use the same health care delivery systems as other Americans. At state option, the Chafee plan will permit states to enroll Medicaid beneficiaries in health plans. However, the Chafee proposal does establish a phase-in period for the number of Medicaid beneficiaries that are allowed to enroll in the plans. Given that the Chafee proposal is a voluntary system, this phase-in is justifiable and assures that the market is minimally disrupted by the inclusion of a population whose premium is not negotiated but rather set by the federal government.

Low-income individuals, previously categorically denied participation in Medicaid, will be eligible for low-income suisidies. The Chafee proposal establishes a new low-income subsidy program. Eligibility for the program is based on income and phases in over a seven-year period. Governors support this effort to make health care eligibility dependent on income.

Governors cannot support a cap on the federal contribution to Medicaid spending. The Chafee plan establishes an annual per-capita federal cap on acute care spending in the Medicaid program. Thus Governors categorically reject this proposal. The federal government cannot assume to balance its health care budget problems on the backs of states when its own actions over the last decade have contributed directly to this problem. If the federal government wants to limit its financial exposure, the states' financial exposure should be limited as well

Governors cannot support the elimination of the Disproportionate Share Hospital program. For reasons previously mentioned, the DSH program under Medicaid cannot be eliminated. States and local governments will continue to rely on those funds to help defray the cost of uncompensated care. And when compared to the President's plan, the need for the DSH program is even greater given the phase-in of the broad-based low-income subsidy program. It would seem reasonable however, to revisit the DSH program once the broader subsidy program is fully phased-in.

THE MANAGED COMPETITION ACT

Senator Breaux's proposal also establishes a new broad-based low-income subsidy program and eliminates the complex categorical eligibility categories that now characterize the acute care portion of Medicaid. This proposal goes farthest in meeting the service delivery and eligibility goals of the Governors. The Governors strongly support this approach.

Unfortunately, Governors also strongly oppose the financing structure that funds this approach. Under the Breaux plan, the federal government assumes acute care costs and states assume all the costs of long-term care over a five year phase-in period. When one examines the legislation to understand which services are involved in the "swap," only a subset of services typically classified as long-term care are included in the state responsibilities. As such, the swap is probably less favorable to states than imagined. However, Governors believe that in the final legislation, the list of long-term care services for which they would be responsible would grow and the swap would be unacceptable. Moreover, Congressional Budget Office estimates of the fiscal impact of this provision do not take into account demographic changes that will inevitably drive up the costs of long-term care. In fact, Governors have long-standing policy if there was to be a swap, states should assume the cost of acute care and the federal government should assume the cost of long-term care.

CONCLUSION

Mr. Chairman, each of the lead sponsors must be commended for their efforts to reform health care for America's poor. The Governors believe that while it may not be the most discussed aspect of this health care reform debate, it is one of the most complex and has the most direct impact on local, state and federal budgets.

While the public policy objectives of Medicaid are sound, the program was designed as a critical safety net in a fragmented and inequitable health care system. The Governors believe that an unprecedented opportunity exists to re-define health care for poor people, as well as people with chronic conditions and disabilities, so that their care is integrated and seamless. They encourage you to be bold in your restructuring efforts. From the states' perspective, the Governors encourage you to be guided by the following principles.

- Eligibility for the low-income subsidy program must be relatively simple and uniformly applied. We need to abolish the complex categorical eligibility structures like those used in the Medicaid program.
- Individuals who receive low-income subsidies for their health care must have access to the same health care delivery system as those who receive no subsidies.
- Managed care must be an important component of that health care delivery system.
- States must be assured of stability and predictability in their contributions toward the funding of a new national low-income subsidy program.
- Finally, any federal cost containment strategy that limits the financial exposure of the federal government for publicly funded entitlement programs must also limit the financial exposure of the states. A cap only on the federal share of the Medicaid program is simply no solution at all.

The opportunity for major change is upon us and should not be squandered. The nation's Governors are key stakeholders in ensuring that any new health reform system includes and integrates health care for the poor. They look forward to working with this committee as this debate evolves and hope that a true state/federal partnership can be formed through health care reform. Mr. Chairman and members of the committee, on behalf of the NGA leadership, I would like to propose a bipartisan meeting with Governors in the very near future so that they can discuss with you directly their perspectives on national health reform. The nation's Governors are ready to work with this committee, Congress, and the administration to craft meaningful and rational health care reform.

Thank you for the opportunity to appear before you today. I will be happy to answer any questions.

PREPARED STATEMENT OF KAREN WINTRINGHAM

My name is Karen Wintringham and I am Senior Vice President for Corporate Development for the Health Insurance Plan of Greater New York (HIP), a not-for-profit, prepaid group practice model health maintenance organization. Today, the HIP system serves nearly 1.2 million members throughout the New York City metropolitan area, New Jersey and Florida.

HIP will share with this Committee our nearly thirty years of experience enrolling Medicaid beneficiaries and will provide the Committee with some recommendations on what Congress, the states, and health plans should consider when mainstreaming Medicaid and other special needs populations into private sector, managed care health programs. In addition to Medicaid, HIP has also actively enrolled other groups that require unique considerations when delivering health care services including small business, the employed uninsured and uninsured children.

I would also like to commend Chairman Moynihan for his support of Medicaid managed care. His bills, S. 2077 and S. 3191, the "Medicaid Managed Care Improvement Act of 1991" and the "Medicaid Coordinated Care Improvement Act of 1992" respectively, would have greatly expanded the numbers of Medicaid recipients with access to coordinated prepaid health care. The cooperative work done by Senator Moynihan, his staff, government and industry on Medicaid reform has contributed greatly to the overall health care reform debate.

HISTORY AND THE CONTEXT FOR REFORM

HIP was established in New York City nearly 50 years ago, as a not-for-profit organization with a mission to provide affordable health care of high quality to all members of the community. Its mission was derived from the vision of Mayor Fiorello LaGuardia and the distinguished public health physician Dr. George Baehr. They challenged the medical establishment to provide all New Yorkers with access to medical care.

Today, however, barriers to access continue.

A recent study, conducted by the Eisenhower Center at Columbia University, reported on the "changing structures for delivering health care services to the poor" in the 1980s.[1] The study looked at the nation's four largest metropolitan areas; New York, Chicago, Houston and Los Angeles. Among its findings were these alarming observations:

> Relatively early in the study, our resident analysts in Chicago, Houston, and Los Angeles reported the progressive deterioration in the delivery of health care to the poor and the indigent since the beginning of the 1980s. This finding appeared grossly incompatible with the concurrent escalation in total national health care outlays, from $250 billion in 1980 to over $600 billion in 1990 (about 140%), despite a generally low rate of inflation after 1982 . . . . The starkest impression that emerged from the study was the incontrovertible fact that notwithstanding $350 billion of incremental annual expenditures over the decade, the poor and the homeless did not benefit appreciably. In fact, access to health care for these marginal groups actually declined . . .
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> A second finding was the substantial variability in access of the poor to medical care depending on the metropolitan region in which they lived. Although the study avoided a comparative ranking of the cities with respect to access, had one been attempted, it would probably have read in descending order: New York, Los Angeles, Chicago, Houston . . . .
>
> Irrespective of national trends and national policy, the quantity and quality of medical care provided to the poor and uninsured in the four metropolitan areas—and inferentially in urban areas throughout the United States—depend primarily on the liberality or meagerness of the state Medicaid program on the one hand and the scope of public institutions on the other, with considerable importance attaching to the history, capacity, and practices of the voluntary sector. Outside of New York, the study found a consistent picture of severe system-wide failure to respond adequately to the needs of the poor . . . .

Among the study's recommendations:

> Closely linked to physician redistribution is the need to move the locus of medical care from the emergency rooms and clinics of neighborhood hospitals to alternative delivery sites, specifically to conveniently located community clinics (linked to backup hospitals) and expanded health maintenance organizations (HMOs). . .[2]

Testimony presented late last year by Diane Rowland of the Kaiser Commission on the Future of Medicaid provides clear data on the Medicaid population. "Medicaid, our joint federal-state program for financing health care for the low-income population, provides health insurance protection to 23 million non-elderly Americans,

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[1] Ginzberg, E. (1994). Improving health care for the poor: Lessons from the 1980s. Journal of *the American Medical Association, 271,* 464.

[2] Ginzberg, 464–467.

but still covers less than half (48%) of the non-elderly poverty population."[3] According to the Health Care Financing Administration, "as of June 1992, thirty-six States used managed care arrangements to serve approximately 3.6 million Medicaid recipients. This represented a 35% growth from 1991 to 1992."[4] Clearly, there are considerable numbers of fee-for-service Medicaid recipients and uninsured low-income Americans who could benefit from managed care plans.

NEW YORK STATE AND MEDICAID

New York's involvement with Medicaid is notable. Controlling Medicaid costs and ensuring access to comprehensive rather than episodic acute care has been at the heart of New York State's effort to integrate its Medicaid population into managed care. In 1991, the Governor signed into law the "Statewide Managed Care Act" the goal of which shifts half the State's Medicaid population into managed care over five years.[5]

Many of the proposals for national reform would similarly mainstream the Medicaid population into private plans. The consequences for HMOs and other managed care providers of these changes as well as for the clients enrolled in them are considerable and caution should be exercised by legislators, regulators and health plans alike. Based on our experience and that of other plans around the country we believe managed care plans can enhance access, improve quality and control costs.

HIP AND THE MEDICAID POPULATION: LESSONS FOR REFORM

The Congressional Budget Office has recognized the efficiencies of group and staff model HMOs.

> Fully integrated HMOs with their own delivery systems are the forms of managed care for which demonstrated cost savings are the greatest. CBO has estimated that staff- and group-model HMOs reduce personal health expenditures by 15 percent from their levels under traditional private health insurance with typical coinsurance.[6]

Further, the CBO has found:

> Moving people from fee-for-service medicine into staff- and group-model HMOs would reduce health care spending. If everyone with health insurance were to enroll in these HMOs, national health expenditures could decline by up to 10 percent.[7]

Among the reasons for the success of the group practice model is the use of a highly selective provider network that emphasizes the use of credentialed physicians and the designation of a primary care physician who coordinates all a member's care; emphasis on early access and preventive care; and care that is prepaid with limited out-of-pocket payments. The emphasis on preventive care helps providers detect illness at its initial stages, making early intervention possible and helps to avoid more costly care—often hospitalization—for advanced stages of illness. Fundamentally, prepaid delivery systems provide for continuity of patient care.

By 1990, the escalating cost of New York's Medicaid program, which exceeded $7 billion a year for New York City and $10 billion statewide, set the stage for a major restructuring of health care services delivery to Medicaid recipients. HIP's experience enrolling Medicaid recipients has helped smooth this transition. Our Medicaid enrollment as of January 1994 exceeded 76,000, or 8.1% of our total membership in New York. HIP's Medicaid enrollment represents approximately 50% of New York City's Medicaid recipients who receive managed care.

Problems in the fee-for-service Medicaid program persist and must be recognized by legislators if mainstreaming Medicaid recipients into a private, reformed health system will be successful. These problems include:

1. Lack of access to primary care;
2. Fragmented and uncoordinated care;
3. Lack of preventive care; and
4. High utilization and high cost.

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[3] Rowland, D. (1993, November). *Meeting the health needs of the low-income population in health reform.* Testimony present to the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, Washington, D.C.

[4] Medicaid Bureau. (July 6, 1993). *A health care quality improvement system for medicaid managed care: A guide for states.* Washington, D.C. Health Care Financing Administration, Department of Health and Human Services.

[5] Chapter 165, Laws of 1991. (18 NYCRR 360–10).

[6] Congressional Budget Office. (1993, July). *Estimates of Health Care Proposals from the 102nd Congress.* Washington, D.C.

[7] Congressional Budget Office. (1993, May). *Managed Competition and Its Potential to Reduce Health Spending.* Washington, D.C. U.S. Government Printing Office.

Success in providing care to Medicaid recipients requires changing the patterns of utilization that many Medicaid recipients have developed. Most commentators agree that Medicaid recipients, usually for want of another alternative, are accustomed to fragmented and episodic care, most frequently using the emergency room for non-emergent care. They are not accustomed to a comprehensive and methodical approach to health care delivery. In addition to the emergency room, many Medicaid beneficiaries will use a variety of delivery sites for care including community health clinics, outpatient departments in public hospitals, shelters for the homeless, and disease-specific treatment clinics for AIDS, tuberculosis and other maladies. To change these patterns, HIP assigns a Medicaid Program Officer to each new Medicaid enrollee who helps orient the member to the delivery system. The role of the Medicaid Program Officer is crucial to the success of HIP's ability to serve Medicaid recipients. Through the use of these Medicaid Program Officers, HIP encourages Medicaid members to make use of preventive health care services including routine examinations, screening, prenatal care, and other preventive health services, including the periodicity schedules for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and immunizations.

In addition, HIP has a case management program that is available to all HIP members with chronic or complicated conditions. The case management program assures that all services required by patients are effectively coordinated, that routine prenatal visits are scheduled, and that there is appropriate follow up on all problems that arise. For example, all teenage mothers—many of whom are on AFDC—are included in the case management program because they are considered to be at risk.

We have found that these outreach, incentive and orientation programs address the special needs of our members. HIP's attention to the special needs of our Medicaid enrollees does not result in the separation of Medicaid members from other HIP members. To the contrary, all patients receive care in the same facilities and from the same doctors. Despite these additional services, we have been able to achieve significant financial savings.

By way of example, HIP's rate data for Medicaid compared to commercial accounts demonstrates both the additional needs and costs of Medicaid recipients as well as the savings that can be achieved from enrolling Medicaid in managed care. HIP's basic community rated per member per month (PM/PM) premium is $128:91. For Medicaid, additional services are added to the basic rate including dental, drugs, optical, speech, in some instances methadone maintenance and transportation resulting in an adjusted PM/PM premium rate of $147. 10. Based on the New York State Department of Health Data Set, had these Medicaid recipients been in fee-for-service (FFS), their projected PM/PM costs would have been $174.15, representing a 16% difference between HIP's Medicaid premium and what the State would otherwise have paid. Based on HIP's September 1993 Medicaid enrollment this translates into a total federal-state savings in FY1993–1994 of $17,854,121 (State estimate).

RECOMMENDATIONS

HIP's experience suggests that large scale reform of the Medicaid program that would shift Medicaid recipients into managed care can be achieved successfully. However, such a large scale change raises issues that must be addressed. The effectiveness of any health care delivery system depends in large measure upon the active participation and cooperation of those who are receiving care. There is a causal link between the success of HIP providing care to Medicaid recipients and the fact that each person enrolled in HIP made a decision to do so. Proposals to mainstream Medicaid recipients into accountable health plans, many of which will be managed care entities, offer significant potential for improving health care services, while reducing the high costs of the current Medicaid program. At the same time, it is essential that government and providers work together to develop solutions to potential problems that could result from a massive integration of Medicaid into private health plans. Based on our experience, we would recommend that health reform proposals that attempt to mainstream Medicaid and other special needs populations consider the following:

1. Establish a realistic approach to costs and program goals. The desired benefits of mainstreaming Medicaid into managed care plans can be attained only if government continues to view cost containment goals in the context of the overall program objectives of providing high quality comprehensive health care. Benefits packages must be comprehensive and reflect the special needs of low-income populations. In addition to health benefits, the costs of enabling

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services like transportation should be considered when calculating the capitation rate.

2. Share the risk across all health plans. Medicaid recipients are more costly to serve than HIP's non-Medicaid population. At present, the additional cost can be accommodated in the community rate because Medicaid membership constitutes a reasonable proportion of the total membership, and because a significant portion of HIP's Medicaid population is in the AFDC category. Mainstreaming the current cash and non-cash assistance Medicaid population presents different delivery as well as financial challenges for health plans. We believe significantly larger numbers of members can be served well within managed care plans, but only if all plans participate and do so under reformed insurance practices.

3. The importance of member choice. HIP's success in serving Medicaid recipients appears to be linked to its members' decision to choose HIP as the source of their medical care. Government must ensure that there is adequate choice among health plans for all populations. To help insure greater choice in underserved areas we would suggest that Congress allow health plans to assume part or all of the educational loans primary care physicians have incurred without such payments being deemed to be taxable income to the provider.

4. Provider selection. Legislators must understand the way in which prepaid delivery systems operate in order to recognize proposals which seriously threaten HMOs and other managed care plans from operating efficiently:

a. Any-willing provider (AWP) laws: State laws which restrict an HMO's ability to contract with a closed panel of providers or suppliers of services. AWP laws should be federally preempted.

b. Point-of-Service (POS) products: These are products which allow enrollees to seek care outside of the HMOs provider network for items and services covered in a benefit package. POS should be permitted by not mandated.

c. Essential Community Providers. Funding for providers that have traditionally acted as a safety net for low income populations must be addressed. However, requiring that health plans have contracts with every one of these providers threatens the very nature and success of closed panel HMOs which provide comprehensive health services. Just last week, the Health Subcommittee of the Ways and Means Committee in the other body adopted an amendment which would require all health plans to contract with a broadly defined universe of essential community providers. Nationally, we believe this could include 3,000 city and county health clinics, 877 federally qualified health centers, 463 disproportionate share hospitals, 409 sole community hospitals, 1,470 rural health clinics, 557 Medicare dependent hospitals, and tens of thousands of practitioners in health professional shortage areas. While well intentioned, such an amendment guts an HMOs ability to control the continuity of care, appropriate utilization of services, contain costs, maintain a continuous medical record to evaluate outcomes and to provide comprehensive services in a group practice setting.

5. Oversight and Quality Assurance. Because of the considerable enrollment growth of Medicaid recipients in managed care, increased concern and attention has been given to the development of a standardized, national quality improvement program. HIP has actively participated in these efforts for both the commercial as well as Medicaid populations. However, we would suggest that health plans which demonstrate expertise and a consistent, good record be subject to less intrusive oversight. Further, health plans achieving acceptable independent accreditation, such as NCQA certification, should be deemed to have met some elements of the oversight and review process. To the extent that the emphasis on managed care is aimed at providers who serve mainly non-Medicaid patients, it would be helpful for government to reconsider some of the more burdensome and conflicting data requirements that are imposed on Medicaid providers. Some of this work is underway. Over the past two years we have made significant progress at the federal and state level concerning Medicaid reporting requirements. The general direction of that progress has been a decided move away from encounter and claims data and towards "outcomes" and "performance" information. Currently, HIP participates in the National Committee for Quality Assurance (NCQA) Health Plan Employer Data Information Set (HDIS) and its "Report Card" project which seek to develop a common set of performance measures.

6. Uniform standards and financial solvency. HIP has worked closely with our trade association and the HMO industry to develop health plan standards that provide a uniform level of protection for health care consumers, including

low income individuals and families, while creating a level playing field for all forms of health plans. These proposed standards, which have been presented to this Committee's staff by the Group Health Association of America (GHAA), address the health care delivery system, quality assurance, confidentiality, market conduct, administration, and health plan fiscal health including solvency and capitalization. HIP believes that taken together these are the most comprehensive standards to date and would best serve to guarantee all Americans, including low income populations, access to quality health care.

7. Beneficiary protections. Plans must administer formal member protections that provide for prompt attention to member grievances. In addition to statutory requirements that include disenrollment upon one months notice, internal procedures such as the use of an ombudsman, case manager or Medicaid Program Officer, consumer or member council, and internal grievance procedures should be a part of any plan's beneficiary protections.

CONCLUSION

HIP's experience as a provider of comprehensive services to Medicaid recipients has been a positive one for HIP, the members it serves and its physicians. As indicated above, the savings we have achieved is also a positive result for government. Our experience, along with those other plans around the country that enroll Medicaid, indicates that reform of the health care system should seek to mainstream Medicaid and other special needs populations into integrated health plans. With appropriate attention to the lessons we have learned, Medicaid recipients, like the nearly fifty million Americans who are already enrolled in HMOs, can also benefit from improved quality, accessibility and cost-effective medical care.

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