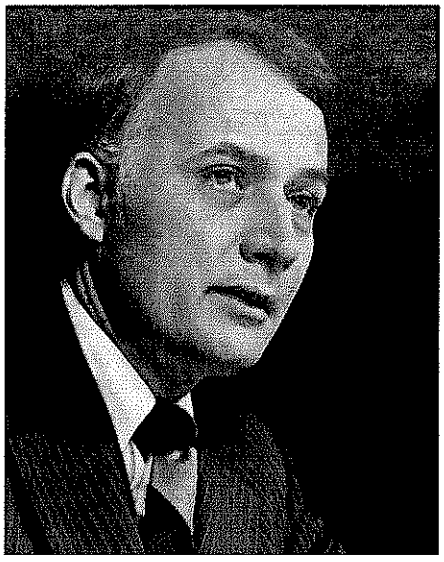
Intergovernmental PERSPECTIVE

Spring 1992, Vol. 18, No. 2

Intergovernmental Focus on Health Care

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS

A View from the Commission



In order to solve our health care crisis, we need to get all the actors in the system—providers, insurers, employers, consumers, and government—pointed in the same direction and motivated to move. Our destination should be a health system devoted to:

- *Economic efficiency* in the way we deliver medical care;
- *Personal responsibility* in how we demand or avoid unnecessary care; and
- *Equity* in the way we distribute the benefits of care.

The challenge of getting our federal, state, and local governments to adopt these goals and consistently apply them will be difficult, especially following a decade of intergovernmental conflict. Perhaps it will be the need for a working partnership in health care, however, that will build momentum for a "better federalism."

Overall health reform demands that we all go through a collective reality check. So let's get real.

The heart of our problem is not quality. We have the best for the rest to emulate. It's not access, per se. Our medical system, with rare exceptions, will provide miraculous care in any emergency and, if necessary, send the bill to someone else.

The problem is the disastrous spiral of cost and coverage. High costs drive up premiums, which price people out of coverage. People don't get the care they need, and when they do get sick, the bill is shifted to someone else. That increases the costs, premiums, and on and on.

What steepens the spiral is the insulation of both consumers and sellers of medical services from the consequences of their actions with a bill-paying service called health insurance. You can't respond prudently to forces you can't feel. Government, in the interest of equity, is also a primary "cost shifter," through the tax code, health programs, and social insurance programs.

Here are a few real solutions.

First, get rid of all the fire and casualty insurance agents who are pretending to be health insurers. Return the market to people who know health. For example, the Bentsen-Durenberger Small Group Insurance Reform bill or its House counterpart, as amplified by the President's proposals, redefines health insurance as financial security, not bill paying. It expands small-group buying power and pushes administrative reform. What we will get is greater economy, fairness, and access. Do that in 1992, and by the opening of the next season, we'll see some real competition from real insurers that will give us what we consumers want: "the best for less."

Second, totally restructure the federal government's health coverage financing policies. Our goal: every American buys coverage (financial security) the same way, by buying a health plan.

Low-income persons would buy with the help of the President's tax credit/deduction contributions to premiums, and we would abandon the Medicaid (welfare) approach. The elderly and disabled would buy one "Medicare" plan with doctor, hospital, drug and catastrophic coverage, plus a long-term care supplement. Older companies with retiree health plan commitments would trade off their current first-dollar commitments for a Medicare supplement and long-term care. Seniors today are buying multiple, overlapping policies that give them no additional protection. The key is "one plan" to saving the elderly billions!

Third, we can use $60 billion in current federal tax subsidies for high-income big company employees to secure 100 percent coverage in the workplace for all employed persons without any sacrifice.

Fourth, we need employers to be smarter buyers of coverage. Move from fringe benefit competition through cost sharing past a managed care system, which merely manages your cost, to getting committed to the health of employees by "buying right among the health plans in your community." Small employers would do it in large groups, large employers would do it on their own, the way they buy any other good or service.

Fifth, if every doctor, hospital, nursing home, and home health agency practiced medical care the way the best in this country do, we could reduce the cost of health care by 35 percent. If we change the practice of medicine, we will increase quality at a much lower price. Custodians of the old fee-for-service, solo practice, specialty clinic system will scream. but we can no longer afford to "keep the past on its throne."

Sixth, put the "public" back in public health. If government can force everybody to put their kids in school, we should be able to put additional responsibility on parents for their children's health. We need to energize communities for health education and behavioral adjustment, such as mental health, chemical dependence, and the like. The silent health problem is the daily medical consequences of homicide, abuse, drugs, alcohol, and accidents.

Seventh, turn the 50 states into experimental sites on how best to get essential health services to people who aren't getting them now. Good public health has to be community based because only local people really understand the problems and the kind of solutions that will "take." Only by turning the states loose are we going to develop new ways of getting the job done.

The winds are picking up in the health care debate. What we need now is to pick out the harbor we want to sail to, with efficiency, responsibility, and equity being the points we need to navigate by.

Sen. Dave Durenberger
Ranking Member
Senate Medicare Subcommittee

Intergovernmental PERSPECTIVE

Spring 1992, Vol. 18, No. 2

Intergovernmental Perspective
(ISSN 0362-8507) is published
four times a year by the
U.S. Advisory Commission
on Intergovernmental Relations
Washington, DC 20575
202–653–5640

On the ACIR Agenda

The last meeting of the Advisory Commission on Intergovernmental Relations was held in Washington, DC, on March 20, 1992. Following are highlights from the agenda and Commission actions.

Federal Regulation of State and Local Governments

The Commission convened a panel to comment on the background chapters, preliminary findings, and policy options that accompany the Commission's pending update of its 1984 report *Regulatory Federalism: Policy, Process, Impact, and Reform.* That report traced the growth of federal regulation of state and local governments during the 1960s and 1970s and explored early attempts to bring this trend under control.

Panel members were asked to comment on policy recommendations the Commission should adopt in conjunction with the updated report. Participating on the panel were James Blum of the Congressional Budget Office; Paul Colborn of the Office of Legal Counsel in the Department of Justice, Jeffrey Hill of the Office of Information and Regulatory Affairs at OMB, and William Niskanen of the CATO Institute and editor of *Regulation*.

The Commission focused the discussion on practical steps that might be taken to reduce unnecessary regulation and promote a federal-state-local partnership in the rulemaking process. Chairman Hawkins asked Mayor Victor Ashe, along with Commissioners Mary Ellen Joyce and Barbara Todd, to work with Sen. Daniel Akaka, and Reps. Donald Payne and Craig Thomas on developing recommendations for the June 1992 Commission meeting.

Restoring Intergovernmental Balance in the Medicaid System

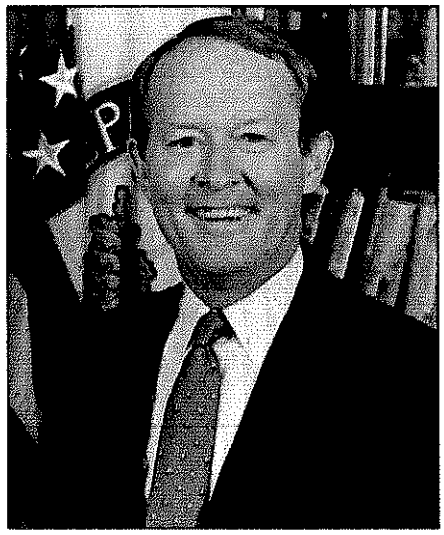
The Commission adopted findings and recommendations for restoring balance in Medicaid policymaking between the federal, state, and local governments, increasing program flexibility for operating Medicaid, and limiting shifts in program funding that have occurred within Medicaid and between Medicaid and other programs targeted to the disadvantaged. Sen. Dave Durenburger emphasized the need for a stronger local government role.

IP LETTERS

We invite comments from readers on articles appearing in *Intergovernmental Perspective*, the work of the Commission, and intergovernmental issues generally. Send your letters to: Editor, Intergovernmental Perspective, Advisory Commission on Intergovernmental Relations, 800 K Street, NW, South Bldg., Suite 450, Washington, DC 20575. Letters should be kept brief, and may be edited for length and clarity. Not all letters can be published. Please include an address and phone number where you can be reached.

Federal Grants to State and Local Governments

The Commission released *Characteristics of Federal Grant-in-Aid Programs to State and Local Governments: Grants Funded in FY 1991*, an information report that updates all federal grant programs available to state and local governments. There have been several significant changes in the type, number, dollar amount, and other characteristics of these programs. The Commission first cataloged these programs and measured their characteristics in 1975 and has updated this analysis six times. A 25-year trend analysis of the grant system is included in this update.



Lamar Alexander

Barbara Sheen Todd

Commission Appointments

President George Bush has appointed Lamar Alexander, Secretary of Education, and Barbara Sheen Todd, County Commissioner, Pinellas County, Florida, to two-year terms.

Lamar Alexander was appointed Secretary of Education by President Bush on January 22, 1991. Before taking

(continued on page 39)

Medicaid Reform: Major Trends and Issues

Elliott J. Dubin

Medicaid (Title XIX of the *Social Security Amendments of 1965*) was enacted as a joint federal-state program with the intent of improving access to mainstream medical care for certain groups of low-income people.[1] Since its inception, Medicaid has grown into one of the major health care programs in the United States, accounting for more than 12 percent of the nation's total health care expenditures and covering approximately 12 percent of the population. Due to rising health care costs generally, an aging population, and federally mandated changes in program conditions and requirements, Medicaid expenditures are projected to rise sharply in the near future. The additional Medicaid expenditures will put increased pressure on federal and state budgets.

This article reviews the major trends in Medicaid, some of the principal causes for increases in Medicaid expenditures, and the impact of Medicaid on federal and state budgets. Also discussed are options for reforming Medicaid by restoring the original goals and design of the program.[2]

Major Trends

Expenditures

Total Medicaid expenditures grew from $1.3 billion in 1966 to $75.2 billion in 1990.[3] Figure 1 shows that the rate of growth in Medicaid expenditures was only slightly lower than that for Medicare but significantly greater than the rate of growth in other government-financed personal health care expenditures and total personal health care expenditures.

Medicaid expenditure growth outpaced enrollment growth and increases in the general price level and general medical care prices. Between 1969 and 1990, Medicaid vendor payments (excluding administrative costs), per enrollee, grew by 10.7 percent per year—from $331 in 1969 to $2,818 in 1990 (3.1 percent in constant 1982 dollars, from $918 to $1,752). (See Figure 2).[4]

In 1990, Medicaid was the fourth largest source of funds for medical services, following private health insurance (31.8 percent), individuals' out-of-pocket payments (23.3 percent), and Medicare (18.6 percent). The remainder (14.1 percent) was financed through other federal, state, and local programs. Medicaid spending accounted for 11.1 percent of hospital care, 9.0 percent of drugs and other medical nondurables, and less than 4 percent of physicians' and dentists' services, but 31.9 percent of home health care and 45.4 percent of nursing home care, making it the largest payer for such services.[5]

Medicaid expenditures as a percentage of state general expenditures grew consistently, from less than 3 percent in 1966 to 14.8 percent in 1990, with only a slight slowdown between 1984 and 1987.[6] The National Association of State Budget Officers (NASBO) projects that state Medicaid spending will reach an average of 17 percent of state budgets by 1995.[7]

National averages mask large variations in state budgets, both across states and for a given state over time. For example, Medicaid expenditures as a proportion of total state expenditures in 1990 ranged from 4.2 percent in Alaska to 19.1 percent in Rhode Island.[8] Similarly, increases in expenditures from 1989 to 1990 ranged from 0.6 percent in Montana to 75.7 percent in Michigan.[9] These generally high but uneven growth rates make budgeting for Medicaid difficult. In FY 1990, more than half the states had to make supplemental Medicaid appropriations.[10]

Federal Medicaid expenditures as a percentage of federal general expenditures increased steadily from less than 1 percent in 1966 to 3.4 percent in 1981, leveled off for several years at 3.1 percent, rose to 4.0 percent in 1989, and are projected to reach 6.5 percent of the federal budget by 1996.[11]

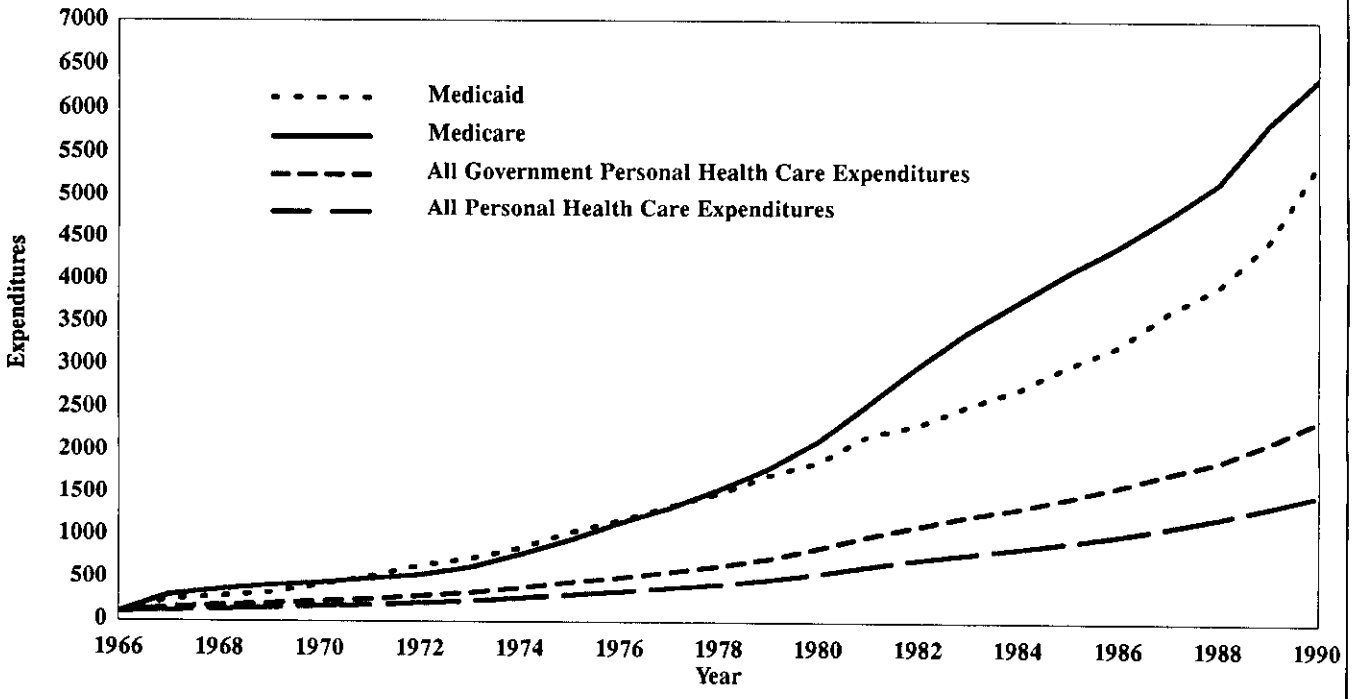
Increases in Medicaid Expenditures

There are four major causes of rising Medicaid expenditures: (1) general price inflation, (2) specific medical

Figure 1

Index of Expenditures for Medicaid, Medicare, Government-Financed Personal Health Care Expenditures, and All Personal Health Care Expenditures, 1966-1990

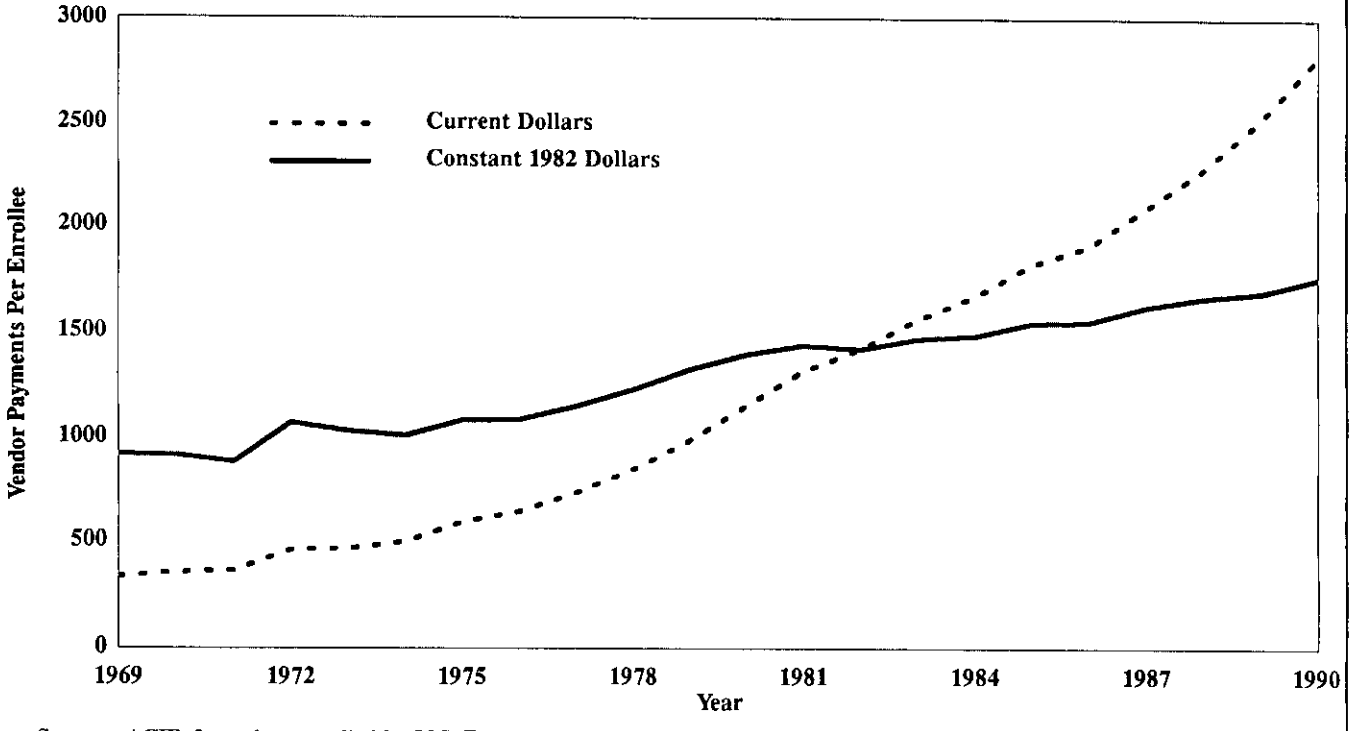
(1966 = 100)



Source: U.S. Department of Health and Human Services, Health Care Financing Administration.

Figure 2

Medicaid Vendor Payments per Enrollee, Current and Constant 1982 Dollars, 1969-1990



Source: ACIR from data supplied by U.S. Department of Health and Human Services, Health Care Financing Administration.

medical care price inflation, (3) enrollment growth, and (4) residual factors. This last category consists of increased use of medical care, changes in the composition of the Medicaid clientele, and increased use of expensive new medical technology.[12]

Inflation in prices generally and for medical care have been (and will probably continue to be) a major impetus for Medicaid expenditure growth, accounting for approximately 77.3 percent between 1979 and 1984[13] and 60 percent of the increased costs between 1984 and 1989.[14] Enrollment growth accounted for 0.7 percent of growth in 1979-1984 and 16.8 percent in 1984-1989.[15] The residual factors were responsible for 21.4 percent of Medicaid expenditure growth in 1979-1984, and 26.9 percent in 1984-1989.[16]

Trends in Medicaid Enrollment

Although it is not possible to separate the residual factors into individual components, it is clear that the changes in the composition of the Medicaid clientele have had a profound impact on expenditures. The total number of Medicaid recipients grew by 3.6 percent per year on average from 1972 to 1990. The disabled (including mentally ill and mentally retarded) grew by 4.6 percent; adults in AFDC families grew by 3.7 percent.

There was a decrease in the number of elderly, blind, and other recipients between 1972 and 1990,[17] but the share of Medicaid vendor payments for the elderly ranged between 34 and 38 percent for 1973-1990.

Disabled persons accounted for 15 percent of the Medicaid population and 37 percent of payments in 1990, compared to 9.2 percent of recipients and 21.5 percent of payments in 1972. Adults and children in AFDC families accounted for 62 percent of the Medicaid population and 43.4 percent of payments in 1972, and 68.2 percent of population and 37.2 percent of payments in 1990.

The elderly and disabled (and to a slightly lesser extent, the blind) are the most expensive groups of recipients to cover, averaging nearly $6,717 per recipient in 1990 (approximately $5,212 for the blind), or over 250 percent of the $2,568 average for all recipients. In contrast, the 1990 average payment for children and adults in AFDC families and all other recipients ranged from less than $811 (32 percent of average) to just over $1,429 (56 percent of average). By far the most expensive service financed by Medicaid is for mentally retarded persons in intermediate care facilities (ICF/MR), which cost slightly more than $50,000 per recipient per year in 1990.

Issues and Options

Several problems with Medicaid are the result of legislation that changed the structure, size, and scope of the program. Other problems, such as rapidly increasing medical care costs, stem from problems in the overall health care system.

Compounding the budgetary problems facing state officials is the projected cost of new Medicaid conditions and regulations imposed unilaterally by the federal government, which NASBO estimates at approximately $16 billion through 1994.[18] The U.S. General Accounting Office (GAO) has found that new program requirements extending coverage to older children and expanding screening programs and follow-up care will be more costly than previous regulations.[19] GAO predicts that most states will find it difficult to finance the new conditions and regulations without: (1) higher taxes, (2) shifting Medicaid resources by reducing or eliminating some optional services or closing public clinics, or (3) reductions in other state spending.[20] Further, the new requirements limit state flexibility in providing for the health care of their citizens.

The next section presents possible options that restore the balance in Medicaid policymaking between the states and the federal government. Following sections present options for increasing state flexibility in designing and implementing programs, and for shifting the responsibility for financing some services to other state or federal programs.

Restoring the Decisionmaking Balance

Medicaid was originally envisioned as a partnership between the states and the federal government. In recent years, major changes in federal requirements have become more frequent and are often costly for the states to implement. Sometimes, entirely new programs must be started and, from the time a requirement is issued until final regulations are promulgated by the Health Care Financing Administration (HCFA), several changes to the program may be necessary. In addition, new federal requirements may involve significant changes in computer programs, additional staff training, and changes in other inputs, which are often costly.

In order to provide state officials with a formal role in Medicaid policymaking, a permanent panel could be established, made up of federal representatives designated by the U.S. Secretary of Health and Human Services (HHS), state representatives designated jointly by the National Governors' Association and the National Conference of State Legislators, and local representatives designated by the National Association of Counties, the National League of Cities, and the U.S. Conference of Mayors. The panel would provide a consultative role for the states and localities as revisions to Medicaid are considered by the Congress or the Executive Branch. The panel would have the authority to make recommendations for changes to the Executive Branch, the Congress, and state Medicaid officials.

Another option is to relieve the states of the necessity of implementing new program requirements until HCFA issues final regulations. This would minimize additional state and local administrative costs.

Also, the federal government would bear the full cost of the new conditions and requirements for two years. After the initial period, the states would gradually assume increasingly larger shares of the costs until the overall state matching ratio (FMAP) is reached. This would make the Congress and the Executive Branch more cognizant of the costs of new regulations imposed on states and localities.

Improving Program Flexibility for the States

Along with a formal role in Medicaid policymaking, states and localities need greater flexibility if they are to be able to control Medicaid costs, target assistance to the most needy, and experiment with innovative methods of improving access to health care. Present Medicaid regulations require a waiver from HCFA for any deviation from statewide norms regarding the amount, duration, and scope of services. State and local officials are hampered in their ability to respond to variations regarding the need and ability to provide certain services. Greater flexibility would improve their abilities to experiment with case management or home or community-based care rather than institutional care.[21]

Improving access to health care for Medicaid clients can result in lower expenditures. For many recipients, especially in sparsely settled rural areas and in inner cities, access to health services can be problematic, and they often obtain medical care inefficiently by using hospital emergency rooms as primary providers. Further, Medicaid enrollees who do not have a primary medical care provider on a consistent basis are often sicker and require more services than other patients.[22]

One option is to allow states, selected by the Secretary of HHS, to experiment for two years with personal care case-management (PCCM) systems and/or with setting up their own clinics in areas where access to health care through enrollee-chosen providers is not feasible.[23] Should these experiments prove successful, other states could initiate their own programs without a HCFA waiver.[24] Medicaid enrollees should be permitted to utilize these clinics, with Medicaid reimbursement, even if the clinics do not meet federal requirements, but meet comparable state requirements as determined by HCFA. Further, health care providers should be eligible for Medicaid reimbursement if they conform to acceptable state standards, procedures, and regulations, as determined by HCFA.[25]

If limited access to health care is the result of low reimbursement rates, states could raise reimbursement rates for certain service providers and in localities where access is poor. States should have the option to set copayments and deductibles, for some Medicaid enrollees, without HCFA waivers in order to defray a portion of the additional costs. The copayments and deductibles would be based on enrollee income and/or asset levels.[26]

Limiting Shifts in Program Funding

There are three options for changing Medicaid to ensure access to mainstream health care for the low-income population and to account more accurately for differences among states in the incidence of poverty and fiscal capacity.

One option is moving the costs of providing custodial care, in institutions or home or community-based facilities, for the elderly and the long-term disabled under Medicare. Medicaid would not cover the custodial, educational, or job training costs associated with the elderly, blind, disabled, or mentally retarded. Medicaid would cover, for those who are eligible, services not covered by Medicare (e.g., prescription drugs, eyeglasses, and prosthetic devices).

The savings that would accrue to states and the federal government by adopting this option is difficult to determine. In fiscal year 1990, total Medicaid payments for SNF, ICF and ICF/MR totaled $25.0 billion or 38.6 percent of Medicaid expenditures.[27] However, a portion of this total was spent for routine medical care, some of which would still be covered by Medicaid under this option. Similarly, it is difficult to estimate the budgetary impact on the states if this option were adopted. State education and job training expenditures would rise while Medicaid expenditures would fall.

Another option is to change the formula determining each state's Medicaid matching ratio to a measure of fiscal capacity. The current base for allocating federal Medicaid funds is per capita personal income, which is a poor measure of state fiscal capacity. The distribution of income among households within states can vary substantially although average per capita incomes can be similar.[28]

The last option is state assumption of all of the administrative and program costs currently borne by counties. Studies have shown that Medicaid program costs are higher in states where local governments have a significant administrative or financial role.[29] Further, statewide administration eases the burden of complying with the regulation for uniform statewide Medicaid services and eligibility criteria.

Summary

The options for changing the Medicaid system discussed here address the problems that have resulted from legislation that changed the structure, size, and scope of the program. These recommendations are intended restore the balance in Medicaid policymaking between the federal government and the states and to ensure access to health care for the low-income population. These proposed reforms are also intended to make Medicaid more efficient by allowing greater program flexibility for the states and localities.

Many of the problems currently associated with Medicaid stem from problems in the overall system of health care delivery in the United States. Among those problems are rapidly rising medical care prices and the lack of any kind of medical insurance for a significant segment of the population.

These short-term options will improve the functioning of Medicaid, but do not totally correct fundamental problems in the system of health care delivery in the United States. A major restructuring of that system is required to address all of Medicaid's problems adequately.

Medicaid reform alone will not solve all of the nation's health care problems. Without redressing deficiencies in the overall system, the benefits of the reforms discussed here will be limited. However, until a comprehensive review of the health care delivery system is completed and steps are taken to implement necessary changes, the measures discussed here would provide some improvement.

Notes

[1] In 1990, 45.2 percent of all persons below the official poverty line were covered by Medicaid. U.S. Department of Commerce, Bureau of the Census, *Poverty in the United States: 1990* (Washington, DC, 1991), p. 168.

[2] In some cases, state costs for Medicaid may actually increase if these recommendations are adopted, if the states change their provider reimbursement policies or add other groups to the Medicaid clientele (e.g., the currently uninsured). In other cases, state costs may decline as the federal government assumes more of the burden of financing the health care needs of certain individuals.

[3] Medicaid enrollment in 1990 was 25.3 million.

[4] The medical care price deflator was estimated by ACIR from the data and methodology furnished by the Health Care Financing Administration (HCFA).

[5] Out-of-pocket payments were the second largest source of funds for nursing home care, representing 45.0 percent of all spending. Medicare, which pays for only limited stays in nursing facilities, financed only 4.7 percent of all expenditures for such services, and private insurance paid even less—1.1 percent of all payments. *Health Care Financing Review* 13 (Fall 1991): 52.

[6] Over the life of the program, however, over half of all Medicaid expenditures—55.5 percent on average—have been financed by the federal government. That percentage has remained fairly constant over time. HCFA, Office of National Cost Estimates. See also U.S. Department of Commerce, Bureau of the Census, *Historical Statistics on Governmental Finances and Employment*, 1982 Census of Governments, Vol 6, No. 4; and *Government Finances, 1989-90*. Using a somewhat different methodology, the National Conference of State Legislatures calculates the rise in Medicaid expenditures, as a proportion of state general expenditures, as less than 6 percent in the mid-1960s to 12 percent in 1990. Anthony M. Hutchison, "The Medicaid Budget Bust," *State Legislatures* 18 (June 1991): 10.

[7] National Association of State Budget Officers, unpublished estimates based on Congressional Budget Office baseline.

[8] _____, *State Expenditure Report, 1991* (Washington, DC, 1991), p. 43.

[9] Ibid., p. 45.

[10] *State Budget and Tax News* 9 (June 20, 1990): p. 4.

[11] Congressional Budget Office, *The Economic and Budget Outlook: An Update* (Washington, DC, August 1991), pp. 52, 54.

[12] ACIR computations from data supplied by HCFA. See *Health Care Financing Review* II (Summer 1989): 4-5, for methodology.

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

[17] Two reasons have been given for the decline in the number of elderly receiving Medicaid. First, fewer elderly are now receiving SSI benefits than were receiving them in 1974, due to the growth of Social Security benefits and the income from private pensions and other assets. Second, the low level of countable assets ($1,900 for a single person and $2,850 for a married couple in 1988) disqualify many aged for SSI. To some extent, the reduction in the number of aged receiving Medicaid as a result of their eligibility for SSI has been offset by the increase in the number of elderly who are medically needy. See U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1989*, p. 318; and *Social Security Bulletin* 53 (September 1990): 75. *Medicaid Source Book*, p. 42 and 43.

[18] Hutchison, p. 13.

[19] *The Omnibus Budget Reconciliation Act of 1989* (OBRA 89) requires provision of all Medicaid-allowed treatment to correct problems identified during Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) even if the treatment is not otherwise covered under the state Medicaid plan. The act also requires interperiodic screenings under EPSDT if medical problems are suspected. OBRA 90 requires Medicaid coverage of children under age 18 if the family income is below 100 percent of the federal poverty line.

[20] U.S. General Accounting Office (GAO), *Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress* (Washington, DC, June 25, 1991), pp. 4, 5.

[21] It is assumed that home or community-based care is less expensive than institutional care. This is not always true. However, in some cases, home or community-based care may be more appropriate than institutional care, even if it is more expensive.

[22] Emily Friedman, "Medicaid Overload Sparks a Crisis," *Hospitals* (January 10, 1987): 51.

[23] States are required to obtain a two-year waiver from HCFA to set up case-management systems because of the Medicaid requirement that Medicaid enrollees have unrestricted access to health-care providers. Two conditions must be met before waivers are issued: (1) Medicaid costs will not rise under a managed care system; and (2) patient care will not deteriorate. Currently, 16 states have some sort of managed-care system in operation. *Medicine and Health Perspectives* (October 7, 1991).

[24] HCFA estimates that states save $121 per year per enrollee with case-management systems.

[25] This would necessitate the federal government waiving the requirement that state-run clinics meet federal requirements, as long as comparable state requirements are met, as determined by HCFA.

[26] Those Medicaid enrollees who must make copayments or meet deductibles would, presumably, utilize medical care less frequently than those who are not liable for copayments or deductibles, thus reducing program costs.

[27] *Social Security Bulletin* 54 (December 1991): 271.

[28] GAO, *Medicaid: Alternatives for Improving the Distribution of Funds* (Washington, DC, May 1991), p. 3; and "Medicaid Formula: Fairness Could be Improved," Statement of Janet L. Shikles, Director, Health Financing and Policy Issues, Human Resources Division, before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, U.S. House of Representatives.

[29] See, for example, Charles J. Barrilleaux and Mark E. Miller, "The Political Economy of State Medicaid Policy," *American Political Science Review* 82 (December 1988): 1089-1107; Robert J. Buchanan, Joseph C. Cappelleri, and Robert Oshfeldt, "The Social Environment and Medicaid Expenditures: Factors Influencing the Level of State Medicaid Spending," *Public Administration Review* 51 (January/February 1991): 67-73; John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-Off between Cost Containment and Access to Care* (Washington, DC: The Urban Institute, 1986); Saundra K. Schneider, "Intergovernmental Influences on Medicaid Program Expenditures," *Public Administration Review* 48 (July/August 1988): 756-763; Frank A. Sloan, "State Discretion in Federal Categorical Assistance Programs: The Case of Medicaid," *Public Finance Quarterly* 12 (July 1984): 321-346; and GAO, *Medicaid: Interstate Variations in Benefits and Expenditures* (Washington, DC, May 1987), pp. 38-41.

Elliott J. Dubin is an analyst with ACIR.

Medicaid and Health Care Reform

Rep. Henry A. Waxman

At long last, a serious debate about health care reform has begun in the Congress. Recommendations for addressing the crises of access and costs have been issued by the Pepper Commission, the National Commission on Children, and the Advisory Council on Social Security. A number of thoughtful proposals have been introduced by the House and the Senate. The Senate Committee on Labor and Human Resources has reported a bill, and the Bush administration has released a white paper entitled "The President's Comprehensive Health Reform Program."

Medicaid will be central to this debate. First, until health care reform is enacted and implemented—a process that under the best of circumstances will take a number of years—Medicaid will remain the principal source of health care financing for the poor. We need to be sure that it continues to function well during the transition. Second, the experience of federal and state governments with Medicaid over the past 25 years has much to teach us about how to reform our health care financing system. We need to avoid making the same mistakes that have brought us a means-tested, underfinanced, second-class health care program.

The Current Impasse

In 1991, the Bush administration published *Healthy People 2000*, a list of health objectives for the nation for this decade. Among these is the reduction of this nation's shamefully high infant mortality rate to no more than 7 per 1,000 live births. No one disputes—not the administration or governors—that early access to prenatal care will help reduce the infant mortality rate. No one disputes—not the administration or governors—that Medicaid coverage will improve access to prenatal care by low-income pregnant women.

In 1987, the Congress gave the states the option to extend Medicaid coverage to pregnant women and infants with incomes below 185 percent of the poverty level. More than three years after this option took effect, only 23 states have taken it. That leaves roughly 150,000 near-poor pregnant women and 100,000 infants uninsured. Yet neither the administration nor governors will support legislation that would extend this coverage to pregnant women and infants in all 50 states. So where does that leave us? Denying coverage for proven, cost-effective preventive services and technologies to hundreds of thousands of low-income pregnant women and infants—and a long way from our national infant mortality objective for 2000.

Clearly, we cannot allow this impasse to continue. The question is how to work our way out of it. I think we have to proceed on two tracks, incremental improvements and comprehensive health care reform. Comprehensive reform is probably not going to be enacted this year, and even when it is enacted, it will take several years to implement. The reality is that until reform is in place, babies will continue to be born to low-income parents, the number of poor children will continue to grow, low-income women will continue to have undetected breast and cervical cancer, and the drug and HIV epidemics will continue to destroy low-income communities. We cannot afford to ignore these problems while we wait for the arrival of a new health order.

Incremental Improvements

There are a number of improvements that should be made in Medicaid. First, we should extend Medicaid coverage, at 100 percent federal cost, to all pregnant women and infants with incomes between 133 and 185 percent of the poverty level. This will ease the financial pressure on those states that do not now cover this population as well as those that do. Second, we should give states the option to extend Medicaid coverage to all children under age 19 with family incomes at or below 185 percent of the poverty level. This would extend basic health services to an estimated 460,000 children next year.

Third, we should expand the basic Medicaid benefit package to include coverage for screening mammography

and screening pap smear services. To help the states, this coverage should be financed at 100 percent federal share. This would make medical technology used to permit early detection and treatment of breast and cervical cancer, now available to Medicare-eligible women, accessible to poor, non-elderly women as well.

Finally, we should give states the option of offering coverage for early intervention services to low-income individuals who are infected with the HIV virus but who do not have AIDS. We have spent millions on research to develop drugs that delay or prevent altogether the onset of AIDS and its complications. We now have an obligation to make these drugs accessible to the poor before they become disabled with AIDS.

Some of these proposals are mandates; others are options. In the case of the mandates, I believe the federal government should pay 100 percent of the cost. This recognizes the fiscal pressures on states that do not offer this coverage, and it also provides some modest fiscal relief to those states already covering these populations. It also lays the groundwork for full federalization of acute care coverage for the poor as part of comprehensive health care reform.

Health Care Reform

I served on the Pepper Commission and support its recommendations for health care reform, that are set forth in the Pepper Commission "Health Care Access and Reform Act of 1991" (H.R. 2535). Under this bill, all Americans would have coverage for basic health care services through their employer, a new federally run public plan, or Medicare. Employers would be responsible for providing basic coverage to their employees and dependents. Employers could offer this coverage privately, or they could enroll their workers in a public plan for a premium set at a percentage of payroll.

Americans outside the workforce would have access to health insurance through a public program which, like Medicare, would be run by the federal government and, unlike Medicaid, would not be tied to the welfare system. This program would serve those employees and family members whose employers choose to pay rather than offer private health insurance coverage, as well as those who are now eligible for Medicaid and those who are uninsured.

The new public program would pay for hospital, physician, diagnostic, and preventive services, as well as EPSDT services for children. Payment rates would be based on Medicare payment principles and would be substantially higher than the rates now being paid by many states for these services.

Those now eligible for Medicaid who are not covered under an employer plan would be eligible for the new public program. Existing state payments for hospital, physician, and other basic health services provided to Medicaid eligibles—roughly $22.5 billion in FY 92—would be phased out over a three-year period, easing the fiscal pressure states are now facing, and freeing up state funds for improvements in public health, long-term care, or other programs. The Medicaid program would continue to provide, to those currently eligible, "wraparound" coverage for prescription drugs and other optional services not included in the basic benefit package.

In short, my bill would federalize much of the acute care portion of the Medicaid program. I see no alternative if an employer choice approach is to work. Under this approach, employers have to have a meaningful alternative to buying coverage from private insurers or self-insuring, otherwise the private insurers will have little incentive to restrain costs, and employers will have no assurance that their financial exposure for health care costs can be limited. Enrolling their employees in Medicaid will not be acceptable to most employers, because their employees simply will not tolerate it. The sad fact is that, despite Medicaid's strengths, its welfare stigma and poor reputation among providers make it an unattractive option for working Americans.

Role of the States in Health Care Reform

Any model of health care reform, whether the employer choice approach that I favor or the single payer approach, will require a public program that works. Medicaid, with its heavy reliance on state financing, shows us the path we should not take.

In many ways, Medicaid is a small miracle. No other public or private health insurance program is asked to shoulder as much responsibility for as vulnerable a population. From low birth weight babies to ventilator-dependent children to individuals with mental retardation to the frail elderly to terminally ill AIDS patients, the range of needs that Medicaid is called on to meet, and the scope of services that Medicaid must define and pay for, is unrivaled.

We cannot let Medicaid's achievements obscure the basic flaw in the program; the difference between the rate of growth in state revenues and the rate of growth in program spending. For example, in FY 93, Medicaid spending is projected to grow by 16.4 percent. However, even if state revenues were to grow at the same rate as nominal Gross Domestic Product, they would increase by only 6.7 percent.

In the past, these differences in rates of growth between revenues and spending have had two major consequences. First, they have resulted in chronic underfunding of the program itself. In 1989, states paid 78 percent of hospital costs of treating Medicaid patients and 69 percent of Medicare prevailing charges for physician services. Secondly, they have led to "crowding out" of other state programs, especially those for the poor, like AFDC and General Assistance. There is every reason to think that these trends will continue into the future unless current financing arrangements are changed.

The single largest factor in Medicaid cost increases is inflation in the price of the services Medicaid buys. Yet even if health care reform is successful in reducing the rate of increase in medical care costs, state revenues are unlikely to keep pace with acute care costs over the long haul. That will inevitably lead to calls for greater state "flexibility" over eligibility rules, patient cost sharing, the scope of coverage, and how providers are paid—the same "flexibility" that has undermined Medicaid's ability to achieve national coverage goals. This is not the type of tension that we should build into a new health care program.

There are other problems with state financing, as the current recession clearly demonstrates. While all state economies are suffering, some states are worse off than others. These states face a greater need as more people become unemployed, yet they cannot respond to that need because their revenues are reduced. The certainty of state-by-state economic variations guarantees that at any

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Medicaid: Successes, Failures, and Prospects

Jane Horvath

Medicaid is among the most complex of government programs. Federal Medicaid laws and regulations have been described as Byzantine and worse by various courts around the country, and that complexity is compounded by the fact that the states have a certain amount of discretion to vary their programs.

Historically, Medicaid has been a health care financing system; its role was to pay provider claims. In recent years, Medicaid has grown into a program concerned with health outcomes, continuity of care, provider satisfaction, and appropriate client access. Medicaid must grapple with all the problems that affect the larger health care system, such as the need to compensate hospitals for charity care, the effects of malpractice costs on provider availability, rural health care delivery problems, medical cost inflation far in excess of annual general inflation, the adverse effects of substance abuse on children and families, lack of proper health education in the general public, and deeply entrenched poverty. As Medicaid takes on greater responsibility for larger concerns, the debate about its effectiveness grows.

The Medicaid program will serve approximately 30.1 million clients in FY92, up from 27.7 million in FY91. Total program service costs for FY92 are expected to be $122 billion, an increase of approximately 35 percent over FY91 expenditures. Medicaid serves the young, the old, and the disabled—roughly 12 percent of the population. It is a means- tested program, with numerous federal eligibility categories and even more in the states, which have various options. The program finances medical care, long-term care, and some social services. It is funded by federal, state, and, in some cases, local government.

Given its many forms, only the most sweeping generalizations can be made about Medicaid. It seems fair to say that most groups and individuals involved with the program both commend and criticize it. Few who see the program's benefits can overlook its flaws; few who see the flaws can dismiss the benefits. Perhaps more instructive are recent, divergent characterizations of Medicaid as a program either in crisis or finally coming of age. This difference in perception is analogous to the old debate about whether the glass is half empty or half full.

Clearly, both perception and fact about Medicaid will influence its future. That future seems inextricably tied to the current and growing debate about health care and long-term care financing reform. The basic elements of most reform proposals contain some form of public program, for which Medicaid may be a model or at least an experience from which to learn. Proposals favoring either a national health care financing and delivery system or a single payer system involve a public financing/administrative program. Most "play or pay" proposals include a public program aspect. Medicaid's tie to long-term care financing proposals is equally strong.

As health and long-term care financing reform rise to the top of federal and state public policy agendas, it is important to understand the current Medicaid program—its successes and its problems—to better evaluate its potential within a new system.

Program Successes

States have used the Medicaid program in innovative ways to respond to the myriad health financing and access issues. States have experimented with service delivery, payment reforms, outreach, and claims processing. Some of these innovations have become models for national policy.

State Medicaid programs were among the first to implement case management to ensure better service

utilization by high-risk clients and other targeted groups. For high-risk pregnant women, case-management services work to assure early and continued prenatal care. For the elderly or developmentally disabled, case management can assist the client in choosing and arranging for an array of needed social and health services. States also are taking advantage of recent requirements in child health to design comprehensive programs with integrated service delivery and screening that exceed basic program requirements and provide services frequently more generous than private health insurance policies.

States have worked to simplify and integrate Medicaid eligibility with other state and state-federal assistance programs along the lines of one-stop shopping models. States were also ahead of federal requirements in placing eligibility workers at care sites to improve program participation. State Medicaid administrators have worked with the private sector, community groups, and other state agencies to develop and implement outreach campaigns well in advance of any federal emphasis on outreach. There are now several successful, often replicated models in use across the country.

State Medicaid officials also have been leaders in developing models of home and community-based care for people who would otherwise be institutionalized or who are at risk of institutionalization, such as the mentally ill, the developmentally disabled, the elderly, and AIDS clients. These programs have demonstrated savings and improved client satisfication.

In tackling provider participation and client access, states have experimented with targeted reimbursement strategies to increase provider participation and have led the federal government in seeking tort reform and otherwise addressing malpractice issues as they relate to provider participation and availability. States also have experimented with new payment systems. Diagnostic Related Groups (DRGs), now used by Medicare, were first implemented in a state Medicaid program. The new Medicare Resource Based Relative Value Scale (RBRVS) was implemented in a Medicaid program before being put to use in Medicare. States are experimenting with case-mix reimbursement for nursing facility care as well.

States have taken the lead in developing on-line eligibility verification systems so providers can be guaranteed payment and be aware of service limitations and the like in advance of treatment. Many states have systems for electronic claims submission to reduce provider paperwork and speed payment. Many state payment systems process correctly submitted claims faster than Medicare and private payers. State Medicaid utilization review frequently surpasses that found in the private sector. Medicaid programs have been particularly innovative in prospective and retrospective drug utilization review programs well in advance of federal requirements.

Some of these successes can exacerbate perceived and real program failings. Greater outreach efforts, coupled with eligibility expansions, have increased caseloads by more than 25 percent in the last three years, at a time when states are financially strapped. Case management services together with outreach have increased utilization of services, which is a proper outcome but a double-edged sword in a time of tight budgets. Growing caseloads have also highlighted the fact that in many states or counties there are not enough participating providers to serve new clients. States with significant budget deficits also may have cash flow problems as a result of improved claims processing.

Program Problems

Many state Medicaid problems have to do with the federal-state partnership and are administrative in nature. First and probably foremost is the erosion of traditional state flexibility to operate programs. Since 1987, the Congress has handed down no less than 30 mandates concerning Medicaid eligibility, services, and reimbursement. While the general policy goals of these new requirements may be laudable, state government ability to continue to fund the program at current service levels is being sorely tested. State Medicaid appropriations are subject to the constraints of declining revenues, growing caseloads, and balanced budget requirements. National average annual state expenditure increases of 20 percent in the last several years have been difficult to sustain in the recent economic environment. Mandates have made it increasingly difficult to contain costs by marginally reducing services, eligibility, or reimbursement in key areas. Instead, states are left with few palatable options, most of which will have significant impact on clients because there is no longer room to maneuver at the margins of the program.

What the Congress has not mandated, the courts have. With increasing frequency, states are being sued by hospitals, nursing facilities, and individual providers over reimbursement rates deemed to be inadequate by plaintiffs. In the majority of cases, the states have lost on procedural grounds. In one case, the court took the unusual step of establishing the hospital reimbursement rate for the state. More recent lawsuits are challenging state efforts to enroll potential eligible clients and/or providers.

Increasing levels of federal micromanagement by statute also have proven problematic in Medicaid. This congressional tendency results, in part, from almost a decade with a Democrat controlled Congress and a Republican administration. Through specific statutory provisions, the Congress ensures that its aims will not be thwarted by an administration that may seek to modify statutory goals through regulation or to thwart policy goals altogether by never issuing regulations. This federal tension has placed states over a barrel on more than one occasion. Federal statutes can be so prescriptive as to preclude flexibility that promotes local efficiency. In other cases, the administration has been able to add another level of intricacy. Given more flexibility, state agencies believe they could administer these new requirements more efficiently, while achieving desired goals. This is a pivotal issue for states, especially in times of resource scarcity. The tendency toward national uniformity in administrative and program detail, in a program with a 20-year history of diversity, has caused operational problems.

Sweeping Medicaid program changes enacted with unreasonably short implementation times have put more than one state program in turmoil. Quick implementation

meets federal budgeting requirements, but places undue burdens on states trying to administer the program. Worse, inadequate implementation time can be a prescription for failure. Without time for sufficient federal guidance, states are left to do the best they can—which is viewed as not good enough more frequently than not. Clients are dissatisfied when implementation is not as prescribed or when start-up is not smooth. Providers become dissatisfied when state instructions and rules change to comply with federal guidance that is provided only after a state has implemented a new requirement. Constant change and refinement of procedures cost administrative dollars—state and federal dollars. Sweeping changes in federal requirements on short notice often catch states in the middle of budget cycles; money must be found to cover new costs. Further, the type and manner of change often leaves constituents, providers, and program observers with an impression of mismanagement and ineptitude on the part of states as they have struggled to keep pace with changing program requirements.

All of these intergovernmental tensions have a profound impact on the program and its clients. The fact that states essentially have met the significant challenges of the last several years is seldom acknowledged. What is more frequently noted is a state's failure to do all that is required within a given time. Legislators and governors, for example, may see that Medicaid can never seem to stay within its budget. Advocates for the elderly may see that nursing home reform provisions are not fully implemented. Advocates for children may see that some of the new requirements for child health screening, treatment, or reporting are not yet in place. Advocates for the mentally retarded may see only that the state program has not fulfilled its goal to move clients out of institutions and into community settings. Taken together, such shortcomings of the program tend to loom large, and the multitude of accomplishments is overshadowed.

Medicaid in the Larger Health Care System

Medicaid is plagued by the same problems that affect the rest of the health care sector, particularly, spiraling costs that have defied control. Medicaid has been successful in the past at limiting the growth in per client average costs to below the rate of health care inflation, which has been judged by some to be a shortcoming of the program. This containment is more and more difficult. General health sector cost inflation not only drives mandatory service and reimbursement increases, it also has resulted in faster growth in per capita expenditures as states move to upwardly adjust those payment levels not yet mandated. Also affecting the increase in per capita costs are worsening problems of poverty, substance addiction, and poor education. Medicaid cannot solve those problems but is deeply affected by them.

Medicaid has grown to serve the needs of many divergent groups: the working and nonworking poor, the mentally ill, the developmentally and physically disabled, the frail elderly, and the technology dependent. Some administrators contend that the clear trend is for Medicaid to become all things to all people; they wonder whether a single program, and one built on a medical model, can continue to function in this manner as the strains on the system become more apparent.

Medicaid is called on to fill gaps in the larger health care system. Political expediency has dictated that where the larger system fails a Medicaid solution is crafted. Medicaid now pays client out-of-pocket costs to cover qualified Medicare beneficiaries for whom Medicare cost sharing has become too expensive. Disproportionate share hospital payments are necessary to compensate for the charity care burden of some hospitals. Eligibility expansions that extend above the poverty level result from society's general failure to provide affordable private sector health insurance. Spousal impoverishment provisions and Medicaid long-term care coverage derive from a failure to respond to demographic and technological changes that result in greater need for long-term care, and a systemic failure to achieve affordable coverage of long-term care for people who might otherwise have been able to provide for themselves.

The Lessons Learned

Experience with Medicaid demonstrates that there is a need to separate health care financing from long-term care financing. It is becoming untenable to finance both through the state Medicaid programs. It will be very difficult for states to take on any additional financial responsibility for health care for the poor and/or uninsured if they must continue to fund current Medicaid long-term care services. In some states, long-term care expenditures for all ages constitute almost half of program dollars. Federal policymakers must seriously consider state funding limitations as they move forward. State experience can be instructive. Medicaid demonstrates that reform proposals should not assume inexhaustible general revenue funding for both expanded health and long-term care financing.

For long-term services, Medicaid has shown that home or community-based care can be useful alternatives to institutionalization because they increase client satisfaction and contain costs. In health care, Medicaid has demonstrated how funding of nonmedical intervention services, such as case management and transportation, can improve outcomes and promote appropriate service utilization.

State and local Medicaid administration has led to program innovation and permits the flexibility needed to address local conditions. Such flexibility cannot be found in a uniform program operated by the federal government. Though many people decry the lack of national uniformity in Medicaid eligibility, services, and payment, federal policymakers should consider the benefits of local administrative flexibility to meet area-specific needs and conditions, even if major aspects of any new program are nationally uniform.

Questions Raised by Medicaid

The Medicaid program offers a variety of lessons that can be instructive as the country moves toward health and long-term care financing reform. Medicaid has also raised questions that need to be addressed in any reform. The issues raised could be critical to the success of any new effort.

Among these outstanding issues is proper reimbursement levels. Payment levels and methods must be oriented to contain costs in a rational manner. They must also be

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Medicaid Recipients: The Forgotten Element in Medicaid Reform

Michele Melden

States and the federal government are moving aggressively toward expanding the use of managed care for Medicaid recipients, particularly, mandatory managed care. In the past year, New York, Massachusetts, and Oregon have enacted legislation authorizing a rapid expansion of managed care for almost all eligible Medicaid recipients. California and Maryland passed legislation to require mandatory managed care enrollment for all recipients who fail to specify that they have ongoing relationships with particular providers. Maryland's plan limits recipients to relationships with physicians who will act as "gatekeepers."

The federal government has advocated eliminating the requirement that states obtain "freedom of choice waivers" in order to mandate enrollment in managed care, and the "mixed enrollment" requirement that managed care plans enroll at least 25 percent non-Medicaid and/or non-Medicare recipients. President Bush's recent health care address recommended federal capitation for all Medicaid payments, thereby encouraging states to use managed care in order to minimize their financial burdens. Sen. Daniel J. Moynihan has introduced legislation to allow states to mandate enrollment without a waiver as long as recipients have at least two plans from which to select, and to eliminate the mixed enrollment requirement.

This article will address the impact that increased managed care would have on Medicaid recipients' access to needed care as well as other cost-saving proposals, such as Oregon's rationing plan.

The Danger of Inadequate Access

Many advocates of expanded managed care claim that it can save money and increase access at the same time. Managed care typically is characterized by two fundamental differences as compared with the fee-for-service system. First, managed care often uses capitation, an annual flat payment per enrollee paid by the program to the health care provider, to limit the amount of money that is spent per individual. All capitation fees are pooled, enabling the plan to act as an insurer and a provider. Capitation is used alongside provider incentives to limit care, such as withholding a certain amount of payment if the provider exceeds certain utilization limits. Second, managed care often uses a "gatekeeper," typically a primary care physician who determines whether the patient may receive follow-up or specialty services.

One of the attractions of managed care is that it is supposed to provide access to physicians for the Medicaid population, which has a very difficult time finding physicians to treat them at the low Medicaid rates. In addition, managed care is supposed to save money because it is supposed to control for overutilization, particularly of emergency services, on which Medicaid recipients often rely because they do not have access to primary care providers.

A number of studies on Medicaid managed care plans, however, have shown that in large part it has failed to improve access for recipients.[1] In HealthPASS, for example, a plan set up just for Medicaid recipients in West Philadelphia, there have been gross examples of financial abuse. In addition, a recent study found that, on average, pregnant women enrolled in HealthPASS were unable to schedule their first prenatal visit until the later part of the 5th month of pregnancy, well beyond medically recommended standards.[2] And the costs were high: over 20 percent of the newborns had a low birth weight and required expensive intensive care.[3] Because enrollment is mandatory, these women were trapped in a system that was not serving them.[4]

Even where enrollment is not mandatory, plans that serve the poor predominantly, such as in Chicago, have resulted in dangerous access problems. A recent General Accounting Office (GAO) report on Chicago plans concluded that the incentive mechanisms, underfinancing,

and lack of state oversight combined to make for grossly inadequate access, as well as corruption and financial vulnerabilities leading to bankruptcies of provider groups, which led to further access problems.[5]

Recent GAO testimony cautioned against Oregon's plan to enroll most Medicaid recipients in managed care by 1992.[6] GAO expressed concern that there were not enough Medicaid providers to meet the need and that the state had failed to demonstrate that it could monitor the provider arrangements adequately for financial abuse and risks of insolvency.

Dubious Cost-Effectiveness

As long as Medicaid reimbursements are inadequate, positing managed care as the solution for containing rising Medicaid costs is pure fantasy. Regardless of where recipients receive care, states must plan to pay adequate reimbursement rates. If the rates were adequate, then more mainstream managed care plans would be participating in Medicaid. They are not. Kaiser, for example, a very prominent HMO in California, only reluctantly enrolls a minimal number of Medicaid recipients. Foundation Health Plan, another prominent HMO in California, required its providers to stop seeing Medicaid recipients. There are exceptions: in Minnesota, as well as Arizona, the state is paying good rates and using mainstream providers. In fact, in Arizona, the prenatal and delivery reimbursement rate is among the highest in the country, and over 50 percent of mainstream providers participate in Medicaid. In Minnesota, Medicaid recipients have access to almost all of the mainstream managed care plans.

Promoting managed care as the solution for increasing Medicaid costs avoids some of the real issues. Rising Medicaid costs are largely attributable to inflation in the costs of medical care generally. Solutions that isolate the poor for cost controls do not address these issues, and have little impact on overall inflation.

Moreover, plans that fail to provide adequate care may be increasing costs. Recent data from Ohio's Dayton Area Health Plan, a mandatory managed-care plan, showed a number of failures. High-risk pregnant women waited, on average, 4 weeks for their first prenatal visit; 71 percent fewer children received lead blood tests; only 25 percent of the children were fully immunized; only 7 percent of the children who received Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens were referred for follow-up treatment, compared with the national average of 28 percent; and only 29 percent of pregnant women received prenatal care in the first trimester, compared with 35 percent of Medicaid recipients in the rest of the state.[7]

It is still an open question whether managed care can save money on the population generally. Mainstream HMOs see mainly healthy people. A number of studies have found that when HMO enrollees become sick, they disenroll.[8] In addition, with increasing market penetration, HMOs have become less competitive: inflation in HMO rates is beginning to more closely resemble inflation in health care generally.[9] In fact, there is a great deal of inflation in the Medicare HMO rates as well. A recent study prepared for the Health Care Financing Administration by the University of Minnesota concluded that the Medicare HMO funding method is inherently inflationary and may raise overall Medicare costs.[10]

States should consider other alternatives:

Preventive Care—Investments in prenatal and preventive children's care have *proven* to be cost effective. Where cost savings attributable to Medicaid managed care have not been proven and are still highly speculative, there is abundant evidence that providing adequate prenatal and preventive health care saves money. Finding methods to ensure such access will save money and is much more humane than experimenting with questionable financial incentive mechanisms.

Case Management—States should consider using case management programs within the fee-for-service system. These are sometimes called primary care case-management systems. One program that is being used with some success and saving money is Kentucky's KENPAC. Case management matches beneficiaries with an identifiable physician, coordinates and monitors services, and offers nonmedical, cost-effective services, such as assistance with transportation, scheduling appointments, and health education. Managed-care plans do not necessarily provide these services. In fact, a recent study documenting the inadequate health care delivered by HealthPASS concluded that one of the major problems was the fact that providers had no guidance in providing case management.

Alternative Delivery Systems—In order to ensure access to essential prenatal and preventive care, states and the federal government should devote greater resources to expanding delivery systems available to poor people, such as community and rural clinics and school-based clinics.

Alternative Third-Party Sources—States should consider (1) the cost effectiveness of buying into available private insurance and (2) more aggressive pursuit of third-party coverage sources, such as divorced parents' health care plans.

Finally, investigating and promoting methods for controlling costs generally in health care will halt inflation. These include analyzing the cost effectiveness of:

The use of practice guidelines, such as those being developed by the RAND Corporation;

Stricter controls on physician ownership of expensive diagnostic equipment; and

Simplifying administrative costs through a single payer system.

The 75/25 Requirement

Many states, the federal government, and Senator Moynihan's bill have proposed eliminating the "mixed enrollment" requirement, claiming that it is only a crude

proxy for protecting quality of care. However, according to GAO's recent testimony on Oregon's plan, the "success" attributed to Oregon's use of managed care to date has been its ability to enroll Medicaid recipients in mainstream managed care plans.

A number of reports on Medicaid managed care have documented inadequate access and a failure to overcome poor health outcomes, particularly with respect to prenatal care.[12] Therefore, existing quality assurance methods are not effective. Until we know whether enhanced quality assurance mechanisms will be effective in overcoming these access problems, the mixed enrollment requirement should be preserved.

First, studies on the Medicaid demonstration projects indicated that providers participating in Medicaid only managed-care plans were the same ones who participated in Medicaid.[13] To expand access, states should seek means for enrolling new providers. The best way to do this is to require states to make arrangements with managed-care plans that provide services to the non-Medicaid population.

Second, current capitation rates are too low. That is the reason why mainstream HMOs are reluctant to participate. We should be suspicious of plans that enter the market just to enroll Medicaid beneficiaries, where the rates are inadequate, because such providers are more likely to abuse the system and the patients. The Chicago and Philadelphia experiences confirm this.

Third, the fact that the Medicaid rate is inadequate is buffered by mainstream HMOs' ability to cross-subsidize where necessary. This protects the Medicaid enrollees. Some plans, such as Contra Costa County Health Plan in California, have indicated that they could not have taken Medicaid if they did not have the ability to cross-subsidize with non-Medicaid enrollees.

Finally, it is a meaningful protection for Medicaid beneficiaries to require managed-care plans to compete for and maintain enrollment of a mainstream population. Medicaid recipients, and particularly AFDC-linked recipients, move on and off Medicaid. The plans, therefore, have limited incentives to invest in preventive care. Plans that have proved they will provide adequate preventive and follow-up care to a mainstream population are more likely to provide adequate care to Medicaid recipients.

The Oregon Rationing Plan

The Oregon rationing plan is an extreme and potentially inhumane solution for controlling rising Medicaid costs. The Oregon rationing plan provides a way to eliminate services rather than to explore more intermediate steps for controlling costs. The plan is based on paying for services that provide the most benefits in relation to cost. The rationing methodology is questionable from scientific and ethical perspectives. Under the Oregon Plan, medical services are ranked, based on a medical care ranking developed by a panel of doctors, ethics scholars, and others. The size of the state medicaid budget determines the cutoff for the services provided. It has been acknowledged that rationing would most severely affect people with chronic problems and disabilities. This factor raised political issues that resulted in a decision not to apply rationing to those groups. However, the method will have the most serious effect on those whose treatment is more expensive and whose cure is less certain.

Again, before eliminating services, states should consider more humane cost-saving alternatives.

Conclusion

States should proceed cautiously with expanded use of managed care. States and the federal government could save money if they ensured access to cost-effective preventive and prenatal care. Expanding systems that recipients are likely to use, such as community health centers and school-based clinics, is a wise investment of resources. In addition, case management without the risks of capitation provides an alternative means for controlling and coordinating utilization.

Notes

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[3] Ibid.

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[12] Anderson and Fox, p. 71.

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The Changing Public Sector: Shifts in Governmental Spending and Employment

The Changing Public Sector updates and broadens ACIR's 1982 analysis of expenditure and public employment data. From 1967-1987, the public sector continued to expand, and government spending priorities shifted, particularly those of the federal government. In 1987, states were spending more in relation to both federal expenditures and local expenditures than in 1967. Among local governments, county and special district expenditures increased the most. The analysis is based on the Census Bureau's five-year Census of Governments. Total spending by all governments rose from $257.8 billion in 1967 to $1,811.7 billion in 1987, or by 603 percent (115 percent in constant 1982 dollars). Per capita, total public spending grew from $1,297 in 1967 to $7,427 in 1987, a 473 percent increase (75 percent in constant dollars).

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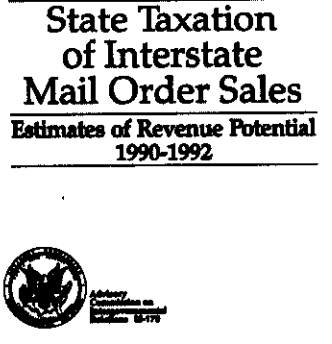
State Taxation of Interstate Mail Order Sales

State Taxation of Interstate Mail Order Sales estimates the 1990-1992 revenue potential for states if they could require out-of-state mail order firms to collect state sales and use taxes. The revenue potential for all states is estimated at $2.91 billion for 1990, $3.08 billion for 1991, and $3.27 billion for 1992. These aggregate estimates show an increase of 73 percent over ACIR's 1985 estimates and 34 percent over 1988. ACIR estimates of the revenue potential if state and local sales taxes were collected are $3.49 billion for 1990, $3.69 billion for 1991, and $3.91 billion for 1992. These new estimates are particularly important in light of the U.S. Supreme Court's agreement to hear *Quill Corporation* v. *North Dakota*. In accepting this case, the Court agrees to review its 1967 ruling in *National Bellas Hess* v. *Illinois Department of Revenue*, which limited the ability of state (and local) governments to require out-of-state mail order firms to collect state and local sales and use taxes.

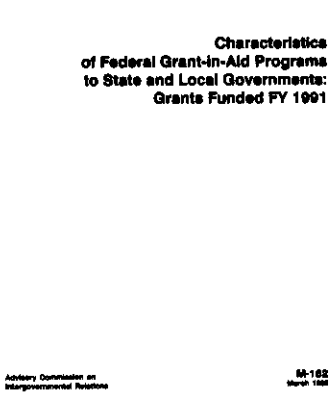


M-179 1991 14 pages **$10**

(see page 30 for order form)

Characteristics of Federal Grant-in-Aid Programs to State and Local Governments: Grants Funded FY 1991

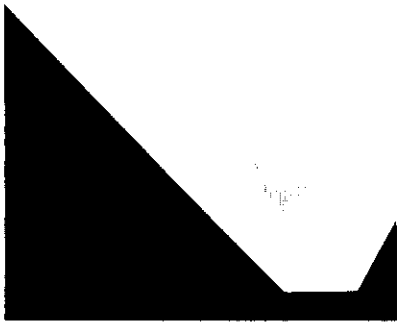
During the past 25 years, federal grants-in-aid to state and local governments have changed dramatically in type, number, dollar amount, and other characteristics. This is ACIR's sixth report on the system since 1975. The number of categorical grant programs grew from 422 in 1975 to 534 in 1981, dropped to 392 in 1984, and rose to an all-time high of 543 in 1991. The number of block grants grew to 14 by 1991. In general, about 75 percent of all grant aid is distributed by formulas, and over 25 years at least 70 percent of the money in the system has been distributed through categorical programs. Medicaid, the largest formula program, accounts for about 30 percent of all grant outlays.



M-182 1992 48 pages **$10**

Coordinating Water Resources in the Federal System: The Groundwater-Surface Water Connection

All types of governments have roles to play in improving water resource coordination. One of the most important of those roles is to change laws and policies that obstruct more efficient resource use. A consensus favoring coordinated use of groundwater and surface water—conjunctive management—has arisen in the past decade. This policy report contains contrasting perspectives on groundwater use and management, and an analysis of institutional arrangements and intergovernmental relations. The report identifies barriers to better coordination and suggests changes that the federal and state governments can make to eliminate those barriers.



A-118 1991 152 pages **$15**

(see page 30 for order form)

Intergovernmental Digest

Preemption Bill Introduced in House

Rep. Craig Thomas recently introduced H.R. 4613, based on ACIR recommendations, which directs that no statute, or federal rule promulgated under that statute, could preempt in whole or in part any state or local government law unless that statute explicitly states that preemption is intended. A companion to Senator Carl Levin's S. 2080, the House bill has been referred to the Government Operations Committee.

In introducing the measure, Representative Thomas, an ACIR member, told his House colleagues,

> Widespread federal preemption of state and local laws is a problem that needs to be addressed. It handcuffs state and local officials as they try to deal with the problems they face first hand. It has increased the caseload of the federal court system. Most importantly, it obscures the fundamental principle of a separate federal and state government created by the Constitution.

As of this writing, S. 2080 awaits action by the Senate General Services, Federalism, and District of Columbia Subcommittee.

Federal Mandates Receive Renewed Attention

Federal mandates have emerged as one of the issues of greatest concern to state and local officials. Mandates were mentioned in the President's State-of-the-Union Message and were the subject of a front-page article in the *New York Times* (March 24, 1992). This article relied heavily on three ACIR reports scheduled for publication this year: *Federal Preemption of State and Local Authority*, *Federal Regulation of State and Local Governments*, and *Federally Induced Costs on State and Local Government*.

Following up on his State-of-the-Union Message, President George Bush issued two memoranda to federal agencies on January 28, 1992. The first concerned regulatory coordination among federal agencies that share responsibility "for promoting safe and efficient energy production while at the same time protecting the environment." The secretaries of Agriculture and Energy were directed to work with the administrator of the Environmental Protection Agency and the chairmen of the Federal Regulatory Commission and the Nuclear Regulatory Commission.

The second memorandum directed the heads of 24 federal departments and agencies to reduce the burdens of federal government regulations on state and local governments as well as the private sector. The memorandum spelled out how these departments and agencies are "to identify and accelerate action on initiatives that will eliminate any unnecessary regulatory burden or otherwise promote economic growth." A written report to the President is required from each department and agency at the end of this 90-day review.

Three bills have been introduced in the Senate to address this issue.

- On February 27, 1992, Sen. William V. Roth, a former member of ACIR, introduced the "Competitiveness Enforcement Act" (S. 2289). This bill would require reports from the congressional committee and the administration estimating the cost and benefits of any federal program and related regulations and their effect on America's competitiveness, productivity, employment, and growth.
- On March 5, 1992, Sen. Don Nickles and eight cosponsors introduced the "Economic and Employment Act of 1992" (S. 2319). This bill would require all legislation considered by the Congress, and any regulation promulgated by a federal agency, to be accompanied by an "economic and employment impact statement."

- On March 12, 1992, Sen. Connie Mack introduced S. 2348, an amendment to the *Congressional Budget Act of 1974*. This bill would reduce the costs imposed on state and local governments by unfunded federal mandates.

These Senate bills join three related bills introduced in the House of Representatives late last year (see *Intergovernmental Perspective*, Fall 1991, page 24): H.R. 3344, to establish a National Commission on Intergovernmental Mandate Reform; H.R. 1546, known as the point of order bill; and H.R. 1547, the federal mandate reimbursement bill.

Emergency Funds Proposed for Local Governments

On February 27, 1992, the House Government Operations Subcommittee on Human Resources and Intergovernmental Relations approved H.R. 3601, the "Local Partnership Act," by a 6-3 vote. This legislation would provide $15 billion to local governments affected by the recession. The bill targets 39,000 local governments for funds within 60 days of enactment. Government Operations Chairman John Conyers, the bill's sponsor, announced his intention to ask the budget committee to designate the $15 billion as emergency spending so that other programs would not have to be cut to pay for it.

On March 12, 1992, the House Banking, Finance, and Urban Affairs Committee approved legislation (H.R. 4073) that would provide local and state governments with $15 billion in FY 92 for programs to create jobs (e.g., construction and rehabilitation of public buildings and other public facilities). Most of the funds would be distributed to states through grant programs similar to the Community Development Block Grant program (CDBG). Seventy percent of the funds under H.R. 4073 would go to metropolitan areas; the rest would go to states for other projects.

Competing legislation under consideration includes: H.R. 4175, a $10 billion infrastructure bill in the House Public Works Committee, and H.R. 4416, a $15 billion supplemental appropriations bill sponsored by Jamie Whitten, Chairman of the House Committee on Appropriations.

State and Local Governments Increase Reliance on User Charges

In fiscal 1990, state and local governments raised $115.4 billion from user fees and charges (e.g., higher education fees, school lunch sales, hospital room charges, sewerage charges, airport fees). As a percentage of state and local own-source general revenue (OSGR), these were the second largest charges (16.2 percent), following property taxes at 21.8 percent. Major sources of user charges were: hospitals, $31.1 billion (26.9 percent); higher education, $26.3 billion (22.8 percent); sewerage, $12.9 billion (8.3 percent); airports, $5.2 billion (3.3 percent); solid waste management, $4.8 billion (3.1 percent); and highways, $4.1 billion (2.7 percent). (See *Intergovernmental Perspective*, Winter 1992, page 25 for data on local government user charges.)

In recent years, state and local governments have increased their reliance on user fees and charges. From FY 87 to FY 90, these revenues climbed 33.9 percent, from $86.2 billion to $115.4 billion. In FY 87, user fees accounted for 12.6 percent of state and local government general revenue and 15.1 percent of OSGR. In FY 90, the corresponding proportions were 13.6 percent and 16.2 percent. This increase is due in part to declining intergovernmental aid. Intergovernmental revenues as a percentage of state and local general revenue declined from 22.0 percent in 1978, the peak year, to 16.0 percent in 1989. They were 16.1 percent in 1990.

State and local governments rely heavily on user fees and charges in Mississippi (27.2 percent), Alabama (26.5), North Dakota (24.8 percent), Tennessee (23.2 percent), and South Carolina (22.7). Lowest use of charges was in the District of Columbia (7.9 percent), Rhode Island (9.4 percent), Connecticut (10.3 percent), Alaska (10.9 percent), and Maryland (11.6 percent).

Long-Term Health Care Reform: Three Approaches

D. William Graham

The U.S. health care system is caught in a paradox. By many standards, it is the best in the world. The training and education of physicians and nurses are provided in the best medical schools and teaching hospitals. Basic medical research, financed by government grants and private industry, is one of the nation's leading export industries and is rewarded with more Nobel prizes in medicine than any other country. The newest technology, from nonintervention diagnostic equipment to 21st century surgery centers, is available to more people than anywhere else in the world. For those able to pay, the U.S. medical care system is the most accessible, most efficient, and most effective system available.

At the same time, the United States spent over 14 percent of its Gross National Product on health care in 1991, nearly ten times the 1950 amount. Today, over $750 billion a year, more than $2 billion a day, is expended to run the medical system. This is nearly three times the amount spent in the United Kingdom and 40 percent more than in neighboring Canada.[1] Still, there are approximately 35 million people without health insurance in the United States.

This paradox has led to calls for radical reform of the health care system from all sectors of society—business and labor; the elderly, poor, and disabled; individuals who see an increasing portion of their paychecks going to finance an essential service; and the medical industry. "Fixing" the health care system, however, will require basic reforms in the way the U.S. delivers and finances health care.

The twin goals of health-care reform are universal health coverage and cost control. Currently, three approaches to reform are attracting the most attention: market-oriented reform of the insurance and tax systems, "play-or-pay" mandated employer-sponsored insurance plans, and a Canadian-style national health insurance (NHI) system. While there are numerous variations on each of these approaches, in general, these three alternatives reflect the range of political, economic, and other salient issues involved in reform discussions.

The chart on pages 24-25 identifies several factors that form a useful basis for analyzing and comparing alternative approaches to health-care reform. Although state and local governments play an important role in the delivery and financing of health care, seldom are the intergovernmental implications of the proposed plan identified or discussed. This article addresses this oversight by examining each major approach in terms of four significant intergovernmental issues, including:

1. The role of Medicaid, one of the fastest growing areas of state expenditures;
2. The implications for the authority of states to regulate the activities of the health insurance industry;
3. Projected changes in the access to or level of health services; and
4. The impact on government finances.

Market-Oriented Approach

Of the three basic reform approaches, those centered on the private market alter the current system the least. Specific proposals range from "incremental" reform of the private insurance system to more "comprehensive" restructuring of the tax treatment of health care benefits. The assumption underlying these proposals is that the marketplace can best determine and allocate the demand for health care and that government intervention will unduly distort the efficient functioning of the market.

Incremental reform options include mandating that private insurance companies offer health care policies to all potential buyers, limiting the annual increase in private insurance rates, eliminating restrictions on preexisting conditions, developing "insurance pools" to allow small firms to secure lower rates, and increasing the use of managed-care systems. These options have wide support

and are included in most specific reform proposals, including many of the play-or-pay reforms considered below. Other incremental reform options involve changing medical liability laws to limit malpractice cases and awards.

More comprehensive proposals involve altering the tax treatment of employer-provided health insurance, which is currently tax exempt as an employment benefit. These plans suggest that individuals are best able to determine their insurance needs and that the proper role of the government is to ensure that individuals have the financial ability to secure private insurance. Thus, the proposals include instituting an insurance voucher/tax credit system. For poor people who pay no income taxes, the government would grant a voucher that could be redeemed for an insurance policy. For taxpayers, a deduction on their federal income taxes would be instituted to allow them to secure insurance. This "refundable" credit would be designed so that taxpayers with a health insurance credit exceeding their tax liability receive a check for the difference.

The Heritage Foundation has developed a plan along these lines that would make employer-provided insurance a taxable benefit, thus removing a distorting influence in current health care purchases.[2] (Heritage suggests that granting tax-exempt status to employer-provided insurance causes individuals to purchase more than they normally would.) The Bush administration has developed a voucher/tax credit plan that retains the current tax treatment of insurance.[3] Thus, under the President's proposals, incentives are provided to both employers and employees to encourage them to secure some health insurance.

One concern about the voucher/tax credit proposals is that a number of poor people may remain uninsured, even with such a plan. Currently, a health policy for a family of four costs $5,000 annually. Under the Administration's proposal, for example, the insurance voucher would be for $3,750, leaving a $1,250 gap. In light of these calculations, the Administration estimates that, even with vouchers, up to 5 million people may remain uninsured.

Determining the intergovernmental implications of market-oriented plans is difficult because most are still in the conceptual stage. However, some implications can be drawn.

The Role of Medicaid. The reduction in the number of uninsured people may encourage a decrease in the scale and/or scope of Medicaid. To the extent that the poor remain uninsured, states and localities may be expected to address their health care needs. Additionally, long-term care, the major expense in Medicaid, is not directly addressed in most market-oriented proposals.

Changes in State Regulatory Authority. Regulation of health insurance companies has historically been a state function. Federal mandates designed to make health insurance more accessible to small companies and individuals are likely to preempt a portion of the states' insurance regulatory authority. Further, some proposals would exempt small company insurance pools from state insurance regulations mandated by the *Income Security Act of 1974* (ERISA), an exemption currently granted only to self-insuring firms. These actions would place more insurance plans beyond state regulation.

Changes in the Provision of Health Services. Market-oriented reforms assume that the current health care system will continue, except that fewer people will be uninsured, and there will be greater use of managed-care systems. Thus, state and local health care systems essentially continue in their current capacities. It is expected that there will be fewer uninsured people using local medical facilities as a source of basic care, thus lowering local costs. Further, institutionalizing preventive and prenatal care may also reduce the need for emergency services. However, some market-oriented reform proposals also include reforms in Medicaid that may eliminate the eligibility of some qualified Medicaid clients for whom localities would have to provide services.

Changes in Government Finances. Thirty-four states have individual income tax systems coupled to the federal income tax. Therefore, any changes in the definition of federal adjusted gross income (AGI) or federal taxable income (FTI) could affect state and local income tax revenue. Although specific tax effects are difficult to determine because of the preliminary and evolving nature of the proposals, for the eight states that tie their income tax base to FTI, instituting a health insurance credit may decrease state revenue. Conversely, for states coupled to the federal AGI, making insurance a taxable benefit could increase state revenue. Other than the limited revenue raised through removing the tax deduction on health benefits, none of the market-oriented reform proposals specify how they would be funded.

Market-oriented reforms would modify little of the health care delivery system. Their proponents argue that the reforms will allow the free market to operate efficiently, unobstructed by government and insurance distortions. Opponents, however, suggest that the reforms will only exacerbate the flaws in the system, leaving too many people uninsured and medical cost inflation unchecked.

Play or Pay

A typical play-or-pay program would require all employers to provide basic health insurance coverage for their workers (and their dependents) or to pay a special payroll tax to finance a new federal program. This new federal program would provide insurance to employees in firms choosing to pay the surtax, and might also cover existing Medicaid clients. Medicare would continue for the elderly. States would act as paying agents for the new federal program, reimbursing health-care providers based on federally determined rates.

Play-or-pay proposals would mandate that all employers above a certain size (e.g., more than ten workers) provide basic insurance coverage for all persons employed for more than the minimum number of hours per week (e.g., 17.5) or pay a surtax to finance a new federal program. Businesses would be required to pay a percentage of the insurance premium and to limit individual deductions.

Additionally, play-or-pay plans usually have explicit cost-control features. In some proposals, medical inflation would be controlled primarily through a new federal health expenditure board, which would set national expenditure

A Comparison of Health Care Plans

	"Play-or-Pay"	Tax Credit	National Health
Description	All employers would either provide workers insurance or pay an additional tax to enroll them in a government program (AmeriCare) with other noninsured workers and the poor/aged	Federal government would give a health insurance voucher to the poor or a tax deduction to families with incomes up to $80,000. The voucher/deduction is worth up to $3,750/family on a sliding scale.	Federal government would finance a single-payer universal coverage national health system with private doctors/hospitals and states acting as paying agents
General Advantages	Coverage for all employees and dependents Builds on current insurance system Can include strong cost-containment features Has strong political support	Provides funds to the poor and middle class to purchase insurance Minimal disruption in current system	Guarantees universal coverage Costs tightly controlled by central payer Administration costs reduced drastically Encourages preventive care
General Disadvantages	Retains 1,500 private insurance firms with related costs Places extra burden on (especially small) business Does not guarantee universal coverage or cost control	Strengthens inefficiencies in current insurance system Does not guarantee universal coverage Value of voucher declines over time No specific cost-control mechanisms	Additional taxation required Medical technology and service usage delayed or rationed Radical disruption in current health system
Coverage	All employees and dependents along with Medicaid/Medicare clients	Coverage remains voluntary but currently potentially affordable to all families	Universal
Acute Care Protection	Mandated as part of basic insurance package	Reform requires insurance firms to offer basic care to all buyers	All essential and preventive care covered but with possible delays
Catastrophic Cost Protection	$3,000 "stop-loss" limit on medical bills	Not addressed	Unlimited care covered
Long-Term Care Protection	Current Medicaid protection only	Current Medicaid protection only	Unlimited care covered
Patient Copayments	Continued current system	Probable increase	None for basic care, charges for extras (e.g., private hospital rooms)
Physician Payment System	Federal negotiation (and possible establishment) or private payment schedules	Market rates negotiated between private insurance firms and physicians	Federally established rates for all NHI payments; non-NHI payments at free-market rates

goals and convene rate negotiations between health care providers and purchasers. The ability of the board to dictate a binding payment rate if negotiations fail is the primary difference among the alternative play-or-pay proposals. (As noted earlier, play-or-pay proposals also contain the "incremental" insurance market reforms included in market-oriented proposals.)

Compared to the market-oriented proposals, several play-or-pay proposals are quite detailed. This facilitates an analysis of intergovernmental issues.

The Role of Medicaid. In the current Medicaid program, federal funds flow into the states, depending in part on the level and scope of services offered by each state. Some play-or-pay proposals reverse this flow by requiring states to remit monies currently dedicated to state programs to the new federal insurance program; other plans include procedures for states to pay a portion of the costs for the expanded system. While financing is not specified in many plans, states cannot expect a financial windfall from the elimination of Medicaid. The joint state and federal decisionmaking characteristics of Medicaid would not continue under most play-or-pay proposals.

Changes in State Regulatory Authority. Currently, physicians and hospitals operate in a relatively free market, able to relocate with population and income shifts, while states license physicians and regulate the construction and operation of hospitals. For many cities and states, the local hospital is a source of pride and economic development. This system has led some critics to argue that the United States has overinvested in health care facilities and that the number of hospitals and clinics should be limited. Although

A Comparison of Health Care Plans *(cont.)*

	"Play-or-Pay"	Tax Credit	National Health
Drug Coverage	No	No	Most pharmaceuticals covered
Capital Construction Controls	National advisory board established	Not addressed	State capital construction limits and budget established
Insurance Reform	Community ratings required, eliminate prior-condition restrictions, promote insurance pools	Community ratings required, eliminate prior-condition restrictions, promote insurance pools	Most insurance will be voluntarily eliminated; retained only for non-covered services (e.g., cosmetic surgery) or to provide additional benefits (e.g., private rooms)
Medical Malpractice Reform	Experiments in states	Reduced court accessibility Caps awards	Liability laws tightened Need for lawsuits reduced
Private Insurance Role	Private companies remain as major insurer with new government program	Private companies remain as private insurers	Government takes over all major insurance functions
Medicaid/ Medicare Status	Medicare remains for the aged Medicaid probably rolled into new government program	Both remain in current roles	Both eliminated All citizens covered by NHI
New Taxes for Financing Plan	Besides 7-8% payroll tax on employers enrolling in AmeriCare, unspecified	Unspecified Limits on future Medicaid growth	Increase Social Security and income taxes; states forgo Medicaid payments and pay per capita stipend to federal government; individual insurance premiums eliminated
Payments Required from Individuals	Individual contribution to new insurance policies limited to 20% Medicare Part B continued	No limits specified Families receive up to $3,750 in assistance	Most Americans would pay no insurance premiums; elderly continue to pay Medicare Part B plus $25/month for long-term care if above 120% of poverty line
Claimed Savings over Current Medical System	$228 billion over 5 years through rate-setting, administration savings	$394 billion over 5 years through managed care, insurance and malpractice reform, Medicaid caps	$1 trillion over 10 years through administration savings, reduced capital purchases, care maintenance

all play-or-pay programs envision regional pay and cost differences, distributing a limited national capital budget and establishing workable national payment rates will be difficult and may entail substantial centralization of authority relative to the current system.

States may be used as paying agents under the new plan, causing them to operate a system similar to the current Medicaid program, but larger. Similarly, expanded insurance programs may remove states and localities from providing any direct medical care. For example, current state-run health clinics may be assumed by private providers and funded through employer associations or the new federal insurance program.

Changes in the Provision of Health Services. A large majority of the currently uninsured have connections to the job market, either as employees or employee dependents. For example, three-fourths of restaurant and hotel workers and half of all retail employees are uninsured. It is this segment that the play-or-pay system is primarily designed to serve. However, employers who may have to provide insurance for the first time may be inclined to lay off marginal workers, leaving them both uninsured and unemployed. This may increase the costs to state and local governments through increased demand for other (nonhealth) services. While there should be an absolute decline in the number of families dependent on state and locally assisted health care, the newly uninsured may require more and costlier services.

Changes in Government Finances. The design of play-or-pay systems can substantially affect the number of employers enrolling in the system and, thereby, government finances. If the surtax is low, employers who would normally enroll workers in private health plans will, instead, opt for the government plan. It is not clear what financial responsibility states will assume for the level of program participation within their boundaries. One potential effect on government finance may be a decrease in corporate tax revenue as firms deduct the costs of the surtax or insurance premium from their income in determining their tax liability. Although this may be balanced

by decreases in health expenditures, adjustment of budgets and, possibly, tax rates may be required for all governments.

National Health Insurance

Unlike a national health service, such as that in Great Britain, an NHI system is rooted in private medical care. An NHI acts as the paying agent, just as private insurance systems do in the United States. Doctors remain private practitioners, not civil servants. Each year, a national insurance board would negotiate medical fees with doctors and hospitals and then pay claims according to those fees. Because it would be a single-payer system, an NHI may have leverage to enforce an agreed-on rate schedule, and thus prohibit doctors from shopping around to find the highest paying insurance firms.

There may be differences between an NHI system in the United States and the Canadian model because of the differences between servicing 250 million people in 50 states (plus the District of Columbia) and 27 million people in ten provinces. Adopting an NHI system may produce major changes in the United States economy, in the way individuals relate to governments, and in how governments relate among themselves.

The Role of Medicaid. Under a U.S. NHI program, Medicaid (and other national health programs) would cease to exist. Health care currently provided by government programs, private insurance, and other public health activities (e.g., Veterans Administration hospitals) would be funded by the NHI.

Changes in State Regulatory Activities. Under an NHI system, states may act as administrators and paying agents for virtually all health services in their area. Changing to an NHI program would mean a fundamental, radical shift in the second largest industry in the United States and the transfer of $300 billion annually from private sector insurance to a government system. Some 1,500 insurance firms and their hundreds of thousands of jobs may be replaced with civil servants.

With NHI, each state may operate a separate medical system with federal financial support. (In the Canadian NHI, the federal government provides approximately 40 percent of each province's health costs. For the poorer provinces, the federal proportion is higher.) Capital expenditure limits may be established by federal and state governments to moderate construction expenses and to avoid the overpurchase of expensive machinery. These limits may apply to private and public hospitals.

NHI may determine national health policy through its rate schedule and capital expenditure budgets. For example, it could support a preventive and emergency care system, while providing less support for experimental or innovative care.

Such a change would require each state to reevaluate its tax and revenue policies, derive new management and control systems for the cash flow, and develop payment systems far in excess of current operations. Physicians may be working in local hospitals under national guidelines while being paid by the state.

This may lead to increased responsibility for states as paying agents while assigning increased authority to the federal government as rate setter. Under NHI, local medical financing would be through a combination of state taxes and federal grants. Medical charges and budgets may be set by federal officials, with regional cost differences applicable. National capital expenditure budgets may be allocated to the states by federal officials, but the direct application of the funds would be determined by state and local officials, allowing the system to be tailored to the specific needs of each state.

Changes in the Provision of Health Services. The function of localities, the ultimate service providers in many U.S. communities, may be changed under an NHI system. However, increased negotiations with state and federal officials are inherent in an NHI system.

One concern about adopting a Canadian-style NHI system is that health care would be explicitly rationed. The cost-control features included in NHI may require changes in the number of surgical operations and the rate of capital expenditures that may be established by the federal government but implemented by localities. States and localities may choose to continue specialized health programs, such as school clinics and certain types of outpatient care in addition to NHI services.

Changes in Government Finance. Some studies of a Canadian-style NHI system have indicated that such a system could save as much as $214 billion a year, or 40 percent of the national health expenditure bill in 1992. The potential savings from adopting NHI could come from several sources. Savings may result from a reduction in administrative costs. All governments will need to examine their tax and revenue systems from such sources as insurance taxes and income from medical supply and construction companies are reduced. As employers, governments may see health care expenditures reduced. Uncompensated care cost for localities will be virtually eliminated while state contributions to local facilities outside NHI (such as school health programs) may also be reduced.

Conclusion

This article examined the three major forms of health care reform under discussion: market-oriented reforms, play-or-pay, and national health insurance. While each has its proponents and opponents, they all will have intergovernmental impacts. Which system, if any, will be implemented is yet to be determined. However, it is clear that health care reform will be an important issue for years to come.

Notes

[1] Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (Washington, DC, 1991), p. ix.

[2] Stuart Butler and Ed Haislmaier, *Health Care in the U.S. Federal System* (Washington, DC: The Heritage Foundation, 1991).

[3] *The President's Comprehensive Health Reform Program* (February 6, 1991).

D. William Graham is a senior analyst at ACIR.

Health Care Reform: The State Perspective

Governor Booth Gardner

Perhaps the plight of little Adam Jacobson of Seattle best personifies the crisis in our health care system. Adam's parents have had to impoverish themselves so their son can continue to receive cancer treatments, while Adam's 67-year-old grandfather continues to work to support his son's family despite having health problems of his own that aren't covered by insurance.

More than the poor are affected by our increasingly dysfunctional system, however.

Consider Harry Gordon of Des Moines, Washington, a retiree whose premiums for supplemental Medicare coverage have risen to $239 per month from $110 per month in two years, straining his fixed-income budget.

Or let's try Mary Bender of Eatonville, whose son was injured by a drunk driver and can no longer get health insurance at any price.

And how about those who have health coverage but are amazed at the costs, not all of it covered. Consider Eugene Budde of Bellingham, whose wife's identical treatment for brain cancer cost $3,200 in Sweden and $48,000 in this country.

These sad stories and many others come courtesy of the hot line to the Washington state legislature, which is considering a plan for health care reform. People are way ahead of their elected officials on this issue. They know their health care system isn't working. It's time we listened to them.

Look to the Other Washington

It's also time to recognize that the other Washington—and its sister states—must provide leadership on health care reform. We can't wait for the federal government in Washington, DC, to act. Only if we push, and push hard, will we get reform to move forward. And we can do that best by demonstrating in the states that health care reform is viable.

That's not to say that it's any easier in the Evergreen State to shove aside the big insurance company lobbyists barricading the doors to the legislature. We're locked in a struggle of our own with special interests that oppose any change in the system, despite the fact that health care costs are rising at three times the rate of inflation.

The stakes, as you know, are enormous. Americans are pouring an estimated $738 billion per year into a system that's consuming 12.2 percent of our gross national product, nearly twice that of industrialized countries such as Japan.

The state of Washington is spending $857 million more on health care in this biennium than the last one, and we expect the tab to rise by another $1 billion during the next biennium. These are dollars that can't be used for other priority programs, such as education, the environment, and economic development. Despite these higher expenditures, the evidence is that Americans on average enjoy a lower level of health care than do citizens in many other nations that spend far less.

While 89 percent of Washingtonians are now covered by some form of health care coverage, more than 550,000 residents are not. More than half of these individuals are either workers or their dependents, blowing the myth that health care reform is primarily for those on welfare.

Citizens such as Lois Shirer of Centralia are a good example. Although her daughter's husband works, he has no health insurance. The last time Shirer's daughter took her daughter to the doctor, they told her not to come back because she took too long to pay.

Prescription for a Healthy Washington

In January, I introduced "Prescription for a Healthy Washington," my health care reform plan, to the state legislature. In a nutshell, my bill would reform the health care system by controlling costs and offering health care to all state residents. Rather than propose a Canadian-type single-payer health care system, I proposed building on the private system already in place through a four-point plan:

Cost Control. The Washington State Health Services Commission, a five-member agency, would be created to regulate and direct health care expenditures. Its most important responsibilities would include:

- Defining the uniform benefit package, the set of services universally available through private insurance and the state's basic health plan.
- Establishing a maximum rate an insurer would be able to charge for the uniform benefit package. The plan also establishes a maximum inflation rate so the rate of medical inflation would match the rate for personal income.

Access to health care through the basic health plan would be extended through:

- Expanding low-income subsidies, subject to available funds.
- Allowing small businesses and individuals to buy into the managed-care program offered by the basic health plan. This offer also would be extended to previous enrollees of the basic health plan who have exceeded the maximum eligible-income level (200 percent of the federal poverty level).

Insurance Reform. Access to health care through private insurance would be enhanced through additional regulation of current insurance industry practices. Insurance companies wishing to sell their products or services in the state would no longer be able to red-line, experience-rate businesses with fewer than 100 employees, or exclude coverage to those with preexisting conditions. Enrollees in private insurance plans would be assured continued benefits at their own expense should they leave employment.

Play or Pay. All employers will have the choice of either providing a minimum health care plan to employees or paying a tax to the state, which would in turn provide those benefits through the basic health plan. Employers who chose to provide health care to their employees could deduct from their tax liability an amount equal to that expense.

Taxes for Health Care. The bill would establish the Health Care Trust Fund to pay for the basic health plan expansion and the commission's operating costs. To finance the fund, a 10 percent surtax would be added to existing alcohol and tobacco taxes, and the 2 percent insurance premium rate would rise to 2.5 percent.

If many of these elements appear familiar, they should. They are included in the health care reform policy passed last year by the National Governors' Association. That policy forged a national, bipartisan consensus on goals of universal access and cost containment; urged progress on Medicaid and insurance reform; and called for accelerated federal action. Equally important, NGA policy helped create a national framework for those of us who want our states to be able to move ahead.

Business Opposition Misguided

Despite the obvious need for immediate action, opposition has arisen, and not just from health care providers who want to preserve their monopoly. Many owners of small businesses, half of which don't provide health care coverage to their employees, also have mounted opposition to my play or pay provision. While the financing mechanism is up for debate, I think business opposition to health care reform is shortsighted.

Health benefit costs now consume more than 25 percent of the average private firm's profits. Cash that once could be used for research, development, or worker pay increases is now being absorbed by medical and insurance costs. Unchecked, rising health care costs will swamp the state's employers and render them unable to make a profit. For those successfully operating in international markets, higher health care costs effectively add a weighty surcharge of 3 to 5 percent to their prices—and that is today. Health insurance rates are increasing 20 percent per year for most businesses. At this rate, health care costs would drain 100 percent of GNP by 2050. Obviously, there will have to be reforms.

This year, Boeing, the state's largest employer, expects to spend more than $3,600 per employee for medical coverage, a 21 percent increase over 1990. At that rate of increase, the cost per employee would be more than $19,000 by the end of the decade.

The greatest benefit of health care reform to employers will be the cost controls my plan will put in place. Costs are now out of control because of soaring health care inflation rates, insurance practices, administrative expenses, and a fee-for-service approach to health care.

Insurance practices often penalize small business. Writing insurance policies for large groups of people cuts administrative costs and is more efficient. For groups of one to four individuals, 40 cents of every dollar paid for insurance is consumed by administrative costs. Furthermore, in a small group, one individual with a chronic and/or costly condition can render the entire group unprofitable, so insurers use "preexisting condition" exclusions to avoid covering people with health problems. If people with known illnesses are covered, astronomical premiums are demanded. Small businesses and individuals don't have the clout to advocate more equitable procedures and charges.

My plan redirects the private insurance system to help small businesses employing 100 or fewer workers. A method called "community rating" would be used to lump small-business insurance purchasers together and devise

benefit plans and premiums for them as one large group. This would increase efficiency and minimize risks for insurers. It also would allow small businesses to avoid the burden of cost shifts from large, more powerful purchasers.

Leveling the Playing Field

Employers that do provide insurance, and most do, are at a competitive disadvantage to those that don't. By requiring all employers to either provide insurance or pay into the state fund, all employers would be on a level playing field.

Under my plan, all businesses would pay a monthly tax of $138 per employee to provide basic health plan coverage. Those businesses already providing health insurance would receive a full tax credit. The tax would be phased in to ease the effect on small businesses. Employers of 100 or more employees would join the plan in 1994, employers of 25 or more in 1995, and all others in 1996. Economic assistance would be provided to small businesses whose existence was endangered by these requirements.

Given today's costs, it is puzzling that any employer that pays for insurance—even when it cuts more and more deeply into profits—should want to give competitors the growing advantage of increasing profits by denying benefits to workers.

Most of all, my plan offers an opportunity for the business community to participate in managing its own health care. The alternative to an employer-based system would be a government-run system.

A Time to Act

By the time you read this, Washington State legislators either will have passed a health care reform bill or avoided the issue despite its crippling effects on the state budget. If the legislature fails to act, I fully expect the people to use the initiative process to force the issue. Reforms must come.

The people who sent us to Olympia are tired of studies, tired of discouraging statistics about our infant mortality rate, tired of filling out unnecessary forms and paperwork every time they want to see a doctor, and tired of waiting for that perpetual future called "after the next election." They want practical solutions now.

The simple fact is that the higher costs rise, the fewer people will have access to health care. And that's the moral dimension of this crisis. Americans want universal access to high quality, affordable health care. It's time we paid attention to the moral convictions of the people who vote for us. They want insurance reform, they want costs controlled, and they want decisions about health care pulled out of corporate boardrooms and into the open air of the democratic process. And they want us to stand up to the special interests that oppose these changes.

A health care system in which everyone shares the burden and everyone shares the benefit will lead to a healthier state, a healthier economy, and healthier citizens. Let's show Washington, DC, that health care reform can be achieved, and achieved before the current system makes the savings and loan crisis look like small potatoes.

Booth Gardner is Governor of Washington State.

Medicaid: Successes, Failures and Prospects
(continued from page 14)

sufficient to encourage provider participation. Payment levels must acknowledge taxpayer interests as well. There is still much debate about what level of reimbursement is necessary to assure the provision of quality care in all settings. A key question that Medicaid has yet to answer successfully is how an economic and efficient facility is to be defined and how rates reflect economy, efficiency, and quality. Medicaid generally has not been successful in this because reimbursement rates have been subject to state budget constraints and thus have not met provider expectations. Reimbursement rates must also necessarily compete with other program priorities. These same tensions could reappear in a new federal program if the underlying questions are not first sorted out.

Medicaid experience has not yielded a consensus on how best to contain costs, a question closely related to the issue of rates but broader as well. Cost containment through utilization review, prior authorization, or limiting coverage will be hotly debated, as is the case in state programs today. There is a growing consensus that reform cannot be successful unless it includes effective cost containment. Medicaid has many models, but few are satisfactory to all potential parties.

Similarly, Medicaid has shown that there is a need to stimulate shifts in physician supply geographically and by medical specialty. Medicaid has not been successful in this effort. Medicaid has shown, however, that access is as much a matter of geography as of affordability.

Summary

It is clear that, despite the progress Medicaid has made in recent years, the program cannot continue on its current trajectory given competing and growing needs in the face of static or declining resources. The more Medicaid is used as an ad-hoc, stopgap "fix" for current and future health care crises, the greater will be the dissatisfaction with program performance among policymakers, advocacy groups, clients, and administrators.

The problems of financing health and long-term care are no longer solely the problems of the poor, if they ever were. A program intended to finance the care of the poor will always be inadequate to this larger task. A program designed to pay provider claims may likely never fully succeed at addressing public health concerns or ensuring that individual clients obtain appropriate care. A program oriented toward coverage of medical-model services may never be sufficiently flexible to provide adequate coverage of social-model services to all those in need.

Change is clearly needed, priorities need to be clearly established, and difficult decisions must be made. Most reform proposals (for both health and long-term care) envision some form of public program. Whether Medicaid is retained in any new system remains to be seen, but the program clearly has a great deal to offer in terms of experience.

Jane Horvath is director of the Health Policy Unit, American Public Welfare Association.

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Implications of the Medicare Fee Schedule for Medicaid

David C. Colby[1]

This article examines recent reforms in the physicians' payment structure under Medicare, and the extent to which these reforms may provide useful approaches for reforming physicians' payments under Medicaid. Low payments under Medicaid are believed to be an important obstacle to improved access to medical services under that program.

Medicare and Medicaid modeled their initial payment policies on those of the private sector, especially some Blue Cross-Blue Shield plans. For physician services, Medicare payments were determined by the customary, prevailing, and reasonable charge (CPR) method. A majority of state Medicaid programs also adopted this payment system.[2]

CPR sets the reasonable charge (the payment amount) as the lesser of the submitted charge, the customary charge (the physician's typical charge for that service in the previous year), and the prevailing charge (the 75th percentile of charges from all physicians in the same specialty for that service in the previous year). As early as 1970, some problems with the CPR method were noted by Senate Finance Committee staff, who recommended the development of fee schedules for Medicare and Medicaid.[3]

Responding to problems with Medicare physician payments, the Congress first adjusted prevailing charges for specific services and later adopted major reforms, including the Medicare Fee Schedule in the *Omnibus Budget Reconciliation Act of 1989* (OBRA 89). The schedule raised fees for primary care services and lowered payments for surgical and procedural services. Payments also are adjusted for geographical differences in the cost of practice (e.g., fees will be about 32 percent higher in New York City than in Sioux Falls). OBRA 89 dramatically altered the Medicare physician payment method and has implications for other payers, including the Medicaid program.

Medicare Physician Payments: Problems

Problems with physician payments under Medicare led to the passage of the OBRA 89 reforms.[4] CPR created distortions and inequities in payments for different services and for the same service provided by different specialties and in different localities. Over time, relative to the intensity, risk, time, and work involved, some services were overvalued, others undervalued.

Some of the distortion occurred because payments, which were based on past charges, did not reflect technological changes that made procedures easier and less risky to perform. For example, even in the late 1970s, cataract surgery required removal of the lens in one operation and a second operation to replace it. Now, the procedure is performed routinely using microsurgery and lasers in less than one hour. Yet prevailing charges for this procedure did not drop with technological changes.

Different specialties were paid different amounts for the same service. For example, in New Jersey in 1985, prevailing charges for a new comprehensive office visit varied from $40 to $75, depending on the specialty of the physician. With the CPR system, differences in payments across geographic areas did not reflect differences in the cost of practice. After deflating prevailing charges for differences in the cost of practice, wide variations remained. Further, an area with a high prevailing charge for one service might have a low charge for others. For example, while the prevailing charge for total hip replacement in New York City was over two and one-half times that in the District of Columbia, the charge for a comprehensive office visit was lower in New York City.

Medicare Physician Payment: Reform

In OBRA 89, the Congress rationalized Medicare physician payment with a fee schedule based primarily on

resource costs. By 1996, after a transition period which began on January 1, 1992, the fee schedule will replace the CPR method of payment.

The fee schedule incorporates four elements that value the resource costs of providing each service. The first element, relative physician work, is a measure of the time and effort for the typical physician to perform the service. Under a contract from the Health Care Financing Administration, William Hsiao and his colleagues at the Harvard Public Health School surveyed physicians from numerous specialties and asked them to rank the relative work involved in providing a specific procedure compared to a reference procedure. The values were crosslinked among specialties and calibrated on a common relative value scale.[5] The strength of the relative value scale is its foundation in physicians' rankings of the work involved in providing various services.

The second and third components of the fee schedule are relative value scales for practice expenses and the costs of professional liability insurance, which incorporate historical costs. Finally, these components are adjusted separately for geographic differences in the cost of practice. Then they are added together to obtain total relative value units (RVUs) for a service and multiplied by a conversion factor to convert RVUs into payments.

The Medicare Fee Schedule has several advantages. It is incentive neutral in that physicians are paid the same for the same resource costs of providing services regardless of the type of service. The fee schedule is equitable—physicians providing the same services in the same area will be paid the same, and physicians providing the same service in different areas will be paid differently based only on variations in the cost of practice. Finally, the fee schedule is simpler and less expensive to administer than CPR.

The Medicare Fee Schedule will realign payments for services, affecting the Medicare revenue for specialties and geographic areas. Payments for evaluation and management services (visits and consultations) will rise, while payments for other categories of services will drop. As a consequence, payments to medical specialties will increase and payments to surgical and hospital-based specialties will decline. In general, payments for services provided in rural areas will increase, and payments in urban areas will fall. The impact of the fee schedule on an individual physician will vary due to previous charges, the mix of services provided, and the geographic location.[6]

Medicaid Fees and Access to Medical Care

State Medicaid programs vary in their payment levels, but generally pay less than Medicare and other payers. Based on a 1989 survey of state Medicaid programs, the Physician Payment Review Commission (PPRC) found wide variation across states in payments for the same service. For example, the fee for an intermediate office visit in New York was $11, while it was nearly $27 in Indiana. The ratio of Medicaid to Medicare fees varied widely, with New York paying 28 percent of Medicare levels and some states paying at Medicare levels (Table 1). This variation has little to do with differences in the cost of practice, but probably reflects deliberate policy decisions made by the states. While there is wide variation, Medicaid fees were about 64 percent of the amounts allowed by Medicare.

The difference between Medicaid fee levels and those of other payers, especially Medicare, raises concerns about the ability of Medicaid beneficiaries to have comparable access to medical care. Since Medicaid purchases physician services predominantly in the fee-for-service market, the level of fees compared to those of other payers likely influences whether physicians will treat Medicaid beneficiaries, and how many they will treat. The shift in relative values due to the Medicare Fee Schedule may exacerbate this for some services by widening the gap, especially in those states that use CPR to set fees.

The available empirical evidence suggests that access to medical care is a problem for Medicaid beneficiaries. The PPRC survey found low physician participation in Medicaid in many states. Forty-three states identified problems with physician participation, and more than half of the states identified participation problems with geographic and specialty distribution of participating physicians. While there are several reasons for low physician participation, 30 states reported low fees as the primary reason.

The importance of low physician fees in discouraging physician participation is supported by a growing body of research. Higher fees increase the likelihood that a physician will treat any Medicaid patients and the number of patients a physician treats. The extent of physician participation is only an indirect measure of beneficiary access to care, however.

The number and type of services received by Medicaid beneficiaries provide better indicators of access. While physician fee levels are not related to the number of visits, they are related to the site of service. Beneficiaries in states with higher fees are more likely to receive services in physicians' offices, while those in states with lower fees are more likely to use emergency rooms or outpatient departments, which is more expensive and does not promote continuity of care.

Access to services other than visits and the quality of care raise additional concerns. Medicaid beneficiaries, for example, receive fewer procedural and surgical services for the same conditions than those covered by private insurance. Further, much of the prenatal care provided to Medicaid beneficiaries appears to be unsatisfactory.

During the 1980s, the Congress and its advisory bodies took steps that indicated concern about access to mainstream medical care for those receiving Medicaid. The *Omnibus Budget Reconciliation Act of 1989* requires states to provide documentation that payment rates for obstetric and pediatric services are sufficient to ensure that access for Medicaid beneficiaries is comparable to that of the general population.

The U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) noted that lower payments to providers hampered Medicaid beneficiaries' access to health care. The commission recommended that public programs pay according to Medicare rates in order to ensure access and avoid cost shifting.

The Physician Payment Review Commission supports the principle that Medicaid beneficiaries should enjoy access to care comparable to Medicare beneficiaries, but noted that such access will remain elusive as long as Medicaid fee levels are substantially below those of Medicare and other payers. Therefore, the Commission suggested that changes in Medicaid policy be directed

Table 1
Index of Medicaid Fees Relative to Medicare Allowed Charges by State

State	Index
Alabama	.80
Alaska	1.07
Arkansas	1.04
California	.62
Colorado	.62
Connecticut	.64
Delaware	.71
District of Columbia	.57
Florida	.73
Georgia	1.14
Hawaii	.78
Idaho	.82
Illinois	.56
Indiana	1.18
Iowa	1.00
Kansas	.69
Kentucky	.51
Louisiana	.64
Maine	.59
Maryland	.50
Massachusetts	.89
Michigan	.64
Minnesota	1.02
Mississippi	.63
Missouri	.52
Montana	.81
Nebraska	1.03
Nevada	.96
New Hampshire	.61
New Jersey	.34
New Mexico	.77
New York	.28
North Carolina	.88
North Dakota	.83
Ohio	.63
Oklahoma	.86
Oregon	.75
Pennsylvania	.54
Rhode Island	.48
South Carolina	.82
South Dakota	.77
Tennessee	.88
Texas	.82
Utah	.83
Vermont	.72
Virginia	.74
Washington	.66
West Virginia	.40
Wisconsin	.81

Source: National Governors' Association and Physician Payment Review Commission, 1990. Health Care Financing Administration, BMAD, 1988, and Medicaid Statistical Information System, 1989.

Note: The index measures Medicaid fees relative to Medicare allowed charges. For example, Alabama's Medicaid fees are, on average, 80 percent of Medicare allowed charges in the state.

toward raising physician fees to Medicare levels. Raising Medicaid fees to Medicare levels may be difficult to achieve in the short term, however. While expenditures for physician services are a small and declining portion of total Medicaid expenditures, states are currently straining under the weight of growing Medicaid expenditures.

State Adoption of the Medicare Fee Schedule

While most of the developmental work on the fee schedule has been completed by the federal government, a state would need to make some decisions if it decided to adopt the fee schedule.[7] First, a state would have to determine the conversion factor that sets the overall payment level for physician services. To date, the states that have adopted the fee schedule have raised their level of reimbursement. Michigan and Maine raised payments for undervalued services. Texas adopted a conversion factor that will raise Medicaid fees to about 87 percent of Medicare fees.

Second, states must decide whether to have a full transitional implementation of the relative value scale. If a state implemented the fee schedule in a budget-neutral fashion, fully implementing the entire relative value scale would probably mean that payments for some services would be reduced while payments for evaluation and management would be increased. If, however, a state increased its total expenditures for physician services, reductions in payments for some services could be minimized while increases for others would occur. For example, in April, the Texas Medicaid program will fully implement the fee schedule with an increase in total payments for physician services.

On the other hand, a state could have a transition by increasing payments for undervalued procedures while holding constant payments for overvalued procedures. Continuing this strategy over time, a state would implement the fee schedule in an incremental fashion. For example, in the first year of its fee schedule, Maine did not reduce payments for overvalued procedures but increased payments for undervalued procedures; Michigan placed a floor on reductions in fees while increasing fees for other services.

Finally, a state must decide whether to conform to Medicare payment policies or adjust relative values for some services to reflect distinctive program policies. Medicare's payment policies determine what services are included in a global package of services and Medicare's relative values reflect the payment policies. Considerable analysis was necessary to develop rational, standardized global service packages for Medicare. If a state wished to retain its current global service package policy, it would need additional analysis to adjust the relative values to reflect different service packages.

Conclusion

The adoption of the Medicare Fee Schedule by Medicaid and other state health programs would have major advantages. It would rationalize payments, basing them on the resource costs necessary to provide service. Relative Medicaid physician fees would likely experience shifts similar to those in Medicare. Medicare fees for evaluation and management services will increase and fees for surgical and other technical procedures will decrease. The use of the same payment method and rules by both public programs would simplify billing practices for physicians. Finally, if a state paid at Medicare levels, access for Medicaid beneficiaries would likely be improved.

Notes

[1] The opinions expressed are the author's and do not necessarily reflect the views of the Physician Payment Review Commission. The author thanks Anne Schwartz and Anne Reisinger for their analysis of Medicaid physician payment, which is reflected in this article, and Paul Ginsburg for his comments.

[2] Rosemary Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971), pp. 448-463.

[3] U.S. Senate, Committee on Finance, *Medicare and Medicaid: Problems, Issues, and Alternatives* (Washington, DC, 1970).

[4] For further information on the problems, see Physician Payment Review Commission, *Annual Report to Congress*, 1988.

[5] W. C. Hsiao, et al., *A National Study of Resource-Based Relative Value Scales for Physician Services: Final Report* and *A National Study of Resource-Based Relative Value Scales for Physician Services: Phase II Final Report* (Cambridge, Massachusetts: Harvard School of Public Health, 1988 and1990.

[6] For more information, see Physician Payment Review Commission, *Annual Report to Congress*, 1992, Chapter 2.

[7] Since the study of relative values was done for the general population, relative work values for most services will apply to Medicaid recipients. Nevertheless, relative values for obstetrical and some children's services need additional analysis. Recently, PPRC suggested that the federal government conduct the research necessary to develop relative values for those services.

David C. Colby is a principal policy analyst, Physician Payment Review Commission.

Medicaid and Health Care Reform
(continued from page 11)

point in time, some states will not be able to finance a decent basic benefit. Under an employer choice approach to health care reform, that would leave employers in economically pressed states with an inferior "pay" option, a particular problem for multistate firms. Federalization of acute care costs would avoid this problem, since the financing would be independent of the economic conditions in any particular state.

Finally, there is the problem of the distribution of need. Neither the poor nor epidemics such as AIDS are equally distributed among the states. If we take the position that taxpayers in hard-hit areas must shoulder all the responsibility for meeting the health care needs of their communities, then we are setting up a situation in which the most disadvantaged areas inevitably get poorer as businesses and the middle class flee to lower tax jurisdictions. Federalization of Medicaid's acute care benefits would spread this financing burden more fairly, and avoid the economic collapse of communities with the greatest health care needs.

States will have an important role to play in health care reform. However, the Medicaid experience teaches us that if we want adequate basic health care coverage for all Americans, we cannot ask the states to finance it.

Rep. Henry A. Waxman is chairman of the House Subcommittee on Health and the Environment.

Partnership Minnesota: An Innovation in Cooperation

Dean C. Larson

Partnership Minnesota is an informal coalition of public employees representing federal and state agencies brought together to encourage intergovernmental cooperation for the benefit of quality service to the public. Its aim is to establish cooperative working relationships or partnerships focused on specific issues or problems of mutual concern among federal, state, and local agencies. The partnership allows better use of limited resources and enhanced service and productivity.

The Setting

In 1987, the U.S. Department of Commerce invited representatives from every state to a meeting in Washington, DC, to set in motion its new federal-state cooperative program. States were asked to volunteer to work with the department in a series of cooperative projects. Lee Munnich, Assistant Commissioner at Minnesota's Department of Trade and Economic Development, saw the potential and volunteered Minnesota. He followed up with a letter of support co-signed by Minnesota's congressional delegation.

The first effort, known as the "Commerce/Minnesota Initiative," encompassed ten cooperative projects between the state and the department. One of these projects—Mn/Win (Minnesota Weather Information Network)—set up a partnership between the National Oceanic and Atmospheric Administration (NOAA), the National Weather Service Office, and the Minnesota Department of Transportation. Mn/Win established a point-to-point radio communication system for early tornado warnings in the Minneapolis-St. Paul area; helped develop a network of 38 state-owned automated weather reporting stations to supplement the five stations staffed by the National Weather Service; and began the NOAA-Minnesota Partnership, a spin-off program with more than 30 federal-state cooperative projects.

The U.S. Internal Revenue Service joined with the Minnesota Department of Revenue in a program to exchange employees and share training efforts.

A cooperative arrangement between the Federal Aviation Administration (FAA) and the state, FAA-MN Partnership, set up employee exchanges and coordinated, standardized, and steamlined airport planning processes in Minnesota. It also helped develop and coordinate the aviation weather programs and placement of automated aviation weather stations. Furthermore, its aviation career and education training programs helped establish an air traffic control training demonstration program in Minnesota that will serve as models for others.

The Strive Towards Excellence in Performance (STEP) program, developed by a former commissioner of the Minnesota Department of Administration, was dedicated to training, supporting, and relying on employees for change. STEP gave employees a chance to experiment with improving service delivery. The program won a Ford Foundation Innovations in State and Local Government Award and recognition from the John F. Kennedy School of Government at Harvard University.

Birth of Partnership Minnesota

In 1988, members of these partnership teams met to swap stories. Out of this meeting Partnership Minnesota was created—with no funding, no authority, and no legislation. It was just a group of people with similar interests who believed in what they were doing—trying to create a more effective government.

On September 1, 1989, Partnership Minnesota completed its first formal charter. Among the important elements of that charter are:

- The group exists to increase cooperative working relationships between federal, state, and local governments for the benefit of quality service to the public.
- Anyone can become a member of Partnership Minnesota by submitting a request and receiving approval from the board of directors. Partnership Minnesota has no membership dues.
- The board of directors consists of about 20 members, with relatively equal representation from federal and state agencies. All board members must be active working participants.
- The Partnership Minnesota organization operates without a formal budget. The charter states, "We are about partnerships and sharing of resources; and our organization will continue requesting membership and organizational participation in meeting these activity needs for such items as stationery, pins, awards, conferences, and other special expenses."

Members

Partnership members are all volunteers supported by their agencies rather than being appointed by their agencies. Members believe that partnerships save time and money and enhance government productivity, and they are committed to improving intergovernmental service delivery to the public. There are few committees, and the emphasis is on action rather than research.

Activities

What can a loosely bound organization with no money, no legislation, and no authorization do? A great deal! Partnership Minnesota is not influenced by the whims of the political process, organizational priorities, or legislative peculiarities. Members act through their own commitment. Partnership Minnesota's major activities include:

- Serving as a network to broker and coordinate technology, skills, and information flow between federal, state, and local governments.
- Engaging in multiple communication and development activities that stimulate intergovernmental cooperation.
- Sponsoring intergovernmental cooperative projects focused on specific issues or programs of mutual concern.
- Conducting an annual one-day workshop for federal, state, and local employees to explore partnerships as a strategy to improve service quality.
- Recognizing outstanding examples of federal, state, and local agency cooperation that benefit the public.

Accomplishments

- Tax Partnership Day brought together more than 100 employees of the state Department of Revenue and the U.S. Internal Revenue Service to share experiences, problems, and common concerns. They looked for ways to reduce paperwork and duplication. The meeting resulted in substantial cooperation between federal and state agency partners.
- In the Guidestar Program, the Federal Highway Administration and the Minnesota Department of Transportation helped develop a program for Intelligent Vehicle Highway Systems (IVHS) in Minnesota. The program has been so successful that in January 1992 Minnesota was described as one of the nation's leaders in coordinating advanced technology for IVHS—commonly called smart cars, smart highways. The traffic management program alone has helped reduce traffic congestion and improve safety by approximately 30 percent on major freeway segments in Minneapolis and St. Paul.
- The Minnesota Information Policy Office and the National Institute of Standards and Technology (NIST) cooperated in the adoption of computer communications standards—called Government Open Systems Interconnection Profile (GOSIP). Minnesota was a leader in adopting the new federal GOSIP standards, which will allow state and federal computer systems to interact directly without separate black boxes for communication conversion between systems.
- Quality Minnesota, a program developed by key members of the Partnership Minnesota team, aids state agencies in developing quality improvement programs. The state Department of Transportation, for example, expects to have all of its employees trained in the "Deming Quality Principles" in the next three years. The Federal Executive Board has worked with the state team in bringing the "Deming Principles" to federal agencies in Minnesota.
- Gambling has become a major industry in Minnesota with the advent of Indian gambling casinos. On November 20, 1991, Partnership Minnesota brought together, for the first time, key players in the fields of social service, taxation, law, state gambling contract and enforcement, and the Federal Bureau of Investigation to look for methods of cooperation. In subsequent meetings, the participants have continued to develop these partnership efforts and program coordination.

In addition to the programs developed by Partnership Minnesota's executive board members, an annual award for partnerships has been developed. In 1990, six partnerships were nominated for awards; there were 21 nominations in 1991 and 58 this year. Examples of the winners include:

- The Minnesota Department of Agriculture and the U.S. Food and Drug Administration's joint development of a pesticide monitoring program to protect animal feed and food from unsafe levels of pesticide residues.

- The U.S. Bureau of Mines, the Minnesota Department of Natural Resources, and the University of Minnesota partnership to develop a technique to explore manganese mining without spoiling the land surface as it did previously. Manganese is a vital mineral no longer produced in the United States, and Minnesota holds the nation's largest reserve. This process allows mining through drill holes without disturbing the delicate surface area.
- The U.S. Department of Housing and Urban Development (HUD) and the Minnesota Housing Finance Agency partnership that helps finance new affordable housing for first-time home buyers.
- Cooperation between the Minnesota Department of Corrections and Arrowhead Regional Corrections, Region 2, on a program called Sentencing to Service. This program provides alternate solutions for convicted offenders through on-the-job training while providing needed improvements to state parks and other public facilities.
- The Cambridge Regional Human Services Center and the Cambridge-Isanti Independent School District 911 partnership has shared educational space and programs at no additional cost to citizens.
- The U.S. Department of Veterans' Affairs Medical Center in Minneapolis and the University of Minnesota School of Medicine project that established an endowed chair for research into mental illness.
- The Minnesota Valley National Wildlife Refuge, Eden Prairie High School, and the Eden Prairie Park and Recreation Department's development of an educational partnership project to restore native prairie lands.
- The Minnesota Department of Natural Resources and the U.S. Fish and Wildlife Service Youth in Natural Resources project that provides on-the-job field experience and career information.

Political leaders often are tempted to develop "quick fix" programs and to publish results in estimated dollar savings. Partnership Minnesota's independence permits it to look longer term at service quality rather than at dollars. Partnership Minnesota efforts cross federal, state, and local agency boundaries in program implementation. Moreover, its members come from all levels within their organizations as they work to improve their agencies' efforts by sharing resources and expertise and to eliminate duplication of efforts.

Sen. Dave Durenberger, in referring to the successful Commerce/Minnesota Initiative said, "This is the result of all too uncommon cooperation and unity of purpose among state and federal officials. We have this tremendous synergy available to us if we can get state and federal agencies working together."

Leonard Inskip from the *Minneapolis Star and Tribune* has featured Partnership Minnesota in his columns. He captured the essence of Partnership Minnesota with the following words:

> Partnership Minnesota comprises federal and state employees interested in collaborating. Their efforts are the kind of government creativity that merit support and recognition.
>
> In an era of tight budgets—federal and state—those efforts could be a model for federal and state agencies everywhere. Partnership Minnesota is believed to be the national leader.

Partnership Minnesota recently received the Public Employees Roundtable's 1992 Public Service Excellence Award for its outstanding contributions to public service.

Partnerships are an effective method of developing quality public services. Partnerships are long term. They help reduce costs, paperwork, and duplication and are an effective way of developing intergovernmental cooperation. Partnerships also provide an excellent outlet for motivated federal, state, and local agency representatives to share expertise, efforts, and experience.

Dean Larson is special programs director, Office of Aeronautics, Minnesota Department of Transportation, and is a founding member of the board of directors of Partnership Minnesota. Anyone interested in starting a partnership may contact him at (612) 297-7503.

Books, etc.

Economic Competitiveness

PUT UP OR GIVE AWAY: *States, Economic Competitiveness, and Poverty.* By John Sidor. Council of State Community Affairs Agencies, 444 North Capitol Street, NW, Suite 251, Washington, DC 20001, 1991. 354 pp. $20.

Put Up or Give Away argues that states can foster economic competitiveness and reduce poverty by establishing economic opportunity strategies that build on successful economic development practice, recognize economic realities, and respond to problems of poverty, increasing income inequality, welfare dependence, and the urban underclass. The book distinguishes between an economic opportunity strategy (providing earnings and assets to the poor) and a neighborhood revitalization strategy. The strategy should provide assistance to business (especially small business)—financing, management, technology, and workplace education. States should also pursue a strong minority business development program. The book notes that the states operate in a federal system with complex programs, financing, and administrative roles for all governments ("buckshot federalism"), especially in welfare and employment policies.

Fiscal Disparities

METROPOLITAN DISPARITIES AND ECONOMIC GROWTH: *City Distress and the Need for a Federal Local Growth Package.* (Research Reports on America's Cities Series). By Larry C. Ledebur and William R. Barnes. National League of Cities, 1301 Pennsylvania Avenue, NW, Washington, DC 20004, 1992. 36 pp. $15.

NLC finds that economic disparities between central cities and suburbs increased sharply in the 1980s. The authors note that changes in the intergovernmental system are compounding these disparities and increasing the fiscal squeeze on cities (e.g., federal cutbacks and fiscal retrenchment in many states, escalating costs of federal and state mandates programs, tight regulation of types of taxes cities can use, and detailed controls over tax rates and assessment practices), as is the lingering recession. The economic destinies of a city and its suburbs are tied together, and disparities inhibit overall economic growth. National economic performance also is dependent on these local performances because the "national economy" is the aggregate of these regional economies. National economic growth requires federal support for "local growth packages" that address the hidden deficits in human capital, technology, and infrastructure.

Government Assistance

GOVERNMENT ASSISTANCE ALMANAC 1991-92. Edited by J. Robert Dumouchel. 5th Edition. Omnigraphics, Inc., Penobscot Building, Detroit, MI 48226, 1991. xviii, 799 pp. $72.

According to the almanac, funding of federal domestic assistance programs increased by $40 billion in FY 1991 to a total of $736 billion in 1,183 programs. This guide to federal financial and other domestic assistance programs covers grants, loans, insurance, personal payments and benefits, subsidies, fellowships, scholarships, traineeships, technical information, business and consumer advisory services, citizenship counseling, investigation of complaints, and sales and donations of federal property. There are comparative funding tables for the last four fiscal years. For each program, the almanac provides (1) the official title and any popular title; (2) the types of assistance available; (3) a brief description of objectives, purposes, uses, examples of funded projects, and a summary of recent accomplishments; (4) eligibility for applicants and beneficiaries; (5) range and average amounts of awards; and (6) contact addresses and phone numbers.

Intergovernmental Relations

IMPROVING LOCAL SERVICES THROUGH INTERGOVERNMENTAL AND INTERSECTORAL COOPERATION. Coalition to Improve Management in State and Local Government, School of Urban and Public Affairs, Carnegie Mellon University, Pittsburgh, PA 15213, 1992. 72 pp. $15.

This report contains 133 case examples to help cities, counties, councils of governments, and states establish policies and procedures to capitalize on the many benefits from cooperative efforts with each other and with the nonprofit and business sectors. The initiatives outlined range from bicounty agreements for handling solid waste to contracts for private maintenance of public parks. Many examples show the advantages of working more effectively with nonprofit organizations, joint ventures, and other nontraditional methods. The report (1) identifies six ways that intergovernmental and intersectoral cooperation can provide better facilities and services at less cost, (2) outlines city and county policy and organizational requisites for planning and implementing goals and programs, (3) shows how specific functions can benefit from cooperation, and (4) lists sources of information and assistance.

Municipal Government

THE STATE OF AMERICA'S CITIES: *The Eighth Annual Opinion Survey of Municipal Elected Officials.* (Research Report on America's Cities Series.) National League of Cities, 1301 Pennsylvania Avenue, NW, Washington, DC, 20004, 1992. 30 pp. $10.

Local government officials think that state and federal governments are doing a poor job of helping to address the nation's problems, with funding for local programs having decreased dramatically over the past ten years.

Moreover, federal and state restrictions are major obstacles to local efforts to address the most pressing community problems. Officials called for a significant reordering of federal priorities. These are among the findings of the NLC 1991 opinion survey of mayors, council members, and other elected local officials. Regarding some community conditions, the divergence of evaluations points to greatly different capacities for addressing these problems. However, there were strong trends of deterioration in most local conditions asked about. The ten conditions cited as having deteriorated the most are overall economic conditions, crime, drugs, unemployment, fiscal conditions, education, cost of living, affordability of housing, solid waste disposal, and streets and roads.

State-Local Relations

STATE POLICIES AFFECTING CITIES AND COUNTIES IN 1991. By Steven D. Gold and Sarah Ritchie. Center for the Study of the States, Nelson A. Rockefeller Institute of Government, State University of New York, 411 State Street, Albany, NY 12203, 1992. 45 pp.

This report describes and analyzes state fiscal policies affecting cities and counties in 1991 in the context of trends from previous years, focusing on financial aid, changes in how responsibilities are sorted out, local revenue diversification, changes in local tax limitations, and mandates. At least 15 states made some reductions in financial aid, with significant cutbacks in Illinois, Maine, Maryland, Massachusetts, and New York (education aid is excluded). At least 16 states enhanced local ability to raise revenue (most options were relatively minor), and nine states changed the limits they impose on local governments (five more liberal; four more restrictive). Mandates continued to be a sore point in state-local relations. Overall, the problems of cities and counties remained a low priority in most state capitols.

State Mandates

STATE MANDATES: *Fiscal Notes, Reimbursement, and Anti-Mandate Strategies.* By Janet M. Kelly. National League of Cities, 1301 Pennsylvania Avenue, NW, Washington, DC 20036, 1992. 90 pp. $25.

This report is the result of a cooperative effort between the state municipal leagues and NLC to find a useful approach to dealing with the problem of unfunded and underfunded state mandates to local governments. The study challenges two pieces of conventional wisdom—(1) fiscal notes and reimbursement legislation are institutional cures for the problem (state legislatures may not have reliable cost estimates or be committed to using them in their mandate decisions), and (2) the mandate issue is mainly one of "who pays" (many mandates restrict local government discretion in administrative decisions). The report is essentially divided into three parts. The first part defines and describes the problems and places the issue of state mandates in its historical and functional context. The second part deals with the "tried solutions," focusing on understanding the potential and pitfalls of fiscal notes (including model legislation) and reimbursement. The final chapter looks at goals rather than process, following the development of a mandate policy through the legislative cycle, and presents strategies for contesting mandates.

Tax Burdens

INTERSTATE COMPARISONS OF FAMILY TAX BURDENS. By Stephen E. Lile and Joel E. Philhours. Institute for Economic Development and Public Service, Western Kentucky University, 212 Van Meter Hall, Bowling Green, KY 42101, 1991. 41 pp.

This study of state-local tax characteristics compares tax burdens for families living in the largest city in each of the 48 contiguous states. Included are 1990 estimates for state and local income taxes, state and local sales taxes, and residential property taxes for families with incomes of $15,000, $30,000, $45,000, $60,000, and $90,000. Income is assumed to come exclusively from wages and salaries, and each family is assumed to own its own home. An hypothetical approach is used for the comparisons to allow easy alteration of the main variables of income level and sources, and place of residence.

ACIR News

(continued from page 4)

office, Secretary Alexander was president of the University of Tennessee, a position he had held since July 1988. He served as governor of Tennessee from 1979 to 1987.

As chairman of the National Governors' Association, he led the 50-state education survey, *Time for Results.* In 1988, the Education Commission of the States gave him the James B. Conant Award for "distinguished national leadership in education."

While governor, Secretary Alexander served as a member and vice chairman of ACIR from 1981 to 1984.

Barbara Sheen Todd, a Pinellas County Commissioner since 1980, is also serving as Second Vice President of the National Association of Counties.

Actively involved in NACo since 1987, Commissioner Todd has served as vice chair of the Environment, Energy, and Land Use Steering Committee; chair of the Subcommittee on Solid Waste Management; and member of the Task Force on Tobacco, the Task Force on Immigration and Health, and the Education Steering Committee. In 1988-89, Todd served as president of Women Officials in NACo.

Commissioner Todd currently serves as vice chair of the Gulf of Mexico Citizens Advisory Committee, and as a member of the Governor's Coastal Resources Management Citizens Advisory Committee, the Florida Advisory Council on Environmental Education, and the Florida Growth Management Conflict Resolution Consortium.

Change in Meeting Dates

The Commission meeting scheduled for June 12, 1992, is now set for June 11, 1:00–5:00 p.m., and June 12, 8:30–11:30 a.m., in Washington, DC. For the evening of June 11, ACIR will sponsor a dinner and symposium on federalism with the Woodrow Wilson International Center for Scholars at the Smithsonian. The symposium speakers will be Justice Sandra Day O'Connor and Sen. Charles S. Robb.

Members of the U.S. Advisory Commission on Intergovernmental Relations

(April 1992)

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Daniel J. Elazar, Philadelphia, Pennsylvania
Robert B. Hawkins, Jr., *Chairman*, San Francisco, California
Mary Ellen Joyce, Arlington, Virginia

Members of the U.S. Senate

Daniel K. Akaka, Hawaii
Dave Durenberger, Minnesota
Charles S. Robb, Virginia

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Members of State Legislatures

David E. Nething, North Dakota Senate
Samuel B. Nunez, Jr., President, Louisiana Senate
Ted L. Strickland, Colorado Senate

Elected County Officials

Ann Klinger, Merced County, California Board of Supervisors
D. Michael Stewart, Salt Lake County, Utah, County Commission
Barbara Sheen Todd, Pinellas County, Florida, County Commission

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