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WORKING PAPERS ON MAJOR BUDGET AND PROGRAM ISSUES IN SELECTED HEALTH PROGRAMS

COMMITTEE ON THE BUDGET
U.S. HOUSE OF REPRESENTATIVES

PREPARED BY THE STAFF

OF THE

CONGRESSIONAL BUDGET OFFICE

FOR THE

TASK FORCE ON HUMAN RESOURCES

DECEMBER 10, 1976

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LETTERS OF TRANSMITTAL

AUGUST 16, 1976.

To the members of the Budget Committee:

Transmitted herewith is a collection of papers dealing with major budget and programmatic issues in federally supported health programs.

The papers are being distributed at the request of the Task Force on Human Resources for discussion purposes. They have not been approved by the committee, nor do they represent the views of all members of the task force. Your comments on the papers should be addressed to the chairman of the Task Force on Human Resources.

Sincerely yours,

BROCK ADAMS, *Chairman.*

Hon. BROCK ADAMS,
Chairman, Committee on the Budget,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Transmitted herewith is a collection of papers prepared by the staff of the Congressional Budget Office at the request of the Task Force on Human Resources. The papers deal with major programmatic and budget issues in federally supported health programs. The papers were utilized as resource materials by the staff of the committee in development of the first budget resolution for fiscal year 1977.

The papers contain analysis and options, not recommendations. While the members of the task force do not necessarily agree with all the points made in the papers, and they have not been approved by the committee, I recommend their publication as a committee print in order to focus discussion by the members of the committee, other interested committees, and Members of Congress, as well as the general public.

Sincerely,

PARREN J. MITCHELL,
Chairman, Task Force on Human Resources.

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PREFACE

This collection of nine working papers deals with major budget and programmatic issues in a number of federally supported health programs. They were developed by the Congressional Budget Office for use by the Task Force on Human Resources of the House Budget Committee.

Section I of the collection contains seven papers analyzing proposals made by the President in the fiscal year 1977 budget to modify the structure of existing health programs or significantly alter the level of Federal support. Section II contains two papers which analyze the operation and effectiveness of two major Federal health programs designed to improve the delivery of health care services.

The papers were prepared between late 1975 and March 1976 to assist the House Budget Committee in the development of its budget targets for the health function in the first budget resolution for fiscal year 1977. Several were developed at the request of the Senate Budget Committee as well. All represent working papers only, designed to focus discussion on major budget issues in Federal health programs. They contain analysis and program options, but no recommendations. The collection has not been approved by the Task Force on Human Resources or the Budget Committee. The papers are being published as a committee print in order to stimulate discussion and obtain reactions to the issues presented by members of the Budget Committee, other congressional committees, and Members as well as the interested public.

The papers were written by the staff of the Health and Veterans Branch of the Human Resources and Community Development Division at the Congressional Budget Office. The principal authors of the papers were: Maureen Baltay for "Public Health Service Hospitals;" Susanne Stoiber for "The President's Medicare Catastrophic Proposals;" Bonnie Lefkowitz for "Short-Term Options for the Medicaid Program," "Short-Term Options for Categorical Health Grant Programs," and "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT;" Stanley Wallack for "Hospital Cost Increases: Causes, President's Proposed Cost Limits and Some Alternatives," and "Federal Support for Biomedical Research;" and Leo Corbett for "The Federal Government and Health Maintenance Organizations." Bonnie Lefkowitz and Stanley Wallack jointly prepared "Federal Support for Health Manpower Development." Alan Fein and Toni Wright provided assistance for many of these papers. Editorial assistance was provided by Katherine Bateman and Patricia Johnston. All of the papers were done under the supervision of Stanley Wallack.

THE PRESIDENT'S MEDICARE CATASTROPHIC PROPOSALS

SUMMARY

In his state of the Union message, the President proposed a limited form of "catastrophic insurance" protection under medicare combined with increases in medicare coinsurance and deductibles. The effect of the amendment package would be to assist medicare beneficiaries who experience extremely long hospital stays or have high medical bills while at the same time increasing the average out-of-pocket cost of health care for most of the aged.

The President's catastrophic protection proposals are based on a "flat expenditure" conception of a medical catastrophe. Specifically, when a beneficiary has spent $500 for services under hospital insurance (HI) or $250 for services covered under supplementary medical insurance (SMI), he is deemed to have crossed the catastrophic expenditure threshold and is no longer required to pay medicare coinsurance. The expenditure level is the same regardless of the income of the beneficiary.

Only a very small percent of medicare recipients would reach these expenditure levels under current cost-sharing requirements—an estimated 40,000 to 50,000 or 0.8 percent of those entitled to HI. The plan could, however, provide substantial assistance to those who exceed the catastrophic deductible levels. For example, chronic renal disease beneficiaries would be saved an average of $3,000 in coinsurance under SMI.

Another way of defining a medical catastrophe is health expenditures an individual cannot reasonably afford. The catastrophic level is reached when individual expenditures exceed a certain percent of income (15 percent is often accepted as the threshold level). This tailors assistance to individual need.

If the "percent-of-income" definition is accepted as the index of a medical catastrophe rather than the flat expenditure approach, the President's medicare amendment package would increase rather than decrease the frequency of catastrophic expenditures in excess of 15 percent of income among the aged. This results from the higher deductibles and coinsurance proposed which would increase average spending by medicare beneficiaries. More than one-third of the aged have income at or below the poverty level, and with "average" expenditures now devote approximately 15 percent of their income to medical care costs. Any increase in "average" medicare expenses will therefore enlarge the number of elderly persons qualifying under an income-based catastrophic test.

INTRODUCTION

Medicare provides health insurance coverage for the aged, the disabled, and persons suffering from chronic renal disease (kidney failure). The program has two parts. HI is provided to all eligible bene-

ficiaries of the social security system who meet one of three criteria: Attaining age 65; passing social security's test of total and permanent disability; or suffering from chronic renal disease (CRD). SMI is an optional supplement to the HI program. HI beneficiaries who elect to participate in the SMI program pay a monthly premium.

In 1977, the Social Security Administration estimates that the hospital insurance program will have 22.4 million aged, 2.4 million disabled, and 19,000 CRD beneficiaries. The SMI program will enroll 22.2 million aged, 2.2 million disabled and 19,000 CRD beneficiaries.

The HI program provides beneficiaries with coverage of hospital services for 90 days in a benefit period. A new benefit period begins whenever a beneficiary is not an inpatient of a hospital or skilled nursing home for 60 consecutive days. In addition, every beneficiary has 60 "lifetime reserve" days of hospital care. The beneficiary must pay for the first day of hospitalization (known as the "deductible"). After that medicare pays the full cost until the 61st day at which time the beneficiary must begin to pay a part of the cost (known as coinsurance). HI also covers 100 days of posthospital skilled nursing services and home health visits.

The SMI program covers physician services, home health care, physical therapy and the rental or purchase of certain durable medical equipment. Beneficiaries must pay a deductible (in 1976 this was the first $60 spent on SMI covered services) and in addition must pay as coinsurance 20 percent of the reasonable charge for such services after the deductible is satisfied.

In his state of the Union message, the President proposed to augment the protection provided under the HI and SMI programs by adding a limited form of "catastrophic insurance" protection. This would be combined with increases in the deductible and coinsurance charges. The effect of the amendment package would be to assist medicare beneficiaries who experience extremely long hospital stays or have very high medical bills while at the same time increasing the average out-of-pocket costs of health care for a majority of the aged.

The President's catastrophic protection proposals are based on a "flat expenditure" conception of a medical catastrophe. Specifically, when a beneficiary has spent $500 for services covered under hospital insurance or $250 for services covered under supplementary medical insurance, he is deemed to have crossed the catastrophic expenditure threshold and is no longer required to pay medicare coinsurance. The expenditure level is the same regardless of the income of the beneficiary.

Only a very small percent of medicare beneficiaries would reach these expenditure levels under current cost-sharing requirements (an estimated 40,000 to 50,000 or 0.8 percent of those entitled to hospital insurance). The plan could, however, provide substantial assistance to those who exceed the catastrophic deductible levels. For example, chronic renal disease beneficiaries would be saved an average of $3,000 per year in coinsurance under SMI.

Another way of defining a medical catastrophe is health expenditures an individual cannot reasonably afford. The catastrophic level is reached when individual expenditures exceed a certain percent of income (15 percent is often accepted as the threshold level). This tailors assistance to individual need.

If the percent-of-income definition is accepted as the index of a medical catastrophe rather than the flat expenditure approach, the President's medicare amendment package would increase rather than decrease the frequency of catastrophic expenditures (i.e., those in excess of 15 percent of income) among the aged. This results from the higher deductibles and coinsurance proposed which would increase average spending by medicare beneficiaries. More than one-third of the aged have incomes at or below the poverty level, and with average expenditures now devote approximately 15 percent of their income to medical care. Any increase in average medicare expenses will therefore enlarge the number of elderly persons qualifying under an income-based catastrophic test.

I. THE PROBLEM OF CATASTROPHIC HEALTH CARE COSTS

Public and congressional attention has recently been focused on the issue of extremely high health care costs. Over the last 25 years health care expenditures have been growing at a much more rapid rate than the overall economy. In 1950, health expenditures amounted to $12 billion or 4.6 percent of GNP; by 1975 such spending had reached $118.5 billion or 8.3 percent of GNP.

Causes

The increase in spending for health care has been caused by three factors: (1) Historically, inflation in the health sector has been more severe than in other segments of the economy; (2) there have been dramatic improvements in the quality or intensity of medical care—these advances have been characterized by an emphasis on diagnostic and therapeutic techniques which are complex, expensive, and often require hospital stays; and (3) individuals use more health services today than they did in 1950.

All of these factors have increased the risk that an illness may prove financially catastrophic. As a result of concern over this problem, a number of legislative proposals have been introduced to provide protection against a catastrophic medical event. The President added to those already under consideration by calling for a limited form of catastrophic insurance under medicare.

Although a belief that the public should be protected against a catastrophic medical event seems to be developing, there is no agreement as to what constitutes a medical catastrophe. At least three views have been advanced.

The first might be called the disease or medical diagnosis approach. Under this approach a person suffering from any of a certain list of diseases would be defined as having suffered a catastrophic event regardless of the actual financial impact of the disease on the person. Using this definition, persons suffering from chronic renal disease were covered under medicare in 1972. Since then, considerable pressure has been brought to extend coverage to persons suffering from other high cost illnesses such as hemophilia.

A second definition looks at a medical catastrophe in terms of a uniform expenditure—$500, $1,000, $2,000—or the consumption of a fixed amount of services, for example, 60 days of hospital care. This view is reflected in the Long-Ribicoff catastrophic insurance bill and in the President's medicare proposals.

The third approach is to define a medical catastrophe as health expenditures an individual cannot reasonably afford. The catastrophic level is reached when individual expenditures exceed a certain percent of income. This is the basis upon which personal health expenses are deducted under the income tax code.

Each of these definitions has certain attractions as a base for developing a catastrophic insurance plan although the first approach has not gained wide support. The advantages and disadvantages of each can be summarized as follows:

TABLE 1.—ADVANTAGES AND DISADVANTAGES OF DIFFERENT DEFINITIONS OF MEDICAL CATASTROPHE

Disease specific	Flat expenditure or utilization	Percent of income
Ignores other insurance	Ignores other insurance	Accounts for other insurance.
Ignores ability to pay across income groups	Ignores ability to pay across income groups.	Accounts for ability to pay across income groups.
Unfair to persons suffering from a costly illness not on "the list."		Requires means test.
Easy to administer	Easy to administer	Complex and expensive to administer.

Magnitude of the problem

The number of persons suffering from a catastrophic medical event depends upon the definition selected. An examination of the magnitude of the problem among the aged under the two most widely held views—flat expenditure/utilization and percent of income—produces very different results.

Flat expenditure/utilization.—The number of persons who suffer from a catastrophic medical event under the flat expenditure/utilization concept will depend upon the threshold level selected. If, for example, 60 days of hospitalization is defined as the threshold for a catastrophic event, 1 percent of medicare hospital stays by the aged would qualify. If the threshold is defined as 90 days, however, only 0.3 percent of hospital stays would exceed the mark. Therefore, if a medical catastrophe is defined as an extremely long hospital stay, a concept used both by the President and in the Long-Ribicoff bill, it is an unusual occurrence affecting an extremely small number of people. (In 1977, for example, an estimated 83,000 aged medicare beneficiaries will have hospital stays in excess of 60 days, approximately 25,000 will exceed 90 days.)[1]

Percent of income.—If health related out-of-pocket expenditures in excess of 10 or 15 percent of income are accepted as the index of a catastrophic medical event, the problem would appear to be more widespread among the aged.[2]

The per capita health expenditures of the aged averaged $1,217 in 1974 compared to $330 spent by persons under 65. Of this amount, $734 was paid by various Government programs—medicare, medicaid, Vet-

[1] Based on a 20-percent sample of medicare discharges from short-stay hospitals during 1971 inflated for 1977 estimated enrollment in HI.

[2] Ten to fifteen percent of income seems to be the accepted index for a catastrophic event. Economists Charles Phelps, Karen Davis, and Theodore Marmor have used 10 percent of income as the threshold of catastrophic expenditures. Senator William Brock has introduced a tax credit bill for medical expenses in excess of 15 percent of adjusted gross income—less personal exemptions of $750 per person which would bring the threshold below 15 percent.

erans' Administration; $63 was paid by private insurance; $5 by philanthropy; and $415 directly by the aged as an out-of-pocket cost.[3]

For the more than one-third of the aged whose per capita incomes were $3,000 or less in 1973, even average out-of-pocket expenditures for health services will consume 13 percent of income. An aged couple with average expenses and an income of $5,000 in 1974 would have devoted 17 percent of their income to health-related expenses. Almost 40 percent of all couples over age 65 had incomes of less than $5,000 in 1973. Of the 23 million persons over age 65 in 1973, 8.4 million had incomes of less than $5,000 for a couple or $3,000 for an individual.[4]

Therefore, if 10 to 15 percent of income devoted to health expenses is considered the threshold definition of a catastrophic medical event, perhaps a third or more of the aged would qualify for catastrophic relief.

II. THE PRESIDENT'S PROPOSAL

The President's proposal for catastrophic protection under medicare is based upon the flat expenditure conception of a medical catastrophe. Specifically, he proposes the following changes:

A. To establish a flat-amount expenditure ceiling for certain medicare-covered services.

—No beneficiary would be required to pay more than $500 annually for services covered under the hospital insurance program. Currently, there is no maximum on beneficiary cost sharing.

—All limits would be abolished on the number of benefit days available for short-term hospital stays and skilled nursing facilities. Limits on hospital stays under current law are 90 days per benefit period with a 60-day lifetime reserve. Nursing home benefits are limited to 100 days in a benefit period.

—No beneficiary would be required to pay more than $250 annually for the deductible and coinsurance of services covered under supplementary medical insurance.

B. To increase the cost-sharing requirements for medicare beneficiaries.

—Beneficiaries would be required to pay a 10-percent coinsurance on actual hospital charges for each day after the first day of hospitalization until they reach the $500 catastrophic protection cap. Under current law there is no coinsurance until the 60th day. From the 61st through the 90th day beneficiaries now pay coinsurance equal to 25 percent of the deductible; from the 91st day until coverage is exhausted, they pay 50 percent of the deductible amount. Currently, coinsurance amounts are the same nationally. The President's proposal would change coinsurance to a percentage of actual charges. Thus a patient's liability would vary for short stays depending on the per diem charges of the hospital.

—The SMI deductible would be increased to $77 in fiscal year 1977 (from $60 at present). In future years the deductible would be indexed to increases in social security cash benefits.

—A 10-percent coinsurance would be imposed on certain SMI covered services (home health care, hospital-based physicians) that are not subject to coinsurance under current law.

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[3] Social Security Bulletin, July 1975.
[4] CPR Special Studies, Series P–23, No. 47, Social and Economic Characteristics of the Older Population: 1974.

Cost of the President's proposals and impact on beneficiaries

If the President's program of catastrophic protection and increased cost sharing is accepted in its entirety, CBO estimates that approximately 1 million out of the 5.9 million beneficiaries using HI-covered services in 1977 would spend $500 and trigger the "catastrophic cap." This estimate assumes imposition of a 10-percent coinsurance on HI services.

The claim that 1 million beneficiaries would be "protected" by the $500 cap is, however, somewhat illusory. Ninety-five percent of the 1 million beneficiaries would never incur deductible and coinsurance costs of $500 under current law provisions. Thus all but 5 percent of the 1 million would be shielded from a risk newly created by the 10-percent coinsurance. Under current cost-sharing provisions a medicare recipient would have to be hospitalized for 73 days before spending $500 on the deductible and coinsurance. Approximately 40,000 to 50,000 or about 0.8 percent of the 5.9 million beneficiaries using HI covered services would be hospitalized for 73 days and thus qualify for catastrophic benefits (compared to the 1 million persons who would spend $500 under the President's plan).

CBO has estimated the cost of providing a $500 cap on cost-sharing under HI and extending unlimited hospital and skilled nursing home services at $1.2 billion in fiscal year 1977. (The most expensive component is extending hospital and nursing home coverage which CBO estimates would cost $800 million.) The 10-percent coinsurance on hospital and skilled nursing home care would produce savings in 1977 which CBO estimates at $1 billion. Therefore, if adopted in its entirety, the President's HI medicare amendments would have 1977 outlays of about $262 million.

HEW estimates that 2 million out of the 14.2 million medicare beneficiaries using services covered by SMI would reach the $250 cap in fiscal 1977. CBO estimates the 1977 outlay costs of this provision at about $208 million. This is not a true full-year program cost for two reasons. First, the provision would not take effect until the second quarter of fiscal year 1977, thus the $208 million estimate is for three-quarters of a year. Second, the long lag time in receiving and paying SMI claims means that almost two-thirds of the costs incurred in 1977 would not show up as outlays until 1978. CBO estimates that obligations for a full year in 1977 would be $690 million.

The class of medicare recipients benefiting most from this provision would be patients suffering from chronic renal disease (CRD). According to Social Security Administration estimates, CRD patients will have average expenditures for SMI-covered services in excess of $15,000 each in fiscal 1977. Under current law their coinsurance costs would exceed $3,000 per capita. The price of lowering this to $250 each will be $54 million in 1977.

Increasing the SMI deductible from $60 to $77 in fiscal year 1977 will, according to CBO estimates, reduce medicare outlays by $140 million. As a result of this increase, CBO estimates that 132,000 fewer medicare recipients will meet the deductible requirements and qualify for SMI benefits. The net cost of the President's SMI amend-

ments would thus be $68 million in 1977. The combined HI and SMI amendments would have a fiscal year 1977 outlay of $330 million.[5]

Analysis of the President's proposals

The net effect of the medicare amendments proposed by the President would be to increase out-of-pocket expenditures for the majority of medicare beneficiaries while decreasing them for the minority who would trigger the "catastrophic gap." This would intensify an already serious problem; to wit: Noninsured health care costs consume a very large share of the disposable income of the aged.

Even small increases in cost-sharing are therefore likely to impose a real hardship on a majority of medicare beneficiaries. It is often assumed that increases in medicare cost-sharing do not affect the aged poor because of the medicaid program. Medicaid pays the medicare deductible and coinsurance as well as certain other expenses for the aged who receive supplementary security income (SSI). Medicaid also covers certain other aged persons not receiving SSI but who have high medical expenses. However, most of the low-income aged are not assisted by medicaid. In 1973, 3.5 million aged persons were covered by medicaid; but 8.4 million aged persons had incomes of less than $3,000 per capita and might therefore be considered poor.

In addition, medicare cost sharing represents only one source of out-of-pocket spending for health care and it is not the most significant one. Other spending occurs for:

—Services not insured by medicare such as dental care, routine podiatry, drugs, eyeglasses, hearing aids, intermediate and custodial nursing home care and physician services when provided for preventive and health maintenance care.

—Hospital or skilled nursing home care provided after medicare benefits are exhausted.

—Residual of charges by physicians which medicare deems to be excessive and not eligible for reimbursement under the program.

Even without increases in medicare cost sharing, expenditures for these noninsured services will consume a constantly growing share of the disposable income of the aged. During the 6 months ending in March 1976, physician fees increased at an annual rate of 13.6 percent. Other medical service prices also increased far more rapidly than the Consumer Price Index (CPI) which, during the same period, increased at an annual rate of 4.8 percent. Social security cash benefits are indexed to the CPI and most private pensions do not increase at all once they are in payment. Therefore, simply to consume comparable levels of health care, the aged must spend a larger share of their income for health services. Increases in medicare cost sharing would add to the problem.

The President's proposal would protect medicare beneficiaries against the risk of exhausting their hospital and nursing home benefits. However, it would not reduce the cost of services not covered by medicare as no addition of new benefits is proposed. The problem of "excess" physician charges would be made more severe by an amendment in the President's package: The stipulation of a 4-percent cap on physician fee increases. This proposal would limit increases in medi-

[5] Explanation of cost estimates available upon request.

care reimbursement of physicians to 4 percent over the 1976 levels. If as seems likely, the 4-percent cap on increases in medicare's reasonable charge causes the physician bill assignment rate to decrease,[6] out-of-pocket expenditures by beneficiaries will go up.

The impact of a decrease in physician assignments on beneficiary expenses would be significant. In calendar year 1975, for example, SSA reduced unassigned physician bills by $525 million because they exceeded reasonable charge levels. A 4-percent physician fee cap is likely to accelerate the decline in assignment and increase beneficiary spending.

An unanticipated consequence of increasing average out-of-pocket expenditures among the aged might be to further distort medicare benefits in favor of the high-income aged. Currently, the elderly in poor health and with low incomes do not utilize health services with the same frequency as higher income elderly with similar health problems. The aged with incomes above $15,000 now receive twice the medicare payments for physician services as those received by persons with family incomes below $5,000. Uniform deductibles and cost sharing under current medicare law are thought to be responsible for the greater use of medical services by those with higher incomes.[7] [See table 2 below.]

TABLE 2.—AVERAGE PHYSICIAN VISITS FOR THE ELDERLY, BY HEALTH STATUS, AND FAMILY INCOME, ADJUSTED FOR OTHER DETERMINANTS

	Health status		
	Good	Average	Poor
Family income:			
Under $5,000:			
No aid	2.78	5.64	10.47
Aid	3.86	7.52	13.42
$5,000 to $9,999	3.14	6.60	11.70
$10,000 to $14,999	3.75	7.27	12.98
$15,000 and over	5.35	9.53	16.98

Source: Health and Society, Milbank Memorial Fund Quarterly, Fall, 1975.

III. ALTERNATIVES

Modifying the flat expenditure approach

There are advantages to the "flat expenditure" approach to catastrophic coverage. The most important of these are simplicity of administration and compatibility with traditional insurance concepts. The insurance rather than income-tested basis of medicare is a valued principle to most medicare beneficiaries. This would to some degree be lost in an income-related catastrophic coverage program.

The President's concept of a flat expenditure cap could be retained without also increasing beneficiary cost-sharing. CBO estimates that removing limits on hospital and skilled nursing home coverage (but retaining coinsurance requirements) would increase outlays $225 million in fiscal year 1977. This could probably be financed without an

[6] A physician who accepts "assignment" of his bill under medicare agrees to accept medicare reimbursement as full payment, and bills patients only for the 20-percent coinsurance. A physician who declines to take assignment bills the patient directly and the patient is liable for both the normal 20-percent coinsurance and any amount by which the physicians' fee exceeds medicare's reasonable charge level.

[7] Despite these higher rates of utilization by the high-income aged, the "average" expenditures of low-income aged persons are probably greater because of the concentration of "poor health status" persons at the lowest income levels.

immediate increase in the HI payroll tax or, it could be paid for by a 1977 premium of $21 or $1.75 per month for HI "catastrophic protection" (perhaps deducted from social security cash benefits). SMI protection could be similarly financed by an increase of $1.17 per month in the SMI premiums. (This amount would be matched from the general fund.)

Adopting an income-related definition of catastrophic coverage

Alternatively, catastrophic protection could be provided on an income-related basis. This would insure a greater degree of equity among medicare beneficiaries by relating costs to ability to pay. For example, SMI deductibles and coinsurance could be increased with income. The aged below the poverty level could be exempted from the deductible and coinsurance requirements. Above the poverty level cost-sharing could be gradually increased with income. Additional cost-sharing, such as that proposed by the President, might be imposed for persons with higher incomes.

Alternatively, cost sharing might be retained for all beneficiaries but a ceiling could be placed on out-of-pocket expenditures. A reasonable figure might be 10 percent of income (the national average expenditure for nonaged, nonpoor families is 3.8 percent of income).

Both of these proposals would represent a major departure from the traditional insurance character of medicare and would be strongly opposed on that account. The income testing which would be required to administer either benefit would be complex, expensive and burdensome to many of the aged. Program costs would also increase as a result of higher utilization by low-income beneficiaries no longer deterred by cost sharing.

Program expansion

Either of the above "catastrophic plans" will be of limited success unless medicare benefits are extended to include such costs as drugs, eyeglasses, hearing aids, and, most important, nursing home care, which now account for more than half of all out-of-pocket spending by the aged. A Federal long-term care program to assist the aged in paying for nursing home care would perhaps be the most important form of "catastrophic insurance" that could be provided. CBO estimates that in fiscal 1976 nursing home care will cost in excess of $11 billion—$5.5 billion of which will be paid out-of-pocket. Seventy-eight percent of expenditures for nursing home care are attributable to the aged.

Although CBO has made no official projections of the cost of a long-term care benefit under medicare, $7 or $8 billion in 1977 would be a very conservative estimate. Future costs would be substantially greater assuming higher rates of utilization than at present due to increased insurance coverage.

A "no-cost" program change which would reduce out-of-pocket costs for medicare beneficiaries under either approach to catastrophic coverage or under current law would be mandatory physician assignment on medicare claims. This would relieve patients of the responsibility for an estimated $0.8 billion in "excess charge" denials by 1977. There is a danger, however, that implementation of this provision could result in substantial nonparticipation by physicians.

76-539—76——2

SHORT-TERM OPTIONS FOR THE MEDICAID PROGRAM

SUMMARY

The medical assistance program, informally known as medicaid, makes funds available to States to reimburse providers of health care to low income persons. Medicaid operates on an entitlement basis with Federal funding keyed to a State's expenditures for all members of its target population.

The Federal share of total medicaid expenditures is estimated at $8.2 billion for fiscal year 1976 and accounts for more than 85 percent of all health care grants to States and localities channeled through the Department of Health, Education, and Welfare (HEW). Under current policy medicaid has been increasing rapidly, with Federal expenditures for fiscal year 1977 estimated at $9.5 billion and total expenditures at $17.2 billion.

Three major issues with regard to medicaid have been raised this year by Congress, the executive branch, States, and other affected parties. The first and probably overriding issue is how to control spending in a program that has become virtually uncontrollable. The second issue involves the distribution of funds among States. The third issue is the degree of authority and responsibility for the program at Federal and State levels. All of these issues affect the adequacy of benefits.

The President has proposed to consolidate Federal medicaid funds, nearly all of the categorical health grants, the new health planning program and the developmental disabilities program, primarily for the retarded, into a single block grant to States. The inclusion of medicaid would change it from an entitlement program to one subject to authorization and appropriation by Congress. Fiscal year 1977 budget authority for the block grant programs in the President's budget would be $10 billion—$950 million less than the total anticipated under current policy for included programs. By fiscal year 1981, budget authority would be $12.2 billion, $3.6 billion less than the $15.8 billion anticipated under current policy. According to a new distribution formula for Federal funds based primarily on the number of low income persons, equity among States would be promoted. Generally speaking, most Eastern and urban States would lose while Southern and rural States, where benefits and eligibility levels have been low, would gain. Finally, maintenance of State contributions would not be required and nearly all authority to define and operate the program would be delegated to State governments.

Past actions with regard to medicaid may suggest how States might be expected to respond to the President's proposal. Many States that stand to lose under the new distribution formula have already been curtailing their expenditures. Thus it is unlikely that they will be able to invest more of their own funds to maintain current levels of service. If cuts are passed on by States, they are likely to fall most heavily

on certain kinds of service, particularly noninstitutional care. It is difficult to predict the behavior of States who stand to gain. The administration hopes that they will continue to invest their own funds and that the higher total expenditures will increase benefits and eligibility levels.

Three alternatives to the President's proposal are presented here. Each applies only to medicaid and no additional Federal authority would be delegated to States.

The first involves "federalizing" medicaid—establishing a uniform comprehensive benefit package for all low income persons and significantly increasing Federal funding to pay for the additional benefits. It represents the greatest departure from the concept of State autonomy. However, it could offer assurances that beneficiary needs are met while still promoting equity among States. As with the current system, the entitlement nature of the program would remain and funding would be determined by levels of participation. Assuming full implementation, total expenditures in fiscal year 1977 are estimated at $27.6 billion, compared with $17.2 billion under current policy.

One version of the first alternative would be a nearly complete Federal assumption of administrative and fiscal responsibility, as proposed in the medicaid reforms which are included in the catastrophic health insurance legislation introduced by Senators Russell Long and Abraham Ribicoff. With this version State contributions would be frozen at their 1976 levels and the Federal Government would be liable for all increases in costs. The Federal share in fiscal year 1977 would be $21 billion, compared with $9.5 billion under current policy. In a slightly different version, benefits and eligibility levels would be set at the Federal level but States would retain responsibility for administration. State contributions for 1976 would be adjusted for inflation in 1977 and in subsequent years would remain a constant proportion of total expenditures. Thus, after initial adjustments for newly mandated benefits, States would share the burden of increased costs. With this second version, assuming a 12-percent increase in 1976 State contributions, the Federal share in fiscal year 1977 would be $20.1 billion.

The second alternative is close to the President's proposal in that a legislative limit would be placed on Federal spending. However, the limit would be higher. In addition, rather than using a distribution formula to allocate Federal shares to States, as the President's proposal does, under this alternative Congress would use the formula to set total minimum expenditure levels for each State. A specific State contribution to the total minimum expenditure would be required and the Federal Government would pay the difference. Thus there would be more protection for beneficiaries. In other respects, States would retain their current responsibility for program administration within Federal guidelines. This approach might pose problems for States since the Federal limits would leave them entirely liable for cost increases within a given year caused by either unexpected inflation or additional beneficiaries. Assuming allowance for a 12-percent increase over 1976 medicaid expenditures, total expenditures under this alternative for fiscal year 1977 would be $16.7 billion compared with the $17.2 billion projected under current policy. Because the Federal Government would be providing additional funds to States whose total minimum

expenditure is set higher than current levels, its share in 1977 would rise to $10.5 billion compared with $9.5 billion under current policy.

The third alternative would establish a process of negotiation within guidelines to prospectively determine each State's total expenditures and Federal share for the coming year. By using negotiation rather than a formula, this approach would provide incentives to contain costs, meet beneficiary needs, and encourage efficiency-promoting services. Because of the high degree of uncertainty involved, no cost estimates are provided. Since the level of Federal support would be fixed, as with the second alternative, States would be liable for unexpected cost increases within a given year.

INTRODUCTION

Medicaid is the Federal Government's major vehicle for providing health care to low income persons. It makes funds available to States for reimbursement to hospitals, other health care facilities and individual practitioners. States have a great deal of latitude in determining reimbursement rates and covered services. They also have latitude in determining who can receive benefits. While States must provide basic coverage for persons who receive federally assisted welfare payments, it is they and not the Federal Government who set income eligibility levels within Federal definitions of family type, age, or disability.

Medicaid operates on an entitlement basis with Federal funding keyed to total State expenditures. The Federal share of these expenditures, which averages 55 percent, varies from 50 to 78 percent, according to State per capita income. In fiscal year 1976 the Federal share is estimated at $8.2 billion and in fiscal year 1977 at $9.5 billion under current policy.[1] By comparison, other Federal health care grants to States and local agencies channeled through HEW are expected to total $1.6 billion in fiscal year 1976 and $1.7 billion in fiscal year 1977 under current policy.[2]

The President has proposed to consolidate medicaid, the developmental disabilities program, which is primarily for retarded persons and is currently administered by HEW's Office of Human Development, and most but not all nonmedicaid health care grants to States and localities in a single block grant to States. Known as the Financial Assistance for Health Care Act (FAHCA), the proposed block grant would be funded at a level of $10 billion for fiscal year 1977. Current policy estimates for medicaid and the other programs that would be included come to $10.95 billion for fiscal year 1977. Thus the block grant represents a cut of $950 million in budget authority.

This paper will review major issues with regard to the medicaid program, attempt to estimate the impact of the President's proposal on both States and beneficiaries, and analyze alternatives.

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[1] Assumptions for all current policy medicaid estimates in this paper are set forth in Draft Working Paper on 5-year Medicaid Projections, Budget Analysis Division, Congressional Budget Office (CBO), Jan. 26, 1976.

[2] Figures for nonmedicaid health grants are budget authority estimates based on 1976 appropriations and maintenance of current levels of service. These grants include categorical programs targeted on particular conditions or population groups as well as efforts to organize or control the health care system such as health planning, professional standards review organizations (PSRO's) and health maintenance organizations (HMO's). The categorical programs are the subject of a companion report by CBO.

I. MEDICAID ISSUES

Three major issues have been raised this year with regard to medicaid. The first is how to control spending. Specifically, what are the tradeoffs between unilateral spending limits, which would change the entitlement nature of the program, and protection for States and beneficiaries? The second is the distribution of funds among States. Should the present matching system, which rewards eastern and urban States which provide high benefits, be retained or strengthened, or should it be replaced with a formula system that more nearly approximates distribution according to the number of low income persons in each State? The third issue involves responsibility for defining and operating the program. Should State contributions be required, and should States, which now have considerable discretion in determining benefits and eligibility levels, be given more or less authority?

Spending levels

Past increases in medicaid expenditures relate both to the entitlement nature of the program and to general health care cost inflation. Table 1 provides data on trends in medicaid expenditures compared with total health care expenditures for the United States (public and private), total Federal health care expenditures, total State and local health care expenditures, and total HEW health care grants to States and localities. Total medicaid expenditures have increased 142 percent from fiscal year 1971 to fiscal year 1976, from $6.2 billion to $14.9 billion.[3] This resulted from a 29-percent rise in number of beneficiaries, from 18 million in 1971 to 23.2 million in 1976, and a 72-percent rise in average vendor payments per beneficiary, from $353 in 1971 to $606 in 1976. In constant dollars, the average payment per beneficiary has risen only 22 percent. Therefore, inflation has accounted for a much larger proportion of the increase in average payment than additional or enriched services. In addition, the rise in the last 2 years has been increasingly attributable to payments per beneficiary, as growth in caseload has leveled off.

[3] These figures are for all State and Federal costs, including administration and training.

TABLE 1.—TRENDS IN MEDICAID EXPENDITURES COMPARED WITH OTHER SELECTED EXPENDITURES FOR PERSONAL HEALTH CARE

[In millions of dollars]

	Fiscal year									
							1977[1]		1981[1]	
	1971	1972	1973	1974	1975	1976	Current policy	President's proposal	Current policy	President's proposal
Total medicaid expenditures compared with total U.S. expenditures for health care (public and private):										
Total medicaid[2]	$6,176	$7,642	$9,105	$10,171	$12,636	$14,924	$17,236	NA	$25,509	NA
Percent of total United States	(8)	(9)	(10)	(10)	(11)					
Total United States (public and private)[3]	77,162	86,391	95,384	104,030	118,500					
Federal medicaid expenditures compared with total Federal expenditures for health care:										
Federal medicaid[2]	3,359	4,138	4,979	5,833	7,056	8,208	9,480	$9,292	14,030	NA
Percent of total Federal	(18)	(19)	(21)	(21)	(21)					
Total Federal[3]	18,767	22,082	24,280	27,484	33,828					
State and local medicaid expenditures compared with total State and local expenditures for health care:										
State and local medicaid[2]	2,617	3,504	4,126	4,338	5,580	6,716	7,756	NA	11,479	NA
Percent of total State and local	(27)	(32)	(34)	(32)	(35)					
Total State and local[3]	9,837	10,943	12,109	13,395	16,119					
Federal medicaid expenditures compared with total HEW health grants to States and localities:										
Federal medicaid[2]	3,359	4,138	4,979	5,833	7,056	8,208	9,480	9,292	14,030	NA
Percent of total HEW	(80)	(79)	(82)	(84)	(82)					
Total HEW health grants to States and localities[4]	4,201	5,257	6,093	6,974	8,644	9,824	11,206	10,301	16,514	NA

[1] All projections are budget authority.

[2] From HEW, Social and Rehabilitation Services, Medical Services Administration. Includes administrative costs.

[3] From articles on National Health Expenditures, Social Security Bulletin, February 1974, February 1975, and February 1976. Includes expenditures for research, construction, and administration but excludes health manpower training.

[4] Figures for nonmedicaid health grants to States and localities estimated from Federal Aid to State and Local Governments, Budget of the U.S. Government, Special Analyses, 1973, 1974, 1975, 1976, and 1977. Excludes health manpower training.

Medicaid's proportion has grown from 8 percent of total U.S. health care expenditures to 11 percent and the Federal portion of medicaid has grown from 18 percent of Federal health care expenditures to 21 percent. The Federal portion of medicaid continues to account for an overwhelming majority of HEW health care grants to States and localities. Of particular interest is the role of States' and localities' own medicaid expenditures. Medicaid accounted for $2.9 billion of the $6.3 billion increase in all State/local health care expenditures from 1971 to 1975. Legal and political constraints on reducing institutional reimbursement rates have made it difficult for States to limit spending unless they cut noninstitutional services or redefine eligibility standards. At least 20 States did take such actions during calendar year 1975 in the face of continuing economic problems.

Regarding Federal action to curtail medicaid expenditures, the debate centers upon the impact of spending limits, which would change the entitlement nature of the program, on States and beneficiaries. Now, after covered services and eligibility levels have been established, an entitlement program like medicaid has an open-ended obligation to pay for benefits duly received. This is true even if costs increase due to inflation or if the number of beneficiaries increases due to downtrends in the economy and rising public assistance rolls. Currently, responsibility for these unexpected increases is shared by States and the Federal Government. If the Federal Government were to limit its spending unilaterally, States alone would be liable for all increases in costs. Instead of unilateral limits, the Federal Government could offer positive incentives for States to curtail medicaid costs, such as sharing the resulting savings or increasing the Federal share. However, significant economies may not be achieved because of the program's entitlement nature and because of the difficulties in reducing institutional reimbursements described above.

In turn, medicaid's target population can be affected by both spending levels and how reductions are implemented by States. The Federal Government could limit the funds it provides to each State in the aggregate, or it could attempt to influence what the State cuts and incorporate safeguards for beneficiaries.

Distribution

The present distribution of medicaid funds is based on a system that was originally intended to encourage States to provide higher benefits to a larger proportion of their needy populations. Any money a State spends is ultimately matched at least dollar for dollar by Federal funds. While the Federal match varies inversely according to relative per capita income, with the relationship between State and national per capita income being squared to emphasize differences, the resulting figure is adjusted so that no State, however wealthy, receives less than 50 percent. The matching system plus a tradition of higher expenditures in many wealthy industrial States has resulted in such States receiving large proportions of medicaid funds in relation to a federally defined standard of need, as can be seen in comparing the current distribution, shown in column 1 of table 2, with distribution according to proportion of low-income persons and State per capita income, shown in column 3.

TABLE 2.—PERCENTAGE DISTRIBUTION OF FEDERAL MEDICAID FUNDS BY STATE UNDER CURRENT POLICY AND ALTERNATIVE FORMULAS

State	1. Methods based on a Federal match of actual State expenditures	2. Methods based on a distribution formula without the matching feature					
	Current policy	Increasing minimum Federal match to 75 percent	Needy population/ per capita income	Needy population times tax effort factor/ per capita income	Needy population times State health expenditure factor/per capita income	Needy population times medical care cost index factor/ per capita income	Needy population times medical care cost index factor times regional cost of living index factor/per capita income
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Alabama	1.62	1.19	3.47	2.90	2.08	2.86	2.71
Alaska	.09	.09	.10	.07	.03	.10	.11
Arizona	0	0	.97	1.09	.49	1.12	1.13
Arkansas	1.13	.83	2.18	1.81	1.15	1.59	1.51
California	12.18	13.33	6.99	8.45	8.66	9.97	10.08
Colorado	.85	.84	.95	.96	.90	1.06	1.07
Connecticut	1.20	1.31	.64	.67	.41	.78	.86
Delaware	.12	.13	.19	.18	.17	.20	.22
District of Columbia	.69	.76	.31	.29	.99	.40	.45
Florida	1.52	1.45	3.80	3.61	2.23	4.08	3.88
Georgia	2.51	2.08	3.43	3.14	3.82	2.96	2.81
Hawaii	.26	.29	.22	.28	.22	.22	.22
Idaho	.30	.24	.40	.38	.12	.33	.34
Illinois	4.98	5.45	3.40	3.32	3.48	3.45	3.56
Indiana	1.63	1.56	2.05	1.77	1.10	1.88	1.94
Iowa	.92	.88	1.31	1.29	.61	1.14	1.17
Kansas	.72	.73	.98	.99	.96	.92	.95
Kentucky	1.53	1.17	2.80	2.57	1.98	2.16	2.05
Louisiana	1.72	1.30	3.54	3.75	5.74	2.92	2.77
Maine	.66	.51	.67	.74	.31	.58	.64
Maryland	1.73	1.89	1.29	1.30	1.44	1.39	1.55
Massachusetts	3.83	4.20	1.70	2.06	2.36	2.22	2.47
Michigan	5.09	5.58	2.70	2.80	3.02	3.11	3.21
Minnesota	2.12	2.05	1.55	1.88	1.73	1.72	1.77
Mississippi	1.16	.84	3.18	3.11	2.78	2.49	2.36
Missouri	.94	.88	2.56	2.35	1.85	2.49	2.57
Montana	.24	.21	.39	.41	.13	.37	.37
Nebraska	.37	.37	.72	.71	.55	.63	.65
Nevada	.15	.16	.16	.19	.07	.21	.22
New Hampshire	.26	.23	.28	.27	.11	.25	.28
New Jersey	2.57	2.80	1.86	1.73	1.68	2.10	2.34
New Mexico	.31	.23	.99	1.05	.41	.88	.89
New York	18.75	20.52	6.20	8.65	19.44	8.84	9.85
North Carolina	1.75	1.40	3.94	3.47	2.47	3.08	2.93
North Dakota	.20	.19	.34	.32	.10	.33	.34
Ohio	3.06	3.08	3.81	3.30	2.43	3.59	3.70
Oklahoma	1.42	1.15	1.93	1.62	1.47	1.88	1.78
Oregon	.77	.72	.87	.92	.60	.79	.80
Pennsylvania	4.73	4.67	4.68	4.95	4.44	4.60	3.73
Rhode Island	.65	.64	.34	.38	.37	.44	.49
South Carolina	.97	.73	2.35	2.22	.96	1.49	1.42
South Dakota	.23	.19	.53	.54	.18	.45	.46
Tennessee	1.63	1.27	3.27	2.84	3.26	2.56	2.43
Texas	5.33	4.59	7.72	6.45	8.64	8.40	7.97
Utah	.36	.28	.57	.61	.21	.42	.42
Vermont	.33	.26	.25	.35	.19	.28	.31
Virginia	1.45	1.36	2.50	2.22	1.57	1.98	1.83
Washington	1.42	1.52	1.17	1.16	.91	1.06	1.07
West Virginia	.44	.33	1.56	1.51	.53	1.07	1.02
Wisconsin	3.07	2.81	2.04	2.17	1.34	2.05	2.12
Wyoming	.06	.05	.15	.16	.06	.12	.13
Total [1]	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1] May not add due to rounding.

Sources: Needy population: Actual number of persons in each State whose income is under 150 percent of poverty level, 1970 Census. This figure rather than actual poverty level is used to include an approximation of the number of persons potentiallv eligible for medicaid through a spend-down of income for medical purposes. The cut-off is adjusted for rural and urban populations but not for cost differences between one section of the country and another. Per capita income: Total money income for all persons residing in a State divided by the number of residents. From Survey of Current Business, U.S. Department of Commerce, 1975. Tax effort factor: Derived for each State by dividing State and local taxes collected for a given year by the State's aggregate personal income; thus it measures a State's willingness to tax its citizens. From General Revenue Sharing, Initial Data Elements, Entitlement Period 6, U.S. Department of the Treasury April 1975. State health expenditure factor: Derived by HEW from 1975 State expenditures for health. Does not include Federal funds expended by States; it measures a State's willingness to spend its own money on health purposes. Medical care cost index factor: Derived from 1974 medicare expenditures for each State, adjusted for utilization differences. Cost of living index factor: Derived using CPI data, U.S. Department of Labor, to estimate differences between 4 major regions of the country.

Representatives of such States and their medicaid beneficiaries believe that the Federal Government should continue its support for the high benefits and eligibility levels it encouraged in the first place. In fact, since some State and local governments are hard pressed to meet current expenses, legislation has been introduced in Congress to raise the floor of the current Federal match from 50 to 75 percent. This would substantially increase Federal funds and nearly equalize the proportion of their expenditures all States receive from the Federal Government. However, it would shift the distribution of Federal funds among States even more toward wealthy industrial States, as shown in the second column of table 2. Advocates of increasing the Federal match argue that equity among States with regard to needy population should be achieved only by still more Federal funds to bring citizens of poorer States who receive low benefits up to higher levels.

Some of those who want to move towards equity among States without additional Federal funds would alter the current matching system so that wealthy States would receive less than 50 percent. Others would eliminate the matching system altogether, arguing that it is no longer appropriate to encourage State expenditures.

The impact of various formulas to distribute Federal medicaid funds unilaterally without a matching system is also shown in table 2. All utilize a Federal notion of need, defined by proportion of low-income persons, and State ability to pay, defined by per capita income. Switching from current policy to a formula based on these factors alone, shown in column 3, would benefit poor Southern and farm States most. If a factor for relative tax effort is included to reward States for raising higher revenues, as shown in column 4, a number of partially rural but not necessarily poor States would benefit. Some believe that the inclusion of tax effort is not appropriate since State revenues may be spent primarily for education and transportation rather than health care. The distribution in column 5 substitutes State health expenditures for tax effort. New York, Georgia, Texas, and the District of Columbia do best under this formula because of their own high health expenditures.

Others believe that while distribution should not attempt to reward any particular behavior on the part of States, it should reflect the cost of medical care. This distribution is shown in column 6, using an adjustment for State variations in medical care costs as great as 35 percent above and 30 percent below the national average. One problem raised with such an adjustment is that it may encourage inflation. However, it can also be argued that the adjustment merely recognizes higher need in a situation where not doing so would probably have adverse effects on beneficiaries rather than reducing inflated prices. While the reasoning is different, this formula has an effect similar to the one using tax effort.

Finally, column 7 shows the same distribution adjusted again by a very rough factor reflecting cost-of-living differences in four national regions.[4] Again, it can be argued that this kind of adjustment tends

[4] This adjustment is used in addition to that for medical care costs because it affects the number of anticipated beneficiaries as opposed to the cost per beneficiary. Regional variations are extremely imprecise; they are used here for illustrative purposes because reliable published cost-of-living figures are not available by State.

to reinforce lower standards of living in some areas. The counter argument is that the definition of needy does in fact vary by region in a way unlikely to be affected by specific funding allocations. This last distribution has the advantage of including both factors usually suggested as adjustments for need. Most of the States with the highest proportional shares under current policy or the formula that included health expenditures do second best under this formula. However, its redistributional impact is still quite strong: Federal funds allocated to high-benefit States like Massachusetts and New York would be decreased by 36 and 47 percent, respectively, and Federal funds allocated to poor Southern States like Alabama, Mississippi, and Louisiana would be increased by 60 to 100 percent.

Authority for program policy and operation

Under medicaid, States define their own eligibility levels and benefit packages within broad Federal guidelines. State expenditures are required to trigger Federal contributions. HEW must review and approve the State medicaid plan, although implementation is closely monitored in only a few instances. The kind of Federal constraints imposed, as well as the State flexibility that is allowed, have helped lead to great irregularity in benefits received. For example, 28 percent of those defined as poor are not covered at all. Some are not covered because they do not fit within Federal welfare definitions and some because they reside in States with lower income cutoffs. Conversely, 30 percent of those who are covered are above the Federal poverty line. Moreover, expenditures per beneficiary are more than five times as great in the highest benefit State, Alaska, as they are in the lowest benefit State, Mississippi. This difference is much greater than the variance in medical care costs.

Many believe that the existing division of authority for medicaid between States and the Federal Government is less than optimal. Some, including the administration, argue that States can best determine their own residents' health care needs, are better situated to contain costs because of their own budget limits, and should be allowed to formulate programs with virtually no Federal restrictions and no required contributions. Others think the Federal Government has a responsibility to beneficiaries that States may not always fulfill. They would move in the direction of federally imposed eligibility standards and more extensive required benefits. It should be noted, however, that if the Federal Government also assumed all financial responsibility for the program, States would have no incentive for cost control.

II. THE PRESIDENT'S PROPOSAL

The President's proposed health block grant would deal with the issues discussed above by unilaterally reducing the total sum available for both medicaid and nonmedicaid grants, redistributing funds among States according to a formula based on the proportion of low-income persons and per capita income adjusted by State tax effort, and delegating nearly all authority to State governments.

Impact of funding cuts

The $950 million cut from the current policy level of $10.95 billion to $10 billion for fiscal year 1977 has already been noted. In addition, the block grant would establish three spending categories: Personal health services, including medicaid and categorical grant programs providing medical services; community health services, including categorical grant programs providing mental health and disease prevention services; and health planning and resource development. Most of the cuts would be concentrated in the personal health services category, for which States could spend no less than $9 billion but no more than $9.5 billion in Federal funds during fiscal year 1977. Under current policy, Federal expenditures for medicaid and the other programs that fall into this category are expected to equal $10.2 billion. Thus between $700 million and $1.2 billion would be cut from personal health services.

In future years, the President's proposal would change medicaid from an entitlement program to a straight grant program on the Federal level. Federal funds would be subject to periodic authorization ceilings and annual appropriations as part of the FAHCA block. Assuming that annual increments of $500 million for fiscal year 1978–80 and $600 million to $700 million thereafter are authorized and appropriated, as planned in the proposal, by fiscal year 1981 States would receive $12.2 billion—$3.6 billion less than the $15.8 billion estimated by CBO for 1981 under current policy for all programs included in the block grant.

Impact of redistribution

The President's proposal takes the position that substantial change in the current distribution is desirable to achieve equity among States. The formula by which it would redistribute medicaid and nonmedicaid health grants is based on the proportion of low income persons and per capita income, adjusted for State tax effort but not adjusted for regional differences in cost of living. The tax effort factor serves to soften the blow of redistribution slightly.

The new formula would be phased in slowly so that no State would experience an actual dollar loss from 1976 levels. However, in real terms the President's proposal would entail very substantial shifts away from the wealthy States that currently provide high benefits.[5]

Table 3 provides annual dollar estimates of each State's total for all block grant programs under current policy and if FAHCA were implemented. By 1981, 17 States would be receiving 75 percent or less of aid projected under current policy and 13 would be receiving 65 percent or less. Seven of the latter are Eastern urban States. Conversely, 13 States would be receiving 115 percent or more of aid projected under current policy. Of these, 10 are Southern and 3 are Western rural States.

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[5] The proposal originally called for redistribution to begin immediately and for the new formula to be fully implemented by 1986. HEW legislation provides for a much slower redistribution during the first few years; starting in 1981 redistribution would accelerate but the yearly increments of $600 to 700 million, rather than $500 million as originally planned, would soften the impact. Implementation would be completed for all but seven States in 1986.

TABLE 3.—COMPARISON OF FEDERAL HEALTH AID UNDER FAHCA AND CURRENT POLICY, BY STATE, FISCAL YEARS 1977 AND 1981

[Dollar amounts in millions]

	Fiscal year 1977			Fiscal year 1981		
	Federal aid under current policy[1]	Federal aid under FAHCA	Federal aid under FAHCA as percent of Federal aid under current policy	Federal aid under current policy[1]	Federal aid under FAHCA	Federal aid under FAHCA as percent of Federal aid under current policy
Alabama	$179.7	$171.5	95	$259.0	$298.9	115
Alaska	14.0	11.8	84	19.2	11.5	60
Arizona	18.1	13.8	76	22.2	24.0	108
Arkansas	128.4	122.2	95	184.5	213.0	115
California	1,281.1	1,155.2	90	1,862.5	1,127.5	61
Colorado	108.4	94.5	87	165.2	115.2	70
Connecticut	125.4	113.5	91	182.4	110.8	61
Delaware	16.2	14.2	88	22.6	21.7	96
District of Columbia	86.6	76.3	88	122.7	74.4	61
Florida	195.4	181.0	93	276.1	315.5	114
Georgia	269.8	259.3	96	390.8	375.5	96
Hawaii	34.2	30.1	88	48.2	33.2	68
Idaho	36.5	34.2	94	52.0	45.5	87
Illinois	522.3	470.5	90	759.7	459.2	60
Indiana	182.7	173.6	95	263.1	211.0	80
Iowa	99.9	95.5	96	144.5	154.2	106
Kansas	82.4	78.0	95	118.4	118.1	99
Kentucky	176.6	167.7	95	253.2	292.2	115
Louisiana	183.7	176.6	96	266.4	307.6	115
Maine	74.2	70.9	96	106.8	88.2	82
Maryland	196.3	174.3	89	282.1	170.1	60
Massachusetts	403.0	363.6	90	586.0	354.9	61
Michigan	523.6	473.9	91	764.0	462.5	61
Minnesota	219.8	198.6	90	320.3	224.6	70
Mississippi	134.7	128.0	95	193.1	223.1	116
Missouri	124.4	115.2	93	175.2	200.7	115
Montana	30.4	28.4	93	43.1	49.4	114
Nebraska	48.1	44.7	93	68.0	77.8	114
Nevada	18.6	17.3	93	26.3	23.0	87
New Hampshire	29.9	26.4	88	42.9	32.2	75
New Jersey	281.4	251.0	89	406.5	245.0	60
New Mexico	41.0	38.0	93	57.7	66.3	115
New York	1,878.0	1,711.4	91	2,751.4	1,670.4	61
North Carolina	201.7	191.6	95	289.6	333.8	115
North Dakota	25.8	23.2	90	36.5	38.3	105
Ohio	336.5	310.4	92	485.9	393.9	81
Oklahoma	154.7	148.1	96	223.8	193.4	86
Oregon	89.7	86.1	96	128.5	110.0	85
Pennsylvania	519.7	464.1	89	750.5	591.5	79
Rhode Island	69.1	62.2	90	100.3	60.7	61
South Carolina	121.4	113.9	94	172.2	198.5	115
South Dakota	27.1	25.5	94	38.8	44.5	115
Tennessee	186.3	177.0	95	267.5	308.4	115
Texas	578.1	554.2	96	836.5	771.1	92
Utah	45.5	42.5	93	64.4	72.8	113
Vermont	36.9	32.9	89	53.1	41.7	78
Virginia	162.1	154.0	95	233.4	265.0	114
Washington	158.9	141.2	89	228.8	138.4	60
West Virginia	59.0	54.6	93	82.8	95.1	115
Wisconsin	312.3	283.5	91	456.6	276.7	61
Wyoming	9.7	8.8	91	13.3	15.3	115
Guam	2.0			2.5		
Puerto Rico	48.8			65.3		
Virgin Islands	3.2	47.2		4.1	53.7	
American Samoa	.8			1.0		
Trust territories	1.7			2.1		
Total	10,951.0	10,000.00		15,800.0	12,200.0	

[1] Block grant programs only. Includes local aid within each State. Columns do not add precisely to totals due to allocation of increases (medicaid and other programs) by State.

Impact of State authority and likely response

The impact of delegating to States nearly all policymaking and operating authority for funds now channeled through the medicaid program would be to eliminate Federal approval of plans, mandated State contributions and minimum benefits and eligibility requirements.[6] Thus, State responses will determine how the FAHCA block grant will ultimately affect medicaid beneficiaries. While there is no precedent for the sweeping changes that FAHCA would generate, it may be useful to examine past State actions with regard to medicaid.

Table 4 provides information on State medicaid histories as well as whether each State would gain or lose Federal health dollars under FAHCA. There appears to be a high correlation between major losers under FAHCA and those States whose medicaid expenditures are high relative to overall personal income and which serve a larger proportion of their low-income populations. Many States who stand to lose have been curtailing outlays, indicating their budgets are already severely squeezed. Thus, it is extremely unlikely that most of the losers will be able to spend more of their own funds at current tax levels, particularly if the economy does not recover rapidly. Furthermore, for many who lose, the decreases are substantial enough so that even if the State chose to cut all possible nonmedicaid programs first, some further reduction in medicaid would also be necessary unless it raised taxes.

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[6] One exception is that while States could establish cost sharing for beneficiaries within a set reimbursement rate, providers would be prohibited from billing recipients for additional payments on their own. In addition, States would be required to establish their own public planning procedures for spending the block grant funds.

TABLE 4.—STATE MEDICAID TRENDS RELATED TO GAINS AND LOSSES IN FEDERAL AID UNDER FAHCA PROPOSAL

	Projected FAHCA share as percent of Federal aid under current policies, fiscal year 1981	Total program growth exceeded 250 percent, fiscal year 1971–76	Ratio of State medicaid contributions to personal income was above national average, fiscal year 1974	Received lowest possible Federal share under current policy, fiscal year 1976	Were serving over 50 percent of low income population, fiscal year 1970	Among top 20 in total medicaid expenditures, fiscal year 1974	Initiated cutbacks during calendar year 1975
Major losers:[1]							
Alaska	60			X			X
California	61		X	X	X	X	
Colorado	70				X		
Connecticut	61			X	X	X	
District of Columbia	61		X	X	X		
Hawaii	68			X	X		
Illinois	60		X	X	X	X	X
Maryland	60			X	X	X	X
Massachusetts	61		X	X	NA	X	X
Michigan	61		X	X	X	X	X
Minnesota	70		X		X	X	
New Hampshire	75	X					X
New Jersey	60			X	X	X	X
New York	61		X	X	X	X	X
Rhode Island	66		X		X		
Washington	60				X	X	
Wisconsin	61		X		X	X	X
Major gainers:[2]							
Alabama	115	X					X
Arkansas	115	X					
Kentucky	115	X					
Louisiana	115	X					X
Mississippi	116	X					
Missouri	115	X					
New Mexico	115						
North Carolina	115					X	
South Carolina	115	X					
South Dakota	115	X					X
Tennessee	115	X					
West Virginia	115	X					
Wyoming	115	X					
Other States:							
Arizona	108						
Delaware	96			X	X		
Florida	114					X	X
Georgia	96	X				X	X
Idaho	87	X					
Indiana	80	X				X	
Iowa	106	X					
Kansas	99	X					
Maine	82	X					X
Montana	114	X					
Nebraska	114						
Nevada	87			X			X
North Carolina	105						
Ohio	81	X				X	X
Oklahoma	86					X	X
Oregon	85	X					
Pennsylvania	79				X	X	
Texas	92	X				X	X
Utah	113	X					
Vermont	78	X	X		X		
Virginia	114	X				X	X

[1] Projected FAHCA share in fiscal year 1981 is 75 percent or less of Federal aid projected under current policy.
[2] Projected FAHCA share in fiscal year 1981 is 115 percent or more of Federal aid projected under current policy.

Based on the reaction of the 20 States with medicaid reductions during calendar year 1975, future cuts resulting from the block grant may fall most heavily on the number and type of services covered (15 of the 20 States eliminated certain services). Second, the block grant cuts may cause reductions in the rate at which providers are reimbursed (9 of the 20 States reduced rates). Third, the beneficiary could be asked to pay a share, or a larger share, of his medical bills (6 of the 20 States increased beneficiary charges). Fourth, and least likely, the number of eligible persons could be reduced (3 of the 20 States eliminated some eligible persons). In choosing what kind of services to eliminate or reduce reimbursements for, States are more likely to protect hospitals and nursing homes, as they have in the past, because of statutory restrictions and because institutions are so dependent on existing funding. Traditional physician services would be less protected, but most likely to suffer would be newer outpatient alternatives such as preventive and home health care. In addition, States that have not approved reimbursement for physicians' assistants and nurse practitioners as alternatives to the exclusive use of physicians may continue their resistance. Thus, two kinds of alternatives believed to increase efficiency may not be implemented. On the other hand, it is possible that the cuts may stimulate major reforms such as experimentation with prepaid health care.

For States that gain funds under FAHCA, relevant historical information is extremely scanty. The gainers in most cases are fairly poor States that have had high Federal matching shares in the past and have provided comparatively low benefits. The administration hopes that they will continue to invest their own funds in the absence of matching requirements and that the substantial increases that would result from combined State and Federal sources will result in a richer benefit package for a greater proportion of their low income populations. The fact that nearly all of the major gainers were above the median State medicaid growth rate for fiscal years 1971–76 may tend to support this. However, they could eliminate their own contributions and have a program financed by Federal funds only. Furthermore, as with losing States, the tendency to favor institutional and traditional physician services might continue.

III. ALTERNATIVE OPTIONS

The anticipated State response to the President's proposal—or the degree of uncertainty that surrounds the State response—may or may not be acceptable. Three alternative options are presented here. Each applies only to medicaid and would not involve delegation of additional Federal authority to the States.[7] The first would "federalize" medicaid by establishing uniform eligibility levels and a comprehensive benefit package. This alternative would add significantly to Federal funds to pay for the additional benefits. This could be accompanied by complete Federal assumption of administrative responsibility and

[7] For a discussion of alternative options for nonmedicaid health grants, see CBO's companion report on categorical programs.

an eventual phaseout of State financial participation, or the Federal Government could continue to share responsibility for administration and for subsequent cost increases with States. The second alternative would distribute Federal funds according to a formula similar to FAHCA's, but with a higher cap on expenditures and a required State contribution. The third would establish a process of negotiation within guidelines to determine total expenditures, using incentives to achieve Federal objectives. Table 5 summarizes spending and distribution variables, while table 6 provides information on expenditures by State under current policy, the President's proposal and the first and second alternatives. The third alternative is not susceptible to cost estimates.

The following objectives, which represent the differing points of view about each issue discussed in section I, can be used as criteria to evaluate any of these medicaid options:

TABLE 5.—SUMMARY OF SPENDING AND DISTRIBUTION VARIABLES FOR MEDICAID OPTIONS: CURRENT POLICY, PRESIDENT'S PROPOSAL AND ALTERNATIVES

[Dollar amounts in billions]

	How would spending be determined initially to implement the new mechanism?			Fiscal year 1977 costs, assuming full implementation of new mechanism					How many States would gain or lose Federal funds compared with current policy for 1977 assuming full implementation?	
	Total [1]	Federal	State [1]	Total	Federal	State	Federal share as, percent of total	What will happen to Federal spending as a percentage of total costs in subsequent years?	Gain	Lose
Current policy	Retrospective reimbursement of actual expenditures by States, with Federal guidelines.	A percentage of each State's expenditures, with higher percentage for States with lower per capita incomes.	Difference between total and Federal.	$17.2	$9.5	$7.6	55	Will remain constant at 55 percent except for changes in per capita income.		
President's proposal	The Federal share allocated by formula plus whatever the State wants to spend.	A predetermined amount authorized and appropriated by Congress for medicaid and other health programs and allocated to the State by formula.	Whatever the State wants to spend—no required State contribution.	[2] (15.9)	[2] (9.3)	[2] (6.6)	(58)	Variable according to States' contribution.	37	14
Alternative 1a: Federalized medicaid with Long-Ribicoff provisions.	Retrospective reimbursement of actual expenditures directly by the Federal Government.	Difference between 1976 State contribution and total expenditures.	Same contribution as under current policy in 1976.	27.6	21.0	6.6	76	Will increase each year.	50	1

Alternative 1b: Federalized medicaid with maintenance of State responsibility.	Retrospective reimbursement of actual expenditures by States with explicit Federal requirements for comprehensive benefits to all low income persons.	Difference between adjusted State contribution and total expenditures.	Same contribution as under current policy in 1976, but adjusted for inflation—e.g., 12 percent.	27.6	20.1	7.5	73	The new percentages for each State established in 1977, which average 73 percent nationally, will remain constant. However, they could be adjusted for changes in per capita income.	49	2
Alternative 2: Formula distribution with required State contribution.	Total minimum expenditure determined by Congress and allocated to each State by formula.	Difference between State contribution and total minimum expenditure set by Congress.	If State's total minimum is more than its 1976 total, its contribution for 1976 under current policy would be adjusted for inflation. If State's total minimum is less than its 1976 total, the percent it contributes under current policy would be applied.	16.7	10.5	6.2	63	The new percentages for each State established in 1977, which average 63 percent nationally, will remain constant. However, they could be adjusted for changes in per capita income.	36	15
Alternative 3: Negotiated State and Federal shares.	By negotiation between Federal Government and each State.	By negotiation between Federal Government and each State.	Difference between total and Federal.	NA	NA	NA	NA	NA	NA	NA

[1] Amounts given are minimum. States's and therefore total expenditures could always be greater.

[2] For illustration only. Assumes 1977 Federal medicaid expenditures, projected in Budget of the U.S. Government, which are lower than the CBO estimate, and State maintenance of 1976 effort. Actually under the block grant States could choose to spend more or less of their Federal funds for medicaid and they could spend less or none of their own funds for medicaid.

TABLE 6.—TOTAL EXPENDITURES AND FEDERAL SHARE OF MEDICAID UNDER CURRENT POLICY, THE PRESIDENT'S PROPOSAL, AND ALTERNATIVES, BY STATE (ALL EXPENDITURES EXCEPT THOSE FOR 1976 ARE 1977 ESTIMATES BUT FULL IMPLEMENTATION OF NEW PROGRAMS IS ASSUMED) [1]

[In millions of dollars]

State	1976 expenditures		Current policy		President's proposal [2]		Alternative 1b: Federalized medicaid with maintenance of State responsibility [3]		Alternative 2: Formula distribution with required State contribution [4]	
	Total	Federal	Total	Federal	Total	Federal	Total	Federal	Total	Federal
Alabama	$179.3	$132.3	$206.1	$152.1	$316.5	$269.5	$584.6	$532.0	$354.4	302.0
Alaska	14.2	7.1	16.2	8.1	13.6	6.5	38.0	32.0	23.4	15.5
Arizona [5]					101.3	101.3	297.3	179.8	180.4	109.8
Arkansas	124.1	92.6	142.7	106.5	199.7	168.2	323.4	288.1	195.4	160.1
California	1,994.4	997.2	2,293.6	1,146.8	1,782.4	785.2	3,108.1	1,991.2	1,180.4	934.6
Colorado	126.8	69.3	145.8	79.8	146.7	89.2	301.2	236.8	182.0	98.9
Connecticut	195.8	97.9	225.1	112.6	160.2	62.3	284.8	175.2	172.0	85.5
Delaware	18.9	9.4	21.7	10.8	26.1	16.7	70.1	59.6	41.8	31.3
District of Columbia	113.1	56.6	130.1	65.0	83.5	26.9	161.5	98.1	98.5	48.2
Florida	216.8	124.3	249.3	143.0	427.9	335.4	1,138.9	1,035.3	689.7	586.1
Georgia	310.4	205.2	357.0	236.0	397.0	291.8	683.7	565.9	414.2	296.4
Hawaii	43.1	21.5	49.6	24.8	47.5	26.0	69.5	45.3	41.8	20.9
Idaho	36.1	24.6	41.5	28.3	46.8	35.3	84.9	72.0	51.8	38.9
Illinois	815.6	407.8	937.9	469.0	716.3	308.5	1,113.8	657.1	686.4	340.0
Indiana	232.6	133.7	267.5	153.7	263.4	164.5	514.0	403.2	310.6	199.8
Iowa	131.6	75.2	151.3	86.4	176.3	119.9	316.1	252.9	192.1	128.9
Kansas	109.4	59.1	125.8	68.0	142.3	92.0	266.5	210.2	162.0	105.7
Kentucky	175.2	125.0	201.5	144.0	289.0	238.8	465.5	409.3	282.2	226.0
Louisiana	194.4	140.8	223.6	161.9	402.1	348.5	621.4	561.4	375.8	315.8
Maine	76.2	53.8	87.7	61.9	91.2	68.8	150.9	125.8	91.9	66.8
Maryland	283.1	141.6	325.6	162.8	262.4	120.8	470.4	311.9	283.9	125.4
Massachusetts	627.8	313.9	722.0	361.0	505.3	191.4	728.3	376.7	440.9	219.1
Michigan	834.4	417.2	959.6	479.8	677.4	260.2	965.7	498.4	584.5	290.4
Minnesota	305.5	173.6	351.3	199.7	306.5	174.7	490.4	342.7	297.3	168.0

Mississippi	121.5	95.1	139.7	109.4	55.3	289.0	459.4	429.8	277.2	247.6
Missouri	130.9	77.2	150.6	88.8	272.1	218.4	661.8	601.7	400.8	340.7
Montana	31.6	20.0	36.3	23.0	49.7	38.1	93.3	80.3	56.8	43.8
Nebraska	55.2	30.7	63.5	35.3	90.5	66.0	176.6	149.2	106.9	79.5
Nevada	24.4	12.2	28.1	14.2	29.8	17.6	66.3	52.6	40.1	26.4
New Hampshire	35.1	21.1	40.3	24.3	39.0	25.1	71.7	55.9	43.4	27.7
New Jersey	420.1	210.1	483.1	241.6	370.9	160.8	748.2	512.9	452.6	217.3
New Mexico	34.3	25.1	39.4	28.9	106.8	97.6	189.2	178.9	115.2	104.9
New York	3,071.0	1,535.5	3,531.7	1,765.8	2,339.3	803.8	3,100.4	1,380.6	1,875.4	932.1
North Carolina	210.1	142.9	241.6	164.4	389.6	322.4	697.6	622.3	422.5	347.2
North Dakota	28.9	16.6	33.2	19.1	41.9	29.7	97.8	84.0	58.5	44.7
Ohio	461.0	250.8	530.2	288.4	516.9	306.6	1,043.2	807.8	631.3	395.9
Oklahoma	172.5	116.3	198.4	133.8	206.7	150.5	417.1	354.2	252.2	189.3
Oregon	107.4	63.4	123.5	72.9	129.5	85.5	214.9	165.6	130.3	81.0
Pennsylvania	698.8	397.1	803.6	445.1	771.7	460.0	1,424.8	1,086.9	861.7	523.8
Rhode Island	94.7	53.5	108.9	61.6	76.4	35.3	133.9	129.0	81.8	45.1
South Carolina	108.5	79.8	124.7	91.8	235.0	206.3	311.9	279.8	188.7	156.6
South Dakota	28.1	18.9	32.3	21.7	59.4	50.2	111.6	102.3	66.8	56.5
Tennessee	189.6	133.5	218.0	153.6	320.0	263.9	565.2	502.4	342.4	279.6
Texes	685.9	436.2	788.8	501.6	849.0	599.3	2,018.4	1,955.6	1,220.8	941.1
Utah	41.7	29.2	48.0	33.6	69.2	56.7	95.9	81.9	58.5	44.5
Vermont	38.1	26.6	43.9	30.6	44.0	32.5	71.6	58.7	43.4	30.5
Virginia	203.0	118.4	233.4	136.1	290.9	206.9	513.2	287.9	310.6	215.9
Washington	216.0	116.1	248.4	133.5	207.8	107.8	309.1	197.2	187.0	100.8
West Virginia	49.6	35.7	57.1	41.0	154.2	140.3	227.3	211.7	136.9	124.8
Wisconsin	420.8	252.1	483.9	299.9	370.3	201.6	473.3	284.4	287.2	170.1
Wyoming	8.2	5.0	9.4	5.7	18.1	14.9	34.7	31.1	38.4	34.8
Total	14,924.0	8,208.0	17,236.0	9,480.0	15,929.2	9,292.0	27,597.8	20,141.8	16,700.0	10,513.2

[1] Implementation is actually likely to be phased in over several years for new options.

[2] For illustrative purposes, totals assume State maintenance of 1976 effort. Federal share uses administration estimates for 1977 medicaid expenditures without FAHCA: $9,292, distributed according to population under 1.5 poverty level times tax effort divided by per capita income.

[3] Total equals the sum of the following for each State: Population under 1.5 poverty level times cost of living index times $650 times medical care cost index. Federal share equals total minus 1976 State contribution inflated by 12 percent. Please note that for Alternative 1a: Federalized medicaid with Long-Ribicoff provisions, total expenditures for each State should be similar to those for Alternative 1b. State contributions, frozen at 1976 levels, would be slightly smaller. Therefore the Federal share for each State would be slightly larger.

[4] Total equals $14,900 inflated by 12 percent: $16,700, distributed according to population under 1.5 poverty level times cost of living index times medical cost index. Federal share equals total minus 1976 State contributions inflated by 12 percent (for States whose total is larger than in 1976) or current matching formula applied to total (for States whose total is smaller than in 1976).

[5] Arizona does not participate in the medicaid program currently.

Note: Columns may not add to totals because they exclude U.S. territories and in some cases reflect imprecisions in allocation.

—Limit Federal spending unilaterally.
—Provide incentives to States to contain costs.
—Protect States against sudden increases in spending.
—Distribute Federal funds according to equity among States with regard to low-income population.
—Distribute Federal funds to continue support to high benefit States.
—Give States autonomy.
—Insure State contribution.
—Insure reimbursement of efficiency-promoting services.
—Insure that beneficiary needs are met.

Table 7 summarizes the degree to which the criteria are met under current policy, the President's proposal and the alternatives. A more detailed discussion of the alternatives follows.

TABLE 7.—EVALUATION OF MEDICAID OPTIONS: CURRENT POLICY, PRESIDENT'S PROPOSAL AND ALTERNATIVES

Policy criteria	Options					
	Current policy	President's proposal	Alternative 1a: Federalized medicaid with Long-Ribicoff provisions	Alternative 1b: Federalized medicaid with maintenance of State responsibility	Alternative 2: Formula distribution with required State contribution	Alternative 3: Negotiated State and Federal shares
Limit Federal spending unilaterally	No	Yes	No	No	Yes	Partial.
Provide incentives to States to contain costs	Yes	Yes	No	Yes	Yes	Yes.
Protect States against sudden increases in spending.	Partial	No	Yes	Partial	No	No.
Distribute Federal funds according to equity among States with regard to low income population.	No	Yes	Yes	Yes	Yes	Partial.
Distribute Federal funds to continue support to high benefit States.	Yes	No	Yes	Yes	No	Partial.
Give States autonomy	Partial	Yes	No	No	Partial	Partial.
Insure State contribution	Yes	No	Yes	Yes	Yes	Yes.
Insure reimbursement of efficiency-promoting services.	Partial	No	Yes	Yes	Partial	Partial.
Insure that beneficiary needs are met	Partial	No	Yes	Yes	Partial	Partial.

Alternative 1: Federalized medicaid

This alternative incorporates the concept of a federalized medicaid program that is part of legislation to provide insurance coverage for catastrophic illness introduced by Senators Russell Long and Abraham Ribicoff. Uniform eligibility levels and a single comprehensive benefit package would be established. The cost of the additional benefits would be borne by the Federal Government. Once the new requirements were implemented, expenditures would still be tied to participation, as they are now, so that there would be no direct limits on Federal spending. This is the only option reviewed here that would offer assurances of meeting specific beneficiary needs. Efficiency-promoting services and incentives for ambulatory as opposed to inpatient care could be included in the required benefit package.

Total expenditures for a federalized medicaid program in fiscal year 1977, assuming full implementation, can be estimated for each State by multiplying the number of low-income persons, with poverty definition adjusted for cost of living differences, by the cost of a standard comprehensive benefit package ($650), adjusted for variations in medi-

cal care costs.[8] The sum of these estimated total expenditures is $27.6 billion—$10.5 billion more than the current policy estimate of $17.2 billion for fiscal year 1977.

Greater equity than now exists among States would be achieved in the distribution of Federal funds. Federal dollars to poorer States currently providing low benefits would be substantially increased. At the same time, because of the expansion in overall Federal spending, support to States providing high benefits would not be significantly reduced.

Within the federalized medicaid concept, there are two ways of handling the question of State versus Federal responsibility for program administration and financing.

1a. Long-Ribicoff provisions.—Under the Long-Ribicoff proposal, the Federal Government would assume nearly all administrative duties. While State financial contributions would be required, they would be frozen at 1976 dollar levels. Thus the Federal share would increase proportionately in future years, even after initial adjustments are made for newly mandated benefits. States would have neither authority nor incentive to contain costs. They would be completely protected against increases, whatever the cause. With this version of a federalized medicaid program, the Federal share of fiscal year 1977 expenditures can be estimated at $21 billion, compared with the current policy estimate for 1977 of $9.5 billion.

1b. Maintenance of State responsibility.—With a variant of the federalized medicaid concept, States would continue to administer the program within the new Federal requirements. Initially, new State and Federal proportions of total expenditures would be determined by inflating 1976 State contributions. The Federal Government would pay for the remainder, thus assuming responsibility for newly mandated benefits. However, in subsequent years each State's contribution would remain a constant proportion of total expenditures. Thus States would retain both the means and the incentive to contain costs. They would continue to share with the Federal Government the burden of cost increases due to inflation or to an influx of beneficiaries resulting from downtrends in the economy. With this version, the Federal share of fiscal year 1977 expenditures can be estimated at $20.1 billion.

Alternative 2: Formula distribution with required State contribution

This alternative is closer to the President's proposal in that a cap would be placed on Federal expenditures and funds would be distributed among States according to a formula with no matching feature. However, there would be more protection for beneficiaries than with either the present system or FAHCA because spending levels would be higher and a minimum State contribution would be required. States that gain could not shift the burden to the Federal Government.

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[8] The cost reflects a benefit package in 1977 dollars similar to that provided employed persons in the administration's 1974 CHIP proposal for national health insurance but without cost sharing and with unlimited long-term care (full physician, hospital and prescription drug coverage, limited mental health and no adult dental care).

The definition of eligibility used here differs slightly from that of the Long-Ribicoff proposal in order to facilitate State-by-State comparisons. Long-Ribicoff uses a $4,800 cutoff which is further restricted by household income definitions. Our illustration uses poverty level figures, which are readily available by State. It is assumed that actual eligibility would end at the poverty level, but the number of individuals under the poverty level is multiplied by 1.5 to stimulate inclusion of the spenddown population.

No attempt was made here to subtract benefits for persons who would be eligible by virtue of income standards but are covered by private insurance. Thus the estimate provided here may be high.

Spending levels for this alternative and distribution among States would be determined as follows: Congress would establish a total expenditure level for the Nation by allowing for a certain increase in the previous year's costs. If a 12-percent increase over 1976 levels were provided, the total expenditure for fiscal year 1977 would be $16.7 billion—slightly less than the current policy estimate of $17.2 billion. This amount would be distributed among States according to a formula based on number of low-income persons adjusted for geographic differences in both cost of living and medical care costs. Thus a total minimum [9] expenditure level would be set for each State.

With this alternative, distribution would be more equitable than at present in terms of targeting funds on States with greatest need. Federal spending alone and combined Federal and State expenditures would increase in low-benefit States. While States now providing high benefits would lose less than with FAHCA because of adjustments for regional differences, the impact on them would still be substantial.

The handling of State versus Federal responsibility for policymaking, administration and financing would be similar to the current situation in most respects. States would define and administer their own programs within Federal guidelines. One important exception is that their financial contributions would be set rather than self-determined.

If a State's total minimum expenditure for 1977 is less than its 1976 total, its required contribution would be determined by applying the percentage it now pays under the current matching formula. If a State's total minimum expenditure is more than its 1976 total, the dollar level of its 1976 contribution would be inflated by 12 percent. When State contributions are added together and subtracted from total national expenditures, a Federal share of $10.5 billion remains—$1 billion more than the current policy estimate of $9.5 billion. This Federal share would be 63 percent of total expenditures, compared with the 55-percent Federal share under current policy. In future years the new proportion would remain relatively constant, although it could be adjusted for individual States whose per capita income changes.

Thus States would not bear the costs of newly mandated expenditures, but they would continue to share responsibility for inflation. In addition, the unilateral limit on Federal spending would leave States entirely liable for unexpected increases in costs within a given year. Incentives for States to contain costs would therefore be stronger than at present. Some have suggested that in view of the increased State financial responsibility it might also be appropriate to allow States more flexibility to cut costs in selected areas. For example, Federal requirements for cost-based reimbursement could be eliminated, but safeguards for beneficiaries could be retained. There would be no controls beyond current policy over whether efficiency-promoting services would be reimbursable.

Alternative 3: Negotiated State and Federal shares

With the third alternative, total minimum State expenditures, services to be provided and Federal shares would be set at the beginning of each fiscal year by a prospective budgeting process. The process

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[9] The figure would be a minimum because States could choose to spend more of their own funds.

would be based on HEW negotiations with each State, which would provide additional incentives to achieving Federal objectives.

Because there would be a high degree of uncertainty, no cost estimates or distribution projections are provided for this alternative. The desire to secure assurances that beneficiary needs are met and efficiency-promoting services reimbursed would tend to force Federal spending up and possibly to favor high benefit States in terms of distribution. One way of dealing with this might be to set a total limit within which negotiations would take place, or even target ranges for each State. However, these limitations would narrow the opportunity for incentives.

With regard to responsibility for increases in costs during a given year due to the entitlement nature of the program, the impact on States would be the same as with the President's proposal or the second alternative, if the Federal share could not vary once it was set. This situation could be alleviated by an exceptions process through which a State could appeal for additional Federal funds if predicted inflation were exceeded by a certain percentage or if numbers of beneficiaries rose because of downtrends in the economy. However, there would be problems if States anticipated the granting of additional funds too easily.

A major drawback would be entrusting the distribution of large sums of Federal money to a competitive bargaining process where political influence as well as need could become a factor. Another would be the lack of reliable and current data regarding benefits and beneficiaries upon which to base negotiations.

SHORT-TERM OPTIONS FOR CATEGORICAL HEALTH GRANT PROGRAMS

SUMMARY

Categorical health grant programs are aimed at particular conditions or population groups. Usually their target populations lack access to health care for financial and other reasons. Their funds may be distributed on a formula basis to States or as project grants. In the latter case, a service delivery mechanism is usually established to serve a particular geographic area.

The categorical programs comprised roughly 15 percent of the $9.8 billion appropriated in fiscal year 1976 for all health care grants to States and localities channeled through the Department of Health, Education, and Welfare (HEW). Most of the remainder went to medicaid.

Four major issues have been raised this year with regard to the categorical programs. First is the question of appropriate funding levels. This is closely related to whether the Federal Government should involve itself with specific service programs on a continuing basis, and expand such programs to serve larger populations with needs similar to those of persons currently served, or confine its future support to financing systems such as medicaid. The second major issue is whether the categorical programs should be consolidated, allowing States and localities more administrative flexibility and a choice of priorities, or the Federal Government should retain its ability to define programs and target aid. The third issue involves distribution of funds—whether the concept of equity among States, usually achieved by State formula grants, should be superseded by other goals, such as local initiative and support for existing programs. The fourth issue is the degree of authority for program operation at Federal, State, and local levels.

The President has proposed to consolidate medicaid, nearly all of the categorical health grants, the new health planning program and the developmental disabilities program, primarily for the retarded, into a single block grant to States. Budget authority would be $10 billion—$950 million less than the $10.95 billion anticipated under current policy in fiscal year 1977 for programs that would be included. By fiscal year 1981, budget authority would be $12.2 billion, $3.6 billion less than the $15.8 billion anticipated under current policy. Federal funds for all programs in the block grant would be distributed among States primarily according to the number of low income persons and per capita income in the State. This would result in substantial losses for wealthier industrial States currently providing high

medicaid benefits, many which are also major recipients of categorical grants. Funds for the programs included in the consolidated block grant would be distributed into three new spending categories. This could further limit spending for personal health services. Finally, nearly all operating authority would be delegated to State governments, even where local agencies are grantees under current policy.

Based on two previous experiences with consolidation and increased State responsibility, States may be expected to respond to the President's proposal by adhering to their own past practices. That is, when faced with resource allocation choices, they may tend to favor programs with which they have been directly involved (such as disease control and other public health programs), as well as those whose purposes coincide with States' concerns (such as mental health programs, which relieve the burden on State-financed institutions). New programs and those with which they were not previously involved might suffer. This is particularly true of local project grants for personal health services, since some States may be forced to choose between them and medicaid.

The President's proposal represents one set of responses to the issues raised. Three alternatives to the President's program, each limited to the categorical grant programs, are presented here.

The first alternative involves very limited reforms that would allow States flexibility to transfer funds among the categorical grants they now receive directly—more than one-third of all categorical program dollars. States might choose to expand some programs and decrease others, but Federal spending levels would not be cut; nor would new Federal funds be supplied for increased treatment capacity. Finally, little change from current policy would occur in the way funds are distributed or in the degree of operating control delegated to States and localities.

The second alternative would establish three new consolidated grants. A public health formula grant would go directly to States with few earmarks or passthroughs. A mental health, drug and alcoholism grant distributed on a formula basis but with assurance of funding for most existing programs would also go to States, with earmarks and local passthroughs. A personal health services grant would go to localities on the basis of current project location and then to new areas of greatest need, with the specific purpose of establishing comprehensive primary care networks.

The second alternative might help retain Federal program purposes while still permitting increased flexibility for the grantee, State or local. Similarly, distribution methods would reflect a balance between geographic equity and other program goals. Some limited savings could possibly be achieved through coordination among similar programs and elimination of duplication. However, as with the first alternative, Federal spending levels would remain roughly the same and there would be no new funds to increase treatment capacity. Federal

approval, monitoring and evaluation would be maintained, so that there would be little change in the degree of operating control currently delegated to grantees.

The third alternative would emphasize selective increases in treatment capacity within the three grant structure described for the second alternative. Spending levels for the personal health and possibly for the mental health grants would be increased. Where expansion is provided for, larger proportions of target populations could be served. To some extent, the lack of equity among States that has resulted from funding on a project rather than a formula basis might also be addressed. If national health insurance were enacted, less categorical grant funding would be required to maintain current levels in programs providing personal health services because patient revenues would be increased. Thus holding funding for the personal health services programs constant would allow additional persons to be served. Issues of grantee flexibility versus Federal intent and degree and level of operating authority would be dealt with in the same way as with the second alternative.

INTRODUCTION

Federal grants to States and local agencies for health care channeled through HEW are expected to total approximately $9.8 billion in fiscal year 1976 and $11.2 billion in fiscal year 1977 under current policy.[1]

These grants and their funding levels are listed individually in table 1. By far the largest portion is attributable to medicaid, which makes available funds to States to reimburse providers of health care to low-income persons. In fiscal year 1976, Federal medicaid expenditures are estimated at $8.2 billion and in fiscal year 1977 at $9.5 billion under current policy.[2] The remaining $1.6 billion for fiscal year 1976 and $1.7 billion projected for fiscal year 1977 are allotted to a variety of smaller programs.

Most of these nonmedicaid health grants to States and local agencies are described as "categorical" because they are targeted on particular conditions or population groups. They include personal health service programs under the supervision of the Health Services Administration (HSA), disease prevention programs under the Center for Disease Control (CDC), and mental health and related programs under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Their funds may be distributed on a formula basis to States or as project grants to States or local agencies. In the latter case, a service delivery mechanism is usually established to serve a particular geographic area.

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[1] All figures are budget authority estimates, based on 1976 appropriations and maintenance of current levels of service. Grants primarily for health manpower education or basic research rather than health care are not included.

[2] A companion paper by the Congressional Budget Office (CBO) deals in detail with medicaid issues and options.

TABLE 1.—BUDGET AUTHORITY FOR FEDERAL HEALTH GRANTS TO STATES, LOCALITIES AND RELATED AGENCIES UNDER CURRENT POLICY AND PRESIDENT'S PROPOSAL, FISCAL YEARS 1976 AND 1977

[In millions of dollars]

	In proposed block grant				Not in proposed block grant			
	Current policy [1]		President's proposals		Current policy [1]		President's proposals	
	1976	1977	1976	1977	1976	1977	1976	1977
Personal health care:								
Comprehensive grants to States	$ 90	$ 96	$ 68					
Community health centers	197	211	155	$155				
Maternal and child health	322	342	223	210				
Family planning	101	108	79	79				
Migrant health centers	25	27	19	19				
Emergency medical services	37	40	25	25				
National Health Service Corps					$ 15	$ 16	$ 13	$ 25
Center for Disease Control: Project grants	41	44	34	34				
Alcohol, Drug Abuse and Mental Health Administration:								
Community mental health	219	234	160	131				
Drug abuse					157	168	173	195
Alcoholism	124	133	91	79				
Organization and control of delivery system:								
Health maintenance organizations					19	20	19	19
PSRO's					48	51	48	62
Planning	90	96	66	90				
Construction	75	80						
Public Health Service subtotal	1,321	1,411	920	822	239	255	253	301
Developmental disabilities	56	60	54	54				
Medicaid	8,208	9,480	8,208	9,292				
Overall total	9,585	10,951	9,182 [2]	10,168	239	255	253	301

[1] Fiscal year 1977 current policy estimates for nonmedicaid programs: Fiscal year 1976 appropriations times 1.07 inflation factor; does not reflect proposed legislation.

[2] Legislative program offset expected to bring the total to $10,000,000,000.

Often the categorical programs offer a kind of service, or a way of shaping the delivery system, that States have not generally provided on their own initiative. For example, the categorical programs lean toward outpatient and noninstitutional services, while States may concentrate on institutional care. Usually target populations of the categorical programs lack access to health care for financial and other reasons. Often persons not eligible for medicaid, many but not all of whom are poor, can and do receive services. Sometimes, however, the categorical programs merely supplement States' and localities' ongoing efforts.

Some other nonmedicaid health grants are more general attempts to affect availability, organization, and utilization of health care. They include professional standards review organizations (PSRO's), health maintenance organizations (HMO's), and health planning and resource development programs.

The President has proposed to consolidate medicaid, the developmental disabilities program primarily for retarded persons, which is now administered by HEW's Office of Human Development, and most but not all of the other programs described above in a single block grant to States, under legislation known as the Financial Assistance for Health Care Act (FAHCA). Current policy estimates of budget authority for programs that would be included come to $9.6 billion in fiscal year 1976 and $10.95 billion in fiscal year 1977. The proposed block grant would be funded at a level of $10 billion for fiscal year 1977—$950 million less than under current policy. By fiscal year 1981,

budget authority would be $12.2 billion, $3.6 billion less than the $15.8 billion anticipated under current policy.

This paper will review issues related to nonmedicaid health grants, with emphasis on the categorical programs, attempt to estimate the impact of the President's proposal, and analyze alternatives.

I. ISSUES INVOLVING CATEGORICAL HEALTH GRANT PROGRAMS

Four major issues involving categorical health grants to States and local agencies have been raised this year by Congress, the executive branch, and affected parties. First is the question of funding levels and their relationship to the Federal role in health care. Second is consolidation—the tradeoff between increased grantee flexibility to define programs and select priorities, and the preservation of Federal program purposes. Third is equity and effectiveness of the distribution of funds to grantees. Fourth is the degree of authority and responsibility for program operation at Federal, State, and local levels.

Funding levels

Funding levels for categorical health grants tend to be supported primarily on the basis of one's concept of the appropriate Federal role in health care. Major savings are likely to be achieved only by extensive cutbacks or elimination of entire programs.

The administration has taken the view that categorical health grants were demonstration projects whose support should by now have been taken over by States and local agencies. The administration also feels that such grants, which serve mostly low-income persons, are unnecessarily duplicative of the much broader medicaid financing system. Thus there have been repeated attempts to increase non-Federal support and to push for a greater share of costs to be assumed by patient revenues, particularly medicaid reimbursements. In the case of programs providing personal health services, these efforts have been thwarted, in part, by the inability or unwillingness of States or localities to assume additional costs. Efforts at self-sufficiency have been somewhat more successful with mental health programs, possibly because such programs are often administered by hospitals experienced in third-party collections and possibly because States are more willing to pay for services that relieve the burden on their own mental institutions. But legislatively scheduled annual decreases in Federal contributions to mental health programs have been slowed. Despite the apparent inability of categorical grant programs to achieve self-sufficiency, the administration's requests for fiscal years 1976 and 1977 still reflect a desire to reduce the Federal role unilaterally.

On the other hand, advocates of expanding categorical grant programs argue that they are not duplicative because they serve low-income persons without limitations, while medicaid is subject to State-set, means-tested eligibility requirements and benefit restrictions. Advocates also claim that such programs are necessary to deal with nonfinancial barriers to care such as inadequate resources in certain geographic areas, lack of user knowledge and discrimination against low-income patients. Moreover, they contend that categorical grant programs have suffered in competition for Federal health dollars with

the "uncontrollable" entitlement programs of medicare and medicaid. The point is made that current funding for categorical programs enables them to serve far fewer persons than intended by Congress or planned for by executive departments. For instance, current law states that access to community mental health centers should be nationwide. Currently 91 million persons live in catchment areas now served by 571 such centers. Another example involves community based comprehensive health care centers. In 1967, HEW set forth details of a plan to establish 1,000 such centers to serve 25 million poor persons by 1973. Currently 164 community health centers serve approximately 1.5 million persons. Finally, with regard to self-sufficiency, timing is said to be critical since many programs would require far smaller Federal grants to maintain current levels of service if national health insurance were enacted or possibly if Federal medicaid eligibility standards and benefit levels were set.

Grantee flexibility v. Federal purpose

The categorical health grant programs have been under attack from a number of quarters on grounds that their separate, complex regulations contribute to wasteful administrative practices and overlap of services as well as denying States and localities flexibility to determine their own funding priorities. One recent attempt to quantify the cost of fragmented State health services estimated that 7 percent of an average sized State health budget could be saved by integrating program administration.[3] And in a study of outpatient health services in Washington, D.C., the General Accounting Office (GAO) found that some neighborhoods had too many programs of the same type and that many of these programs were underutilized. GAO blamed a lack of coordination among various Federal and local programs.[4]

Organizations representing State and county governments are advocates of consolidating categorical programs into larger, more flexible formula grants, as is the administration.

The counter argument from those who favor retaining specific program definitions is that administrative savings from consolidation may not be significant and that program duplication could be avoided by better planning. More important, it is believed that categorical grant programs result in the most precise targeting of Federal aid. They allow funds to be concentrated on groups for which States may have little incentive to provide care (for example, migrant workers or alcoholics), on services that may be politically unpopular but have significant benefits (for example, family planning for teenagers, whose children have high infant mortality rates) or on alternative methods of health care delivery (for example, community health centers).

Distribution

Funds for more than one-third of categorical health grants are currently distributed on a formula basis to States, which is generally

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[3] The study (Freedman, B., "Cost of Fragmentation of State Government Operated Health Services," *Inquiry* 12:216–226, September 1974) was based on economies of scale alone and made no attempt to distinguish between federally induced and other fragmentation.

[4] Study of Programs for Health Services in Outpatient Health Centers in the District of Columbia, U.S. General Accounting Office, July 31, 1973.

regarded as equitable. For the remaining two-thirds, which are distributed as project grants, factors other than equity among States with regard to aggregate numbers of low-income persons may also be considered.

First, strictly construed equity among States may not take into account the need for development of treatment capacity in substate areas that are medically underserved. Second, even uniform criteria for meeting the needs of medically underserved substate areas may conflict with other program goals. Historically, boundaries of many project grants were defined in terms of the community served. Thus distribution among States and substate areas is uneven. Moreover, the location of health project grants has depended on local initiative. What criteria there were varied from one program to another. Thus, while grants go to areas generally defined as underserved, priorities have been unclear and projects are not always located in areas of greatest need.

Recently, HEW has made some efforts to allocate new grants according to a single list of underserved areas and to redirect funds among the 10 Federal regions according to need. However, some believe that in addition to need criteria, factors which predict success such as the interest and ability of individuals in the local community should continue to be considered. Moreover, it is extremely difficult to redirect funds for currently operating projects and facilities by means of a catchall formula. Particularly if projects were established to build health service delivery capacity where none existed before, withdrawal of funds may waste the earlier Federal investment.

Operational authority

This last issue, which is related to but different from either defining program purpose or the method of allocating funds, is who actually runs the program.

First, how much operating authority does the Federal Government delegate? There are some who believe that minimum Federal intervention is best. Others favor strong accountability to the funding source. Examples of the most extensive Federal authority can be found in experimental or research-oriented programs, where HEW can specify services to be performed and staff to be hired in the form of a contract or protocol. If the grantee initiates a proposal within HEW guidelines, subject to review and approval, and then HEW monitors and evaluates the project closely, as is presently the case with most health project grants, Federal authority is slightly less extensive. If the grantee plays a larger role in defining services and target populations and HEW simply approves and subsequently monitors a more general plan, authority is clearly shared. This is the case presently with medicaid and most health formula grants. Finally, the Federal Government can allocate funds for very general purposes, retaining rudimentary auditing and requiring only a planning process open to the public, as with revenue sharing.

Second, to whom does the Federal Government delegate authority? For some categorical programs, this question is important because grants were originally made specifically to community agencies. It was

believed that State and local governments were not able or willing to be responsive to the poor, often minority populations the programs wanted to serve. Some believe this situation is less true today, and thus State governments should logically control all services in their jurisdictions, including those that have been funded directly by the Federal Government. Others argue that though there has been some improvement, State governments and community projects still have different interests and priorities, as indicated by the use of revenue sharing funds.

II. THE PRESIDENT'S PROPOSAL

FAHCA, the President's proposed health block grant, would deal with the issues discussed above by sharply reducing from current policy levels the total sum available for both medicaid and nonmedicaid grants, consolidating all included programs into a single package, redistributing funds among States according to a formula based primarily on the number of low-income persons and per capita income in the State, and delegating nearly all operating authority to State governments.

Impact of funding cuts and redistribution

The combined effect of the reduction and redistribution would result in substantial losses in real terms for many States. The inclusion of medicaid in the block grant makes the changeover to a distribution formula particularly significant. Currently, Federal medicaid funding is keyed to State expenditures, resulting in more money for wealthier industrial States that provide high benefits. Under the proposed formula such States, many of which are also major recipients of categorical grants, would receive considerably less than under current policy. Table 2 provides annual dollar estimates of each State's total for all included programs under current policy and if the FAHCA block grant were implemented. The formula would be phased in slowly so that no State would experience an actual dollar loss from 1976 levels. However, by 1981, 17 States would be receiving 75 percent or less of aid projected under current policy, and 13 States would be receiving 65 percent or less. Seven of the latter are Eastern, urban States. Conversely, 13 States would be receiving 115 percent or more of aid projected under current policy; of these 10 are Southern and 3 are Western rural States.[5]

Impact of consolidation

Consolidation of nearly all nonmedicaid health grants into one block means that current program definitions would cease to exist. States could shift dollars among existing programs and ultimately determine their future. In the long run, the only constraints would be proportions of the total required to be spent in three new general categories—personal health services, community and mental health services, and planning and resource development.

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[5] For a discussion of the impact on States of various distribution formulas, including adjustments for cost of living, and medical care prices, see CBO's companion paper on medicaid options.

TABLE 2.—COMPARISON OF FEDERAL HEALTH AID UNDER FAHCA AND CURRENT POLICY, BY STATE, FISCAL YEARS 1977 AND 1981

[In millions of dollars]

	Fiscal year 1977			Fiscal year 1981		
	Federal aid under current policy [1]	Federal aid under FAHCA	Federal aid under FAHCA as a percent of Federal aid under current policy	Federal aid under current policy [1]	Federal aid under FAHCA	Federal aid under FAHCA as a percent of Federal aid under current policy
Alabama	$179.7	$171.5	95	$259.0	$298.9	115
Alaska	14.0	11.8	84	19.2	11.5	60
Arizona	18.1	13.8	76	22.2	24.0	108
Arkansas	128.4	122.2	95	184.5	213.0	115
California	1,281.1	1,155.2	90	1,862.5	1,127.5	61
Colorado	108.4	94.5	87	165.2	115.2	70
Connecticut	125.4	113.5	91	182.4	110.8	61
Delaware	16.2	14.2	88	22.6	21.7	96
District of Columbia	86.6	76.3	88	122.7	74.4	61
Florida	195.4	181.0	93	276.1	315.5	114
Georgia	269.8	259.3	96	390.8	375.5	96
Hawaii	34.2	30.1	88	48.2	33.2	68
Idaho	36.5	34.2	94	52.0	45.5	87
Illinois	522.3	470.5	90	759.7	459.2	60
Indiana	182.7	173.6	95	263.1	211.0	80
Iowa	99.9	95.5	96	144.5	154.2	106
Kansas	82.4	78.0	95	118.4	118.1	99
Kentucky	176.6	167.7	95	253.2	292.2	115
Louisiana	183.7	176.6	96	266.4	307.6	115
Maine	74.2	70.9	96	106.8	88.2	82
Maryland	196.3	174.3	89	282.1	170.1	60
Massachusetts	403.0	363.6	90	586.0	354.9	61
Michigan	523.6	473.9	91	764.0	462.5	61
Minnesota	219.8	198.6	90	320.3	224.6	70
Mississippi	134.7	128.0	95	193.1	223.1	116
Missouri	124.4	115.2	93	175.2	200.7	115
Montana	30.4	28.4	93	43.1	49.4	114
Nebraska	48.1	44.7	93	68.0	77.8	114
Nevada	18.6	17.3	93	26.3	23.0	87
New Hampshire	29.9	26.4	88	42.9	32.2	75
New Jersey	281.4	251.0	89	406.5	245.0	60
New Mexico	41.0	38.0	93	57.7	66.3	115
New York	1,878.0	1,711.4	91	2,751.4	1,670.4	61
North Carolina	201.7	191.6	95	289.6	333.8	115
North Dakota	25.8	23.2	90	36.5	38.3	105
Ohio	336.5	310.4	92	485.9	393.9	81
Oklahoma	154.7	148.1	96	223.8	193.4	86
Oregon	89.7	86.1	96	128.5	110.0	85
Pennsylvania	519.7	464.1	89	750.5	591.5	79
Rhode Island	69.1	62.2	90	100.3	60.7	61
South Carolina	121.4	113.9	94	172.2	198.5	115
South Dakota	27.1	25.5	94	38.8	44.5	115
Tennessee	186.3	177.0	95	267.5	308.4	115
Texas	578.1	554.2	96	836.5	771.1	92
Utah	45.5	42.5	93	64.4	72.8	113
Vermont	36.9	32.9	89	53.1	41.7	78
Virginia	162.1	154.0	95	233.4	265.0	114
Washington	158.9	141.2	89	228.8	138.4	60
West Virginia	59.0	54.6	93	82.8	95.1	115
Wisconsin	312.3	283.5	91	456.6	276.7	61
Wyoming	9.7	8.8	91	13.3	15.3	115
Guam	2.0			2.5		
Puerto Rico	48.8			65.3		
Virgin Islands	3.2	47.2		4.1	53.7	
American Samoa	.8			1.0		
Trust Territories	1.7			2.1		
Total	10,951.0	10,000.0		15,800.0	12,200.0	

[1] Block grant programs only. Includes local aid within each State. Columns do not add precisely to totals due to allocation of increases (medicaid and other programs) by State.

Table 3 compares minimum and maximum spending for each FAHCA category and funding for comparable programs under current policy in fiscal year 1977. Of the $10 billion block grant, a minimum of $9 billion and a maximum of $9.5 billion would be spent on

personal health services, while comparable programs (medicaid and others providing medical services) would total $10.2 billion under current policy. Community services would be allocated $500 million to $1 billion of the block grant. Programs included in this category (disease control, alcohol, mental health, comprehensive grants, and developmental disabilities) would come to $567 million under current policy. However, many activities within these programs could also be classified as personal health services, further squeezing the first category and freeing more funds for discretionary community purposes. Anywhere from zero to $500 million of the block grant could be spent on planning and resource development, while the only comparable program is expected to be funded at a level of $176 million under current policy.

TABLE 3.—FISCAL YEAR 1977 FUNDING LEVELS UNDER CURRENT POLICY FOR PROGRAMS INCLUDED IN FAHCA BLOCK GRANT AND SPENDING ALLOWED IN COMPARABLE FAHCA CATEGORIES

[In millions]

Category	Current policy	President's proposal
Personal health services:		
Community health centers	$211	----------
Maternal and child health	342	----------
Family planning	108	----------
Migrant health centers	27	----------
Emergency medical services	40	----------
Medicaid	9,480	----------
Subtotal	10,208	----------
FAHCA minimum	----------	$9,000
FAHCA maximum	----------	9,500
Community programs: [1]		
Community mental health	234	----------
Alcoholism	133	----------
Developmental disabilities	60	----------
Comprehensive grants to States	96	----------
Disease control	44	----------
Subtotal	567	----------
FAHCA minimum	----------	500
FAHCA maximum	----------	1,000
Planning and resource development:		
Planning and construction	176	----------
FAHCA minimum	----------	0
FAHCA maximum	----------	500
Total	10,951	10,000

[1] Many services to individuals in these programs (for example, psychotherapy in mental health programs or medical treatment in disease control or comprehensive grant programs) may also be classified as personal health services under FAHCA.

Impact of State primacy and likely response

The key element in determining how the FAHCA block grant would ultimately affect component programs and their beneficiaries is the primacy of State authority. States would be recipients of all funds, even where local agencies were prior grantees. They may be forced to choose between medicaid, which would tend to keep expanding due to its entitlement nature, and categorical programs in the personal health services category.[6] States could choose to eliminate medicaid if health services were provided to low income persons in some other way, but this is much less likely in view of pressures from private medical care

[6] Medicaid increased 16 percent from 1975 to 1976 while categorical programs providing personal health services increased 4 percent.

providers. Virtually all requirements for Federal approval of plans, program monitoring, matching from States' own funds, and pass-throughs to localities would be eliminated.[7]

While there is little hard evidence that is directly analogous, State action in some similar circumstances may suggest clues as to future response.

There have been two previous experiences with consolidation and increased State responsibility for health grants. Both were much less extensive than the President's proposal, far more Federal control was retained, and funds were increased rather than decreased.

The first began in 1966 when nine small formula grants to States for specific public health purposes (for example, tuberculosis, chronic ailment, and heart disease control) were combined into one comprehensive formula grant under section 314(d) of the Public Health Services Act. A 12-percent funding increase was provided. This program has been popular with States, although some of them have noted that without specific and identifiable purposes, congressional support decreases. In fact Congress has not increased appropriations greatly over initial levels, as had been anticipated. The administration, despite its advocacy of consolidation and greater State flexibility, attempted to eliminate the program in 1976 and has made the same request for 1977 whether FAHCA is approved or not.

In a recent survey of three States, the GAO found that the 314(d) funds were allocated "primarily on tradition and administrative convenience" and that the States failed to reconsider priorities in planning.[8] In a comprehensive national study of 314(d) grants that recommended some additional consolidation, the Advisory Commission on Intergovernmental Relations (ACIR) nevertheless found that large scale redistribution of funds among programs probably did not occur, although specific program purposes were hard to identify; that evaluation was lacking; that local roles varied; and that private agencies had little influence on expenditures.[9]

The second experience involved incorporating funds that had supported separate maternal and child health projects into a pre-existing formula grant to States for other maternal and child health purposes. Amendments to title V of the Social Security Act that had established the projects in 1967 provided that the transfer take place in 1972 on the theory that once the Federal Government had demonstrated the efficacy of new delivery mechanisms, the States could take over and extend them to unserved areas. It did not actually occur until July 1, 1974, according to GAO, "primarily because neither the States nor HEW had made adequate preparation for the transfer."

States that would have lost money in the transfer were given compensatory funds and required to maintain the population served. Of 47 States and territories responding to a brief HEW update survey of previously funded projects requested by CBO, six reported a 5- to 15-percent decrease in the population served and 11 reported reductions in Federal funds channeled to the projects ranging from "slight"

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[7] An exception is that States would have to fund current Federal project grants at 80 percent of current levels in 1977, 50 percent in 1978, and 25 percent in 1979.

[8] How States Plan For and Use Federal Formula Funds to Provide Health Services, U.S. General Accounting Office, Dec. 9, 1975.

[9] Partnership for Health Act: Lessons From a Pioneering Block Grant, Advisory Commission on Intergovernmental Relations, 1976.

to 25 percent. In addition, all States were required to maintain or establish, if none existed, at least one each of five kinds of projects. These were much smaller than the original maternal and infant care and children and youth projects and included, in addition, intensive infant care, dental services, and family planning. Thus, while there are 163 more projects today than before the transfer, the number served has not increased significantly. In the same study cited above, GAO found with regard to maternal and child health funds that States did not plan well for extension to underserved areas. Even where States gained under the formula, the funds were used primarily for ongoing programs.

Thus a pattern of State adherence to past practices and little change in intrastate distribution seems to emerge from two previous health grant consolidations with some funding increases, one of which involved State assumption of authority for what had been project grants. States that gain funds under the FAHCA block grant may behave similarly. That is, programs with which State health departments have been directly involved, like disease control and the non-project part of maternal and child health, might fare well. Programs with less direct State involvement but in functional areas where States have strong interests, like mental health, might also survive. Interestingly, most of the programs with State involvement or interest are part of the one FAHCA category where States could spend more in the aggregate than is currently appropriated.

For those States that lose money under FAHCA, the negative impact on new programs, especially those that are difficult to implement, would be magnified. Thus the network of State and local agencies mandated by the Health Planning and Resource Development Act of 1974, for which no block grant money would have to be spent, might be one casualty. Losses might also affect ongoing programs with which States were not previously involved, such as local project grants for outpatient medical care.

It is worth noting that one effect of FAHCA would be to force States to make extremely difficult political decisions between competing health interest groups. The degree to which States make such decisions in accord with their own health needs would vary, and programs without well-developed constituencies might suffer.

III. ALTERNATIVE OPTIONS

The President's block grant proposal, which cuts Federal spending levels and consolidates nearly all programs, represents only one set of responses to the issues raised in section I. Alternatives could maintain current spending levels or raise them to provide increased treatment capacity. They could also limit the extent of consolidation, or not consolidate at all.

Three alternatives, each limited to the categorical programs, are presented here.[10] The first two reflect varying degrees of consolidation

[10] None of the 3 includes medicaid or developmental disabilities. Neither does any alternative include the efforts at organization and control of the health care system, which are new initiatives whose complex and recently debated mechanisms may require special Federal attention while being implemented. (The President's proposal would include the Health Planning and Resource Development Act of 1974.) However, drug abuse grants and the National Health Service Corps (NHSC), which deliver services and are therefore consistent with other categorical programs, are considered here although not included in the President's proposal.

with little or no change from current spending levels. One alternative involves very limited reforms that would allow State governments flexibility to transfer funds among the categorical health grants they now receive directly. The second involves the creation of three new consolidated grants with existing programs grouped according to purpose. The new grants could be implemented at once or phased in over time. Table 4 shows recipient, method of allocation, and administrative mechanism for each program under current policy, the President's proposal, and these two alternatives.

TABLE 4.—RECIPIENT, METHOD OF ALLOCATION AND ADMINISTRATIVE MECHANISM OF NONMEDICAID HEW HEALTH GRANTS UNDER CURRENT POLICY, ALTERNATIVES AND THE PRESIDENT'S PROPOSAL

	Fiscal year 1977 (millions)	Current policy	Alternative 1: Funding transfers for State grants	Alternative 2: 3 consolidated grants	President's proposal
Comprehensive formula grants to States.	$96	To State (formula)	To State with transfer (formula).	To State in public health group (formula).	To State block.
State project grants for disease control.	24	To State (project)	Unchanged [1]	do	Do.
Maternal and child health/crippled childrens formula grants.	342	To State (formula)	To State with transfer (formula).	do.[2]	Do.
State formula grants for alcoholism.	60	do	do	To State in mental health group (formula).	Do.
State formula grants for drug abuse.	37	do	do	do	Unchanged.
State formula grants for developmental disabilities.	34	do	Unchanged	Unchanged	To State block.
State mental health construction grants.	(14)	To State (project)	do	To State in mental health group (formula).	Do.
Mental health project grants.	234	To local agency (project).	do	do	Do.
Alcoholism project grants.	73	To State or local agency (project).	do	do	Do.
Drug abuse project grants.	131	do	do	do	Unchanged.
Developmental disabilities project grants.	26	do	do	Unchanged	To State block.
Local project grants for disease control.	20	To local agency (project).	do	To State in public health group (formula).	Do.
Community health center project grants.	211	do	do	To locality in personal health group (target).	Do.
Migrant health project grants.	27	do	do	do	Do.
Family planning project grants.	108	To State or local agency (project).	do	do.[3]	Do.
National Health Service Corps.	16	To local agency (project).	do	do	Unchanged.
Emergency medical services.	40	do	do	do	To State block.
Health planning and construction grants to State and areawide agencies.	176	To State and local agency.	do	Unchanged	Do.
PSRO's	51	To local agency	do	do	Unchanged.
Health maintenance organizations.	20	do	do	do	Do.
Total	[4] 1,726				

[1] State project grants for disease control could be included in funding transfer if changed to formula funding.
[2] Approximately $150,000,000 for maternal and child health projects, now in formula grants, could go to locality in personal health group.
[3] Family planning projects not providing other health services could go to State in public health group.
[4] Total does not include mental health construction grants to States, which are previous year's obligations.

The third alternative presented here would emphasize expanding treatment capacity, particularly in the personal health services area. Spending levels would be increased but a three-grant structure similar to that of the second alternative would both target the increase and

induce more effective use of existing capacity through consolidation.

The following objectives can be used as policy criteria to evaluate options for categorical health grant programs. They represent the differing points of view about the issues raised in section I. In some cases, conflict is inevitable and choices must be made. In others, the option may be formulated to effect a compromise:

—Achieve significant Federal savings;
—Provide increased treatment capacity;
—Provide State flexibility to integrate program administration and select priorities;
—Provide local flexibility to integrate program administration and select priorities;
—Retain original Federal purpose;
—Distribute existing funds according to equity among States;
—Distribute existing funds according to need for treatment capacity and likelihood of success;
—Delegate operating control to States; and
—Retain accountability to funding source.

Table 5 summarizes the degree to which the criteria are met under current policy, the President's proposal and alternatives. A more detailed discussion of the alternatives follows.

TABLE 5.—EVALUATION OF OPTIONS FOR CATEGORICAL HEALTH GRANTS: CURRENT POLICY, THE PRESIDENT'S PROPOSAL AND ALTERNATIVES

Policy criteria	Current policy	President's proposal	Alternative 1: Funding transfers for State grants	Alternative 2: 3 consolidated grants	Alternative 3: 3 consolidated grants with selective expansion
Achieve significant Federal savings.	No	Yes	No	No	No.
Provide increased treatment capacity.	No	No	No	Partial	Yes.
Provide State flexibility to integrate program administration and select priorities.	No	Yes	Partial for State grants.	Yes for State grants.	Yes for State grants.
Provide local flexibility to integrate program administration and select priorities.	No	No	No	Yes for local grants.	Yes for local grants.
Retain original Federal purpose	Yes	No	Yes	Partial	Partial.
Distribute existing funds according to equity among States.	Partial	Yes	Partial	Partial	Partial.
Distribute existing funds according to need for treatment capacity and likelihood of success.	Partial	No	Partial	Partial	Partial.
Delegate operating control to States.	No	Yes	No	No	No.
Retain accountability to funding source.	Yes	No	Yes	Yes	Yes.

Alternative 1: Funding transfers for State grants

An alternative that would essentially preserve the present mix of programs but allow a proportion (for example, 25 percent) of each State health formula grant to be used for any other would provide a limited degree of State flexibility. While the role of local grantees would be preserved, they would not be provided any additional degree of flexibility. Existing Federal program purposes would be retained.

Administrative savings would probably be small. States might choose to expand some programs and decrease others, but Federal

spending levels would not be affected significantly. Most project grants would still serve only parts of potentially eligible populations and it is unlikely that need for increased treatment capacity would be met.

Current distribution (one-third according to formula, which promotes equity among States and two-thirds on a project basis, which meets other objectives), would remain unchanged. This alternative would be similar to the present situation in the degree of operating control allowed States—that is, the Federal Government would continue to approve plans or grant applications and to monitor and evaluate programs. Accountability to the Federal funding source would be retained.

Table 4 shows that States could use the new flexibility for nearly all grants they now receive directly: Comprehensive formula grants; maternal and child health and crippled children's formula grants; alcohol, drug abuse, and developmental disabilities formula grants. State project grants for disease control could also be included if their funding were shifted to a formula basis.

Mental health construction funds are allocated on the basis of local project grant plans and would not be affected by the transfer proposal. Included programs would come to $590 million of the $1.7 billion anticipated in fiscal year 1977 under current policy for non-medicaid health grants.

Alternative 2: Three consolidated grants

This alternative would consolidate programs in three groups according to common function—public health, mental health, and personal health or medical services. Recipients for each group, including localities, would be provided increased flexibility. Thus a balance between flexibility and program purpose would be reflected. In addition, the functional groupings might best utilize State and/or local capacity to administer the programs.

Any administrative savings resulting from consolidation might be offset by the need for better State planning. However, there might be some economies from better coordination of similar programs and elimination of duplication. More efficient use of existing facilities might address the need for more treatment capacity to a very limited degree and in geographic areas already served.

Where existing project grants are included in groups with distribution formulas, current distribution might change slightly despite local passthroughs. Federal approval, monitoring, and evaluation functions would be retained, rather than delegating operating control to States. This would preserve accountability to the funding source.

The three new consolidated grants are described below along with their funding totals and allocation methods. They could be implemented simultaneously, phased in one at a time, or each could stand on its own as a consolidation alternative.[11]

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[11] A variant of this alternative is that recommended by the ACIR in their previously cited study of comprehensive health, or 314(d) grants. The ACIR proposes a single block grant exclusive of medicaid and planning, but with groups of programs phased in by type of recipient—State, local government, and private agency—rather than purpose. The phasein schedule would take 5 or 6 years to complete, and programs could be exempted from inclusion by Congress. A planning process similar to that now used by medicaid and formula grants would replace specific Federal directives. Funds would be distributed according to a cost-sharing formula, as with medicaid, but with a ceiling tied to low-income population and per capita income. Thus proportionately low funding levels in poor States could be exacerbated.

Public health programs.—This group would include comprehensive formula grants to States, maternal and child health and crippled children's formula grants, and State and local project grants for disease control, which come to approximately $480 million of the $1.7 billion for nonmedicaid programs in 1977.[12] Except for what were separate maternal and child health projects providing comprehensive health services, most of these funds have been spent previously by State or local health departments on various public and preventive health functions, often supplementing ongoing activity. They would be combined in a new public health formula grant to States with few earmarks but some protection for local programs. It is important to note widespread professional opinion that preventive services are most effectively provided in conjunction with ongoing primary health care. Close linkages with sources of primary care—particularly the Federal programs in the personal health group—should be required.

Mental health programs.—This group would include all projects and State formula grants administered by ADAMHA. Funding would amount to approximately $540 million of the 1977 total. The ADAMHA programs offer many similar services, and consolidation might help break down artificial barriers in treating their target populations. There is an increasing degree of overlap between alcohol and drug abusers and both may at times require not only peer group attention or chemotherapy but also skilled psychiatric care available in community mental health centers.[13]

Because of a strong State commitment and experience in the mental health area, these programs would be combined in a new mental health grant to States. Distribution would be on a formula basis but with allocation for ongoing projects, flexible earmarks for the three purposes and protection for local grantees.[14]

Personal health programs.—This group would include community health centers, migrant health centers, NHSC, emergency medical services, and family planning programs—$400 million of the 1977 total. With the possible exception of family planning and the inclusion of what were formerly maternal and child health projects, these are the programs intended to build new health care delivery capacity in federally defined shortage areas and to overcome other nonfinancial as well as financial barriers to care for low-income persons. Their consolidation could utilize existing treatment capacity more efficiently and create integrated networks of comprehensive primary care services. Inclusion of NHSC would provide flexibility in meeting community needs for small health care teams as well as larger organized centers. In fiscal year 1975 HEW began funding 47 rural health initiative programs which administratively integrate community health and migrant centers and NHSC sites within a given locality.

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[12] Including family planning programs, which go to local agencies but do not provide comprehensive medical services, in this group, and transferring project grants for maternal and child health, which do provide comprehensive medical services, to the personal health grant, may be more rational functionally. This would reduce the public health grant to $440 million and bring the personal health grant to $440 million instead of $400 million. However, any loss of existing authority or funds might not be acceptable to States.

[13] Recently enacted law requires community mental health centers, sometimes accused of discriminating against drug and alcohol abusers, to accept them as patients if no other treatment program exists in the area.

[14] More precise criteria for allocation of alcoholism and drug abuse funds than are currently used for formula grants would be required.

This effort might serve as a basis for more comprehensive legislative consolidation which would include the other programs listed, provide unified cost accounting and establish similar initiatives in urban areas.

Grants are currently on a project basis and have gone traditionally to local agencies, with recipient eligibility based on geographic area. Thus under the second alternative these programs would be combined in a new comprehensive personal health services grant to appropriate local agencies. If the network of areawide health systems agencies mandated by the 1974 health planning legislation is implemented effectively, these agencies, which are tied into a State health planning process, could eventually serve as recipients of personal health services grants. Allocation would be on the basis of current location plus, where new sites are possible, to target areas of greatest need.

Alternative 3: Three consolidated grants with selective expansion

The third alternative would emphasize expanding capacity to deliver personal health and possibly mental health services through additional Federal funds. Its structure would be similar to that of the second alternative. This degree of consolidation would permit increased funds to be targeted on sets of programs where, because of fund limitations, only parts of target populations are currently served, while also helping induce more efficient use of existing treatment capacity as a prerequisite to expansion.

For any of the three block grants described in the second alternative, criteria for increasing funds over current levels would be effectiveness, need for treatment capacity, and, to a lesser degree, distribution problems that could be ameliorated by expansion. Most programs in the public health grant are not inequitably distributed because of formula allocations. For many there is not immediate pressure for expansion, although immunization may be one notable exception with proven benefits.

ADAMHA programs do serve only part of their potential target populations. There is a well-developed constituency in favor of doubling the current number of 571 mental health centers to serve the entire Nation as intended in current authorizing legislation. Such programs provide alternatives to institutional care, thereby making deinstitutionalization of mental patients more feasible and acceptable. However, it is difficult to evaluate the need for additional centers precisely in relation to institutional capacity. A more pressing need may be for continued support of centers that have reached the end of their Federal funding cycles but are having trouble surviving on their own, Alcoholism programs have a less well developed constituency, although statistics indicate need far in excess of treatment capacity. Drug abuse programs have been a recent priority of the administration, as evidenced by their exclusion from the block grant and the President's request for substantial funding increases. This is a notable example of apparent Federal concern for a categorical grant program in the context of an otherwise strong preference for block grants and delegation of authority to States.

A stronger case in favor of expansion may be made for programs providing comprehensive medical services. Evaluations indicate their effectiveness in reaching groups not helped by medicaid and in pro-

viding care more efficiently,[15] although more specific and controlled comparisons are needed. Such programs currently serve only about 3 million people, perhaps 80 percent of them needy. Many millions are similarly needy and/or medically underserved but do not receive such services.

Paradoxically, either reductions or expansions in medicaid could increase the need for Government-sponsored medical treatment capacity. If medicaid programs cut the number of services covered or reimbursement rates for physicians, providers of private ambulatory care, already scarce in some areas, could find practice in underserved areas even less attractive. Increases in coverage could entitle more people to more services in areas where capacity does not exist.

Finally, approximately 80 percent, rather than the current 15 percent, of program costs might be recovered through patient revenues if national health insurance were enacted. Roughly $350 million less in categorical grant funding would be required to maintain the current level of services.[16] Alternatively, if spending for the categorical programs were held constant, together with a health insurance program, about 8 million additional persons could be served and net total Federal spending would effectively increase by $350 million.

Grants could be made for the support services—outreach, health education, and case management—that would remain uncovered by the financing system, but with continued HEW monitoring and quality control of all services provided by the project. Such a plan might be preferable to simply making all services reimbursable, and allowing new programs to develop on their own, because the support services in question could lend themselves to abuse on a straight vendor payment basis. Another method of financing comprehensive care that also might offer protection against vendor abuse would be to make reimbursement for support services available only to approved programs, private or public, as part of a prepaid per capita rate.

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[15] An example of findings that Federal categorical health programs reach persons not helped by medicaid, particularly the rural and minority poor, are those by Davis, K., "Health and the War on Poverty: A Ten Year Appraisal," Brookings Institution, draft 1976. The effectiveness of such programs with regard to outcome measures has been reported, for example, in Gordis, L., "Effectiveness of Comprehensive Care Programs in Preventing Rheumatic Fever," *New England Journal of Medicine,* 289:331–335, 1973, and in Newport, J. and M. Roemer, "Comparative Perinatal Mortality under Medical Care Foundations and Other Delivery Models," *Inquiry,* 12:10–17, March 1975. The efficiency of government programs providing comprehensive health services compared with reliance on medicaid is suggested in Buttery, C.M.G. and L. Holland, "The Use of Health Care Aides In a Medical Assistance Program," unpublished report from the Portsmouth, Virginia Department of Public Health to HEW Social and Rehabilitation Services, February 1974. Reductions in hospitalization attributable to neighborhood health centers have been reported in Bellin, S.S., H.J. Geiger and D. Gibson, "Impact of Ambulatory Health Care Services on the Demand for Hospital Beds," *New England Journal of Medicine,* 280:808–812, 1969, and in Klein, M., et al., "The Impact of the Rochester Neighborhood Health Center on the Hospitalization of Children," *Pediatrics,* 51:833–838, 1973.

[16] It should be noted that this reduction would apply only to the categorical grant programs. Under national health insurance, net Federal budget totals would tend to increase substantially.

HOSPITAL COST INCREASES: CAUSES, PRESIDENT'S PROPOSED COST LIMITS, AND SOME ALTERNATIVES

SUMMARY

In fiscal year 1977, the Federal Government will spend over $42 billion for personal health care services; which will be 9.2 percent of Federal expenditures. In recent years, the proportion of the Federal budget allocated for health expenditures has been increasing. In 1950, such spending accounted for 2.2 percent of Federal expenditures. Most of this growth has come from the entitlement programs—medicare and medicaid. In fiscal year 1971, total medicare expenditures were about $7.8 billion and for fiscal year 1977 the President's current services estimate is $21.7 billion.

Because expenditures are the fastest rising component of medical care, the President's 1977 budget requested that the increases in per diem costs recognized by medicare be limited to 7 percent, rather than the expected 15 percent.

About 80 percent of the increased medicare hospital expenditures in 1977 will result from increase in the cost per hospital day. Between fiscal years 1964 and 1976, the cost per hospital day has increased fourfold. Higher hospital per diem costs result from the higher prices paid by hospitals for the goods and services they buy and because of the new services or the greater intensity of care they provide. Costs per patient day increased more rapidly after the enactment of medicare and medicaid, with the exception of the economic stabilization period, 1971–74. In the late 1960's and early 1970's, the higher wages and prices paid by hospitals were the primary reasons for greater increases in hospital costs. However, the growth rate in new services more than doubled between the years 1960–65 and 1969–71.

Substantial increases in insurance coverage—both private and public—contributed to the higher demand for health care. Currently, over 90 percent of hospital revenues are derived from insurance or third party payers. As insurance coverage assures hospitals payment for the care delivered, little incentive exists for hospitals to hold down their costs.

The economic stabilization period temporarily halted the annual double digit increases in the cost per hospital day. While the phase II objective of an 8-percent increase in cost per day was not achieved, the basic goals of the program were—hospital's wage increases were held to those of the overall economy and the annual increase in new services returned to the premedicare rate. Hospitals held back on staff increases soon after the controls were implemented and, by 1974, nonpersonnel items also were significantly affected. Once the controls were lifted in 1974, annual hospital per diem increases went back to the rates prevailing before the economic stabilization period.

The President has proposed that medicare should provide a uniform increase of 7 percent in its per diem reimbursement next year. This

level would allow for no increase in new services. Moreover, at the rates of inflation assumed, the 7-percent limit would not even allow hospitals to pay wage increases comparable to the overall economy and to purchase the same level of goods and services. As the expected cost increase is about 15 percent, the 7-percent limit yields a first full year savings to medicare of about $1 billion.

There are alternatives to the President's proposal which could also yield significant savings in fiscal year 1977. A 10- to 12-percent per diem reimbursement limit could be established and applied uniformly or with some discretion. These limits would permit some expansion of new services. While a flexible approach would be suitable for meeting the specific needs of hospitals, it would be more difficult to administer. The first full year's savings for an 11-percent limit would be about $500 million. Finally, the allowable increase in cost per day could be set as a percentage, say 133 percent, of the increase on the consumer price index (CPI). This would yield first full year savings of about $625 million.

INTRODUCTION

Federal expenditures for health care have been rising rapidly over the last decade. This paper will assess and analyze the factors which contributed to inflation in the hospital sector, the largest component of medical care. Using this analytical framework, the President's proposal for limiting medicare reimbursements will be discussed as well as some alternative proposals.

In fiscal year 1977 over $150 billion will be spent in this country for personal health care services. Of this total about $42 billion will be spent by the Federal Government. Health care expenditures are rising as a percentage of the gross national product (GNP). In 1950 total health expenditures represented 4.6 percent of GNP. In 1975 that figure increased to 8.3 percent.

Since 1964, prices in general have almost doubled, but the cost per patient day in a hospital has quadrupled. While higher wages for health workers and higher prices paid by hospitals for goods and services have accounted for a large portion of this increase, a significant proportion of this increase has resulted from new and expanded treatments. Thus, rising hospital costs refer to the combined effect of the higher wages and prices paid by hospitals and increases in the services they provide.

The growth in Federal expenditures, particularly medicare, has followed this same trend. In fiscal year 1971, total medicare expenditures were about $7.8 billion. Under the President's current services budget for fiscal year 1977, medicare expenditures are estimated at about $21.7 billion, which includes a $2.9 billion, or 15 percent, increase in the hospital insurance (HI) portion of medicare over fiscal year 1976.

To arrest this growth, the President has proposed in his fiscal year 1977 budget that the increase in medicare per diem reimbursement under HI be held to 7 percent, about half of the expected increase in hospital costs. By limiting the increase to 7 percent, the President estimates a budget savings of about $750 million in fiscal year 1977.

Because the largest portion of both medicare and private health care expenditures are for costs incurred in hospitals, it is worthwhile to focus more closely on the reasons for these higher costs.

I. INFLATION AND HEALTH CARE COSTS

Historically, health care prices have risen faster than overall prices. In table 1 the rate of inflation for the economy as a whole and for health care are compared for selected years over the last two decades. Hospital prices, in particular the semiprivate room charge shown in table 1, have risen much faster than the CPI.

Table 1 also points up the fact that in the years since the passage of the medicare and medicaid legislation, the difference between overall inflation and health care inflation rates increased substantially. The economic stabilization period (August 1971 to April 1974) produced the only abatement in medical care inflation since the inception of medicare. After the price controls were lifted, the rate of inflation returned to the level of the late 1960's.

TABLE 1.—AVERAGE ANNUAL PERCENTAGE INCREASES IN OVERALL AND HEALTH CARE PRICES FOR SELECTED YEARS, 1955 TO 1975, AND FOR THE ECONOMIC STABILIZATION PERIOD

Year	CPI all items	Medical care	Semiprivate room charge
1955	2.2	3.8	6.9
1960	2.0	4.0	6.3
1965	1.3	2.5	5.8
1967	2.9	7.1	19.8
1970	5.9	6.3	12.9
1975	8.5	10.0	19.1
Economic stabilization period (August 1971 to April 1974)	6.4	4.3	5.7

Sources: Quarterly Report, Council on Wage and Price Stability, June 1975; Price Statistics, Bureau of Labor Statistics, Department of Labor; Phase IV Health Care Regulations, Federal Register, Mar. 27, 1974.

Higher prices charged do not fully describe the increased cost of a hospital day. For example, in addition to the substantial increase in the price or charge for a semiprivate room as shown in table 1, the patient is also receiving more intensive care, more drugs, and more tests; all of which are administered by a larger number of hospital personnel and all of which cost more money. Table 2 shows the recent trend in total cost per adjusted patient day, which includes both increased prices and increased services. Between fiscal year 1964 and fiscal year 1976, costs per day will have increased fourfold, while the semiprivate room charge has about tripled.

TABLE 2.—HOSPITAL EXPENSES AND PERCENTAGE INCREASE PER ADJUSTED [1] PATIENT DAYS FOR EVERY OTHER FISCAL YEAR FROM 1964 TO 1976

Year	Dollar cost	Percentage change from previous year
1964	$37	----------
1966	44	7.8
1968	56	14.3
1970	73	13.2
1972 (economic stabilization period)	93	11.8
1974 (economic stabilization period)	111	9.6
1976	[2] 150	17.0-18.0

[1] The adjusted patient day accounts for the changing composition of hospital services between inpatient and outpatient.
[2] Estimated from American Hospital Association, Hospital Indicators.

Source: American Hospital Association, Hospital Panel Survey, fiscal year statistics compiled by Office of Research and Statistics, Social Security Administration.

Again, increases per day rose after medicare was enacted and the increases slowed during the economic stabilization period, which was also true for the economy as a whole during that period.

Table 3 breaks down these increases in average annual costs in a hospital day into the two categories being discussed: Higher wages and prices; and changes in services. Changes in services are further broken down into personnel and nonpersonnel items such as numbers of tests, X-rays, level and type of therapeutic treatment.

TABLE 3.—AVERAGE ANNUAL PERCENTAGE INCREASES IN EXPENSES PER PATIENT DAY[1]

	1950–60	1960–65	1969–71	Economic stabilization period 1971–74	Year following economic stabilization period 1974–75
Total expense	7.5	6.7	14.8	11.5	15.2
Increases in wages and prices	3.8	3.5	8.2	6.4	10.0
Wages	5.2	4.7	10.0	6.1	9.0
Prices	1.5	1.3	5.1	6.8	11.4
Changes in service	3.7	3.2	6.6	5.1	5.2
Number of personnel	3.1	1.7	3.7	2.7	2.5
Other (nonpersonnel, e.g., X-rays, lab tests, etc.)	4.6	5.6	10.3	8.7	9.3

[1] This series does not reflect the increase in outpatient care which was incorporated in table 2.

Source: Hospitals, Guide Issue, August various years; Hospital Statistics, 1975, American Hospital Association; Consumer Price Index, Bureau of Labor Statistics.

In the late 1960's and early 1970's, higher wages and prices were the primary reasons for increased hospital costs. However, the number of personnel and nonpersonnel items were also increasing rapidly. The annual percentage increase of hospital workers rose from 1.7 to 3.7 between 1960 and 1965 and between 1969 and 1971. The other or nonpersonnel component jumped more rapidly, from 5.6 percent to 10.3 percent during the same period of time.

In large part, these increases in health costs—both price increases and increases in services—resulted from the higher levels of demand which did not abate even in the face of higher costs. The substantial increases in coverage provided by health insurance, private, public, and other methods of reimbursement such as medicaid, were the major factors behind the higher demand. Between 1950 and 1975, insurance payments for medical care rose significantly and now pay for about 90 percent of hospital bills. About one-third of this 90 percent comes from medicaid and medicare payments.

Because of this increased insurance coverage and because of the unique pattern of "cost-plus" reimbursement which has evolved in this country, neither the patient nor the hospital has been paying much attention to the costs of care. Since physicians realize that patients will be paying little or nothing out of their own pockets, they may not utilize resources efficiently. Moreover, since hospitals receive over 50 percent of their revenues on the basis of actual costs incurred and, therefore, revenues rise automatically with expenses, they have not made curtailing costs or limiting expensive procedures high priorities. It is because of the greater cost increases and tendencies of the health sector to use resources indiscriminately that significant attention was paid to this sector during the economic stabilization period.

II. REDUCTIONS IN COSTS DURING ECONOMIC STABILIZATION PERIOD

During phase II of the economic stabilization period, hospitals were not allowed to increase their revenues resulting from higher prices by more than 6 percent annually. In order to permit growth of 2 percent in the quality and quantity of services, total costs per diem could rise only 8 percent.

Prices charged by hospitals did correspond to phase II limits, as can be seen from the 5.7-percent increase in the semiprivate room charge shown in table 1 for the economic stabilization period. While the increase in the cost per patient day did fall, it did not decrease to 8 percent. Rather, during the economic stabilization period, costs increased by 11.5 percent. This is because the intensity of services rose at 5 percent rather than the programed for 2 percent.

The measures employed by hospitals to hold costs down during the economic stabilization period are not completely clear. However, the rapid increases after the controls were lifted suggest that stop-gap rather than permanent reforms took place.

Payroll costs

Reductions in the rates at which both wages and personnel rose account for a large part of the slower increases in cost per day.

As is shown in table 4, salary and wage increases were much smaller during the economic stabilization period. In the late 1960's wages rose rapidly as traditionally low-paid hospital workers attempted to gain wage comparability with workers in other sectors of the economy. The extension of minimum wage coverage to hospitals and the growth in collective bargaining contributed to the pressures for higher wage demands. Of course, the higher revenues that hospitals could generate because of greater insurance coverage permitted the increases to occur. In the period after controls were lifted, wages have again risen rapidly, but it does not appear that a total catch-up has resulted.

TABLE 4.—*Annual percentage increases in salary of community hospital employees*
(calendar years)

Year:	*Percentage increase*
1969	9.4
1970	10.1
1971	10.3
1972 (economic stabilization period)	8.0
1973 (economic stabilization period)	4.5
1974	5.7
1975	[1] 9.8

[1] Estimated.

Source: Hospital Statistics, 1975, American Hospital Association.

An additional means of holding down payroll increases is to lower staffing levels or staff-to-patient ratios. While no cutbacks occurred during the economic stabilization period, the growth rate of employees to the average daily number of patients slowed. This is shown in table 5. While the employee-to-patient ratio rose by 4.3 percent between 1969 and 1970, it increased by only 1.6 percent between 1972 and 1973. After the removal of controls, hospitals began to increase their staffs at rates close to those existing before the controls were imposed.

TABLE 5.—EMPLOYEES PER AVERAGE DAILY NUMBER OF PATIENTS IN COMMUNITY HOSPITALS

Year	Employees per patient per day	Percentage increase from previous year
1969	2.80	----------
1970	2.92	4.3
1971	3.01	3.1
1972 (economic stabilization period)	3.10	3.0
1973 (economic stabilization period)	3.15	1.6
1974	3.26	3.5
1975	[1] 3.37	[1] 3.4

[1] Estimated.

Source: Hospital Statistics, 1974, American Hospital Association.

Nonpayroll costs

As indicated in table 3, the purchase of non-personnel items such as drugs, X-ray machines, and the like decreased during the economic stabilization period. Because the purchase of large-scale capital equipment and facilities, which are nonpersonnel items, have a long lead-time, it was not until 1974 that these items were affected. In 1974, the total assets of all hospitals increased by 9.2 percent, which was somewhat slower than the 10.2 percent for 1972–73.

Since the lifting of controls, nonpayroll costs have risen rapidly because of the higher rate of overall inflation and because the annual increase in nonpersonnel items has returned to the level existing before the imposition of controls, about 10 percent.

III. PRESIDENT'S PROPOSAL FOR RESTRAINING HOSPITAL COST INCREASES IN FISCAL YEAR 1977

The President's current services estimate for the hospital insurance program for fiscal year 1977 is $15.1 billion, $2.9 billion above the expected $12.2 billion in fiscal year 1976. (This projected increase covers a 15-month period which includes the transition quarter.) Only about 20 percent of this estimated increase results from a growth in beneficiaries and higher utilization rates per beneficiary. About 80 percent, or $2.4 billion of the $2.9 billion, is estimated to result from higher costs per patient day.

While precise details on how the President developed his current services estimate are not yet available, it appears that the expected rise in cost-per-patient-day is about 15 percent.

In terms of payroll and nonpayroll costs, the breakdown shown in table 6 seems reasonable (using the President's CPI estimate).

TABLE 6.—ESTIMATED COST INCREASES UNDER THE PRESIDENT'S PROPOSAL

	Estimate of fiscal year 1977 percentage increase	Percentage of total costs	Estimate of fiscal year 1977 percentage increase in cost per patient day
Wages	11		
Personnel	3		
Total payroll	14	52	7.3
Prices	6		
Nonpersonnel inputs	10		
Total nonpayroll	16	48	7.7
Total			[1] 15.0

[1] In terms of the breakdown presented in table 3, this projected 15-percent increase would result from an 8.6-percent increase in wages and prices and a 604-percent increase in services.

Although the expected increase in hospital per diem costs is approximately 15 percent, the President has requested that a 7-percent limit be established for increases in medicare. If hospital wage increases were held to that of the general work force and if prices paid by hospitals for goods and services increased at the same rate as for the overall economy, hospital costs would go up by 7.8 percent. While it is very unlikely that hospitals could afford to refuse to participate in medicare, the maximum 7-percent rate rise could lead to a reduction in services being provided to medicare beneficiaries or a shifting of the medicare nonreimbursed costs to other patients in the form of higher prices. If these limits were maintained for a long period of time, hospitals might begin to segregate medicare patients and provide their care with fewer staff or in more crowded settings.

The 7-percent limit on cost increases would result in considerable savings to the medicare program. Each percentage point cut from the expected cost-per-day increase results in a fiscal year 1977 saving of about $125 million according to CBO estimates (1 percent of $12.5 billion). Thus, a full year's savings from the 8-percentage-point reduction (from 15 to 7 percent) in the cost-per-patient-day is about $1 billion.

IV. ALTERNATIVE APPROACHES TO THE PRESIDENT'S REIMBURSEMENT LIMITS

There are other levels and methods of controlling the increase in cost per patient day which also could result in significant savings to the medicare program. However, since these approaches as well as the President's are limited to medicare reimbursements, they could result in discriminatory treatment for medicare beneficiaries and higher costs for nonmedicare patients. The following are three alternatives; the first alternative would establish a higher limit while the latter two present alternative methods as well as higher limits.

Set an annual maximum increase in cost per patient day at 11 percent for all hospitals

If the President's program was carried out, but the rate of increase for all hospitals were set at 11 percent, rather than the recommended 7 percent, hospitals could increase the quality and quantity of services they provide. If it is assumed that wages and prices paid by hospitals rise at the same rate as for the overall economy, hospital staffs could increase by 1 percent and other nonpersonnel items could increase by about 5.6 percent. The 5.6-percent increase in nonpersonnel items would be a reduction from current rates, but it would equal or exceed the rates experienced from 1950 to 1965.

The first full-year savings to medicare under this alternative would be $500 million.

Establish an overall increase at 11 or 12 percent in cost per patient day but permit cost increase variations among hospitals

The increase in nonpersonnel items does not occur equally among all hospitals. In any given year, some hospitals will be remodeling or making major equipment acquisitions while others will not be. Costs will rise faster in those hospitals making larger purchases.

If the basic increase for all hospitals were set at 10 percent, an exception procedure could be established to distribute an additional $250 million in fiscal year 1977 to those hospitals incurring unusually high costs for the reasons discussed above. This adoption of this approach would be equivalent to establishing a 12-percent total limit on cost increases recognized by medicare.

Provision could also be made for those hospitals in financial difficulty. While financial difficulties severe enough to threaten the closure of a hospital are rare, such an occurrence could necessitate a substantial increase in the reimbursement rate.

The 10-percent average rate increase would permit all hospitals to pay higher prices for the goods and services they buy and to increase the medical care services they offer. The exceptions process, which probably would have to be conducted by the Secretary of Health, Education, and Welfare, could be coordinated with the existing planning process at the regional level in order to assure that the needed service expansions are not affected by the reduced rates of reimbursement. Furthermore, to make the process administratively manageable, the reasons for securing an exception would have to be limited and clearly circumscribed.

As the CPI falls or rises, the average increase in the hospital reimbursement rate could be adjusted. The key element of this approach is the establishment and maintenance of an exceptions process with annual expenditures not to exceed 2 percent of the total expected medicare outlays. The importance of such an exception process grows as tighter limits are placed on hospital reimbursement increases.

The first full-year savings to medicare under this alternative would be $375 million.

Set hospital increases at the metropolitan or regional level according to 133 percent of the overall cost increases for that geographic area

By permitting different cost increases for different areas of the country, the rigidity of nationwide price limitations is reduced. If costs in urban areas rise faster, hospital costs would be pushed up more and higher levels of reimbursements should be possible.

Finally, unlike the President's proposal which sets the increase in costs at about the CPI increase, this approach recognizes that the reason for higher hospital costs is more than just higher prices. The 133-percent factor would permit some additional services. A 10-percent overall increase in fiscal year 1977, which is about 133 percent of the expected increase in the CPI, would permit hospitals to increase the services they provide to the rate existing before the enactment of medicare. If the inflation rates in the different regions of the country varied, this approach would lead to different increases for hospitals according to their location—but all hospitals could increase the services they provide. However, if the rate of inflation in a region (or for the country) were brought down to a very low level, this approach would permit very little expansion in hospital services.

Since the overall increase in costs would fall by about 5 percent in 1977, the first full year savings to medicare under this alternative would be approximately $625 million.

PUBLIC HEALTH SERVICE HOSPITALS

SUMMARY

The President has proposed that the remaining eight general Public Health Service (PHS) hospitals be closed and that primary PHS beneficiaries (U.S. merchant seamen, active duty Coast Guard, PHS and National Oceanographic and Atmospheric Administration personnel) be given care through contracts with community facilities and through continued operation of the 26 freestanding outpatient clinics. Responsibility for the care of Coast Guard personnel would be transferred to the Department of Transportation; the alternative treatment of other Federal beneficiaries (secondary PHS) would be arranged by the responsible agencies.

The exact cost of the President's proposal is not known since it depends upon the type of contractual arrangement made by PHS for primary beneficiaries, the future demand of primary beneficiaries for PHS contract care, and the length of stay they experience in community hospitals. Under varying assumptions on future demand and length of stay, estimated costs of the President's proposal range from $137 million to $207 million in 1977. This compares to an estimated cost of $141 million in 1977 to continue to operate the PHS system at 1976 levels. Because the 1977 estimates of the President's proposal contain a one-time cost of phasing out the hospitals, a comparison of 5-year costs is more informative. The 5-year cost of the President's proposal ranges from $620 million to $1.1 billion, while the 5-year cost of keeping the hospitals open is $913 million or $1.1 billion if capital improvement costs are included.

Alternatives to the President's proposal or current policy are to:

—End the eligibility of primary beneficiaries for PHS care;

—Restrict the PHS system to primary beneficiaries; and

—Modify the President's proposal by contracting with the Veterans' Administration (VA) for the care of primary beneficiaries.

Ending the eligibility of primary beneficiaries for PHS care could be based on the increased availability of employer-provided health programs. It is estimated that this could save more than $700 million over a 5-year period. By restricting the use of PHS hospitals to primary beneficiaries, an estimated $20 million could be saved in 1977 if staff and overhead related to the use by other beneficiaries were reduced. Savings would total $290 million through 1981. Contracting with VA would increase the accessibility of primary beneficiaries to Federal hospitals and would probably not overburden the VA system. This alternative could save $190–$300 million over a 5-year period.

INTRODUCTION

The Public Health Service of the Department of Health, Education, and Welfare is responsible for providing health care to four groups of primary beneficiaries: American merchant seamen, active duty U.S.

Coast Guard personnel, active duty National Oceanographic and Atmospheric Administration personnel, and the active commissioned officer corps of the PHS. Health care is also provided on a reimbursable basis to other Federal beneficiaries when resources are available within the system.

To fulfill its basic responsibility, the PHS operates 8 general hospitals and 26 outpatient clinics, purchases health services in 4 outpatient clinics, and contracts with about 250 physicians and dentists to provide health care to ambulatory patients. In emergency situations when PHS facilities are not readily available, PHS will authorize the care of primary beneficiaries in other hospitals.

I. TRENDS IN UTILIZATION

Because of declining patient loads, particularly among seamen, hospitals were gradually closed or converted to outpatient facilities between 1953 and 1973. In 1973, in response to executive branch efforts to close the remaining eight hospitals, Public Law 93–155 was enacted which required congressional authorization to close or transfer facilities or to reduce the level or range of services provided.

Table 1 describes the utilization of the eight PHS hospitals in fiscal year 1974 by class of eligibility.

TABLE 1.—NUMBER OF ELIGIBLE BENEFICIARIES AND TOTAL ADMISSIONS IN THE 8 PHS GENERAL HOSPITALS, FISCAL YEAR 1974

	Number eligible	Admissions
Complete care (DHEW primary beneficiaries)	241,000	13,839
Seamen on American flag vessels	197,000	11,385
Coast Guard personnel on active duty	36,700	2,269
NOAA personnel on active duty	900	42
PHS commissioned officers on active duty	5,500	143
Care for job-related compensable conditions (Department of Labor beneficiaries)	123,000	504
Limited care (full outpatient care; inpatient care if available)	103,800	13,219
Retired NOAA, Coast Guard, and PHS commissioned officers	16,100	723
Special study, emergency, other		2,410
Dependents of PHS commissioned officers, Coast Guard, and NOAA personnel	87,700	854
Other Federal, including retired DOD	NA	9,232

Source: Bureau of Medical Services Annual Statistical Summary, fiscal years 1973 and 1974.

Primary beneficiaries are a declining portion of PHS hospital caseload. As shown in table 1, half of the 1974 admissions were for primary beneficiaries. Slightly over one-third were under the reimbursable program. Primary beneficiaries will represent only about 47 percent of admissions in 1976.

II. THE PRESIDENT'S BUDGET

The President's 1977 budget recommends that primary beneficiaries be provided medical care solely through contracts with medical facilities in their communities and through continued operation of the freestanding PHS clinics. Responsibility for the care of Coast Guard personnel would be transferred to the Coast Guard. The care of other beneficiaries would be provided by the responsible agencies in some other manner. Closure of the facilities in Baltimore, Boston, Galveston, New Orleans, Norfolk, San Francisco, Seattle, and Staten Island is recommended because:

—Only 69 percent of the hospitals' operating capacity will be used in 1976.
—The primary beneficiaries make up too small a portion of the patient load.
—The hospitals are located in major metropolitan areas where adequate facilities are available and where, in five locations, there are excess community beds.
—Were the hospitals to remain open, substantial capital investment would have to be made to enable them to meet modern standards for hospital facilities.

Legislation to close the hospitals will be submitted in order to comply with the requirements of Public Law 93–155. No additional authority is needed to provide contract care.

Factors affecting budget impact

Leaving aside the question of the basic eligibility of primary beneficiaries for PHS care, one can examine the budget implications of the President's recommendation to close the hospitals but keep independent outpatient clinics open. The recommendation is based on the premise that the private sector will be more efficient in delivering health care than the Federal Government.

The budget estimates indicate that the cost of contract hospital care for primary beneficiaries is expected to be no greater than the cost of continuing to operate the PHS hospitals, excluding capital improvement. The actual cost of the proposal will depend, however, on the degree of primary beneficiary participation in the PHS program after the eight remaining hospitals are closed.

Closures of PHS hospitals in the past have resulted in a decline in caseload despite the availability of contract care. It is possible that the closure of the remaining eight would also cause the participation to drop. However, PHS has restricted the use of inpatient contract care to emergencies so that, if a condition is not certified as emergent by a PHS contract physician or other authorized official, a beneficiary must now travel to a PHS hospital or secure treatment at his own expense. Naturally, this tends to restrict demand as the number of operating PHS hospitals shrinks. Once this constraint is lifted by closure of the remaining eight hospitals, the caseload could expand sharply depending upon the nature of the contractual arrangements proposed by the President and the number and location of contract hospitals.

The length of time a primary beneficiary stays in a private hospital is another variable influencing cost about which little is known. The length of stay of primary beneficiaries in PHS hospitals (an estimated 17 days in 1975) is longer than that experienced by males of the same age group in the private sector (10.7 days in 1974). Several reasons have been advanced for this, the major ones being:

—Long distances which must be traveled to PHS hospitals and the resulting reluctance of physicians to discharge patients who are too far from the hospitals for followup;
—Provision of complete care upon admission rather than treatment of a specific acute condition; and
—A greater portion of traumatic injuries.

The distance factor will certainly be minimized if not eliminated through contract care in community hospitals. To the extent that the

patient mix in PHS hospitals (i.e., more chronic cases or more severe diagnoses) contributes to longer lengths of stay, broadening the base of participants by using community hospitals could change the primary beneficiary case mix to a more normal one. Reducing the distances would tend to confine hospital stays to specific conditions. These factors will tend to reduce the length of stay of seamen from that experienced in PHS hospitals. The degree to which length of stay is shortened can offset the higher per diem rates in the community and bring cost per patient treated closer to the PHS cost. Per diem rates, including physician expenditures, in community hospitals are estimated to be $208 in 1977 compared with an estimated $125 in PHS hospitals. The PHS per diem is understated somewhat since it does not include depreciation of capital as does the community hospital rate.

Estimated budget impact

In order to compare the impact of these various possibilities on costs, a series of estimates have been prepared showing costs of providing the same real services over a 5-year period. The projected cost of operating the PHS system at 1976 levels has also been developed to serve as a point of reference. Both public and private sector estimates have been inflated at the same rate. The distribution of 1976 inpatient workloads is shown in table 2.

TABLE 2.—*Distribution of inpatient workloads in PHS hospitals, fiscal year 1976*

	Admissions
Primary beneficiaries (excluding Coast Guard)	11,700
Coast Guard	2,400
Secondary beneficiaries	11,100
Other	4,700
Total	29,900

The estimated cost of treating this number of admissions and providing the same real levels of research, training, and outpatient services is $141 million, including the cost of central management. Moreover, continued operation of the eight hospitals carries an implicit commitment to upgrade the facilities, which were built in the 1930's and 1940's, to more modern standards. Depending upon whether this were accomplished by renovation or new construction, an additional $100 million to $210 million would be needed over the 5-year period. Estimated 5-year costs of continuing to operate the system would then be between $1 billion and $1.1 billion.

TABLE 3.—EXPECTED COST OF KEEPING PUBLIC HEALTH SERVICE HOSPITALS OPEN

[In millions of dollars]

	1977	1978	1979	1980	1981
Primary beneficiaries	$32	$36	$41	$46	$51
Other beneficiaries	47	53	61	68	75
Clinics, Carville, Tuskegee	26	30	33	38	42
Research and training, contracts	14	16	18	20	22
Other	18	21	23	26	29
Operating cost	137	156	176	198	216
BMS central management—3 percent of operations	4	5	5	6	7
Subtotal operations	141	161	181	204	226
Capital improvement [1]			100–210		
Total, 5-year cost			1013–1123		

[1] Range of estimated cost of upgrading 1,700 operating beds by either renovation or new construction. Fewer beds would be renovated than presently operated to raise the occupancy rate to 85 percent.

Costs of the President's proposal under various assumptions of increased participation and reduction in length of stay are illustrated in table 4. The assumptions are:

1. No increased participation of primary beneficiaries and a length of stay (11.6 days) that is 25 percent lower than the average PHS experience.

2. Increased participation by seamen who do not have private health insurance and an 11.6-day length of stay.

3. Increased participation by both privately insured and uninsured seamen (that is, same admission rate as their age/sex counterparts in the private sector) and private sector length of stay experience (10.7 days).

4. Increased participation by both insured and noninsured seamen but a length of stay only 15 percent lower than the PHS experience (13 days).

Costs of closure under all assumptions are higher in 1977 than in later years due to a one-time hospital phaseout cost estimated by PHS to be approximately $46 million. The impact on costs of the various assumptions is quite significant. The 5-year costs under the assumptions in No. 4 are over 70 percent higher than those under the assumptions in No. 1. If the characteristics described in the first set of assumptions prove correct, costs would be lower than under the other assumptions. The costs would also be lower than continued operation of the present system because in the assumptions participation is held at the 1976 levels. Costs under the assumption in No. 2 would be higher than continued operation in 1977, but lower over the 5-year period. Costs under assumptions in No. 3 and No. 4 are higher than under the present system if capital improvement is excluded because of the significant increase in participation but are equivalent to or lower if capital costs are added to the implicit cost of keeping the hospitals open.

III. ALTERNATIVES

Some alternatives to operating the PHS system or to accepting the President's proposal are described below. Their impact on the budget varies considerably.

A. End the eligibility of merchant seamen and other primary beneficiaries for free care. After initial phaseout of the system, there would be no PHS expenditures for this program.

B. Permit only primary beneficiaries to use the system. Close wards which are not necessary to meet the demand of primary beneficiaries and reduce the number of outpatient clinics.

C. Close the hospitals but contract for care in VA hospitals rather than in private facilities.

End eligibility

This alternative is based on a rejection of the premise that the Government should provide free medical care to privately employed merchant seamen and commercial fishermen who compose the bulk of the primary beneficiaries. When the Government first accepted the responsibility for health care of merchant seamen in 1798, it was to control the spread of diseases contracted by them and to stimulate, in some measure, a strong merchant marine which was important to the defense of coastal waters. The availability of alternative health care services and the changing role of seamen in the defense of coastal

waters make the original concept of Government responsibility somewhat obsolete.

Alternative A would end the eligibility of primary beneficiaries for free PHS care and the implicit Federal subsidy the fishing and shipping industries derived from free health care. Both the clinics and hospitals would be closed. Federal employees (NOAA, etc.) would become the responsibility of their respective agencies with their costs and some residual PHS costs (for example, for operation of the Carville Leprosarium) the only ones remaining.

Health care programs have become an important fringe benefit to many workers and an element in contract negotiations. In 1974, the National Bureau of Standards examined the availability of health insurance coverage for merchant seamen. It found that the plans available to seamen were typical of most broad coverage indemnity health insurance plans and that at least 97,000 seamen—half of the eligible seamen—were covered by such plans. Elimination of eligibility would not necessarily leave seamen unprotected but would likely force organizations who do not now offer their members or employees health benefits to do so.

Restrict hospitals to primary beneficiaries

Alternative B would reduce spending below the current policy level by restricting PHS direct services to primary beneficiaries. If wards and some clinics were closed, some overhead and related staff costs would be avoided. Of the $20 million reduction from current policy, more than half results from reduced overhead, staff, research, and training. However, limited capital improvement might still be necessary and further reduction of the operating capacity of existing hospitals might not be the most efficient use of resources. Outpatient care of secondary beneficiaries would have to be provided by the responsible Federal agencies since the clinics would no longer be available to them as under the President's proposal. However, based on experience with Department of Defense beneficiaries, this would not on average be more costly than their present purchase of care in the PHS clinics.

Contract with VA system

Alternative C is the same as the President's proposal with the difference that care for primary beneficiaries would be purchased from the VA rather than from the private sector. VA hospitals are distributed nationally, and are therefore more accessible than the eight PHS hospitals, although not so accessible as community hospitals. They also have excess capacity. If one assumes that an 85-percent occupancy of general medical and surgical (GM&S) beds is optimum, VA had over 10,000 unneeded GM&S beds in general hospitals in 1975.

VA hospitals have a lower cost per day than community and PHS hospitals, but a longer length of stay. Actual costs of this alternative will therefore also depend upon the length of stay experienced by primary PHS beneficiaries in VA hospitals. The VA alternative is estimated to be lower over time than current policy using both the PHS length of stay experience and the VA experience.

TABLE 4.—EXPECTED FEDERAL [1] COST UNDER ALL OPTIONS

[In millions of dollars]

Assumption/option	1977	1978	1979	1980	1981	Total 5 year
Current policy:						
Operation of PHS system at 1976 inpatient workloads:						
Excluding capital improvement	$141	$161	$181	$204	$226	$913
Including capital improvement	141	221	231	234	241	1,068
President's proposal:						
1. Contract care with 1976 level of admissions of primary beneficiaries (11,700) and 11.6-day length of stay (25 percent below PHS)	137	101	114	127	141	620
2. Contract care with admissions related to uninsured beneficiaries (20,000) and 11.6-day length of stay	162	124	140	157	173	756
3. Contract care with private sector admission rate (36,444) and length of stay (10.7 days)	190	161	182	204	226	963
4. Same as 3; length of stay 15 percent lower than PHS experience (13 days)	207	181	205	229	254	1,076
Alternatives:						
A. Elimination of eligibility of primary beneficiaries and complete closure of PHS system (except Carville and Tuskegee payments)	96	49	55	62	69	331
B. Operation of PHS system for primary beneficiaries only; closure of unnecessary wards and reduction of clinic capacity	121	137	152	173	191	774
C–1 Contract care with VA; PHS length of stay (15.5 days); admissions of 30,000	160	127	144	161	178	770
C–2 Contract care with VA; VA length of stay (20.9 days)	176	146	165	184	204	875

[1] Includes estimated administrative costs and the cost of DOD and other Federal agencies who now reimburse PHS for care of their beneficiaries but who would have to find care elsewhere if PHS system closed.

FEDERAL SUPPORT FOR BIOMEDICAL RESEARCH

SUMMARY

Biomedical research attempts to increase our knowledge about the biological bases of diseases as well as our knowledge on how to prevent, diagnose, and treat diseases. The National Institutes of Health (NIH), which is the major source of Federal support for biomedical research, will spend over $2.2 billion in fiscal year 1976. Over the previous three decades, NIH research expenditures have grown at over 22 percent per year. NIH supports research at its own 11 institutes (intramural) and research, in the form of both grants and contracts, on non-Federal premises (extramural). While intramural research comprised almost the entire Federal expenditures in 1947, it currently accounts for about 10 percent.

The growth in NIH research expenditures has not been steady. While expenditures did grow continuously from 1947 to the mid-1960's, expenditures stayed about constant between 1967 and 1970. During these latter years, the growth of social programs, including medicare and medicaid, and the Vietnam war reduced the funding priority of biomedical research. Between 1970 and 1976 biomedical research expenditures more than doubled. A major contributor to this growth was the war on cancer. Roughly half, or $500 million, of the $1 billion increase in NIH spending between 1970 and 1976 has been by the cancer institute.

The President's 1977 budget attempts to reverse the most recent trends. In particular, the budget reduces the NIH 1977 budget authorization below the 1976 appropriation level, redirects funds away from the cancer institute to other institutes at NIH and includes funds for beginning the construction of a new ambulatory care clinical facility at NIH.

The President has requested $2.14 billion for NIH in 1977. This is a decrease from the 1976 appropriation which will be about $2.25 billion. Since the cost of doing research is rising, the real level of Federal support for biomedical research will fall to the 1972 level. If Congress chooses to maintain the real level of expenditures in fiscal year 1977, a budget of about $2.4 billion would be needed. If some real growth is sought, perhaps 4 percent, the 1977 budget should be $2.5 billion.

The President's proposal would result in the cancer institute's share of NIH funds falling to 32 percent from 34 percent in 1975. This would reverse the growth in the importance of the cancer institute, which grew from 16.6 percent of total NIH expenditures in 1967 to 34 percent in 1975. If Congress decides to maintain the current balance, then an $800 million appropriation for the cancer institute rather than the President's request of $688 million will be needed in fiscal year 1977. Alternatively, Congress could redress the growing imbalance by increasing funds to all institutes except the cancer institute.

A new initiative in the President's 1977 budget funds the initial construction phase of an ambulatory care facility at NIH. This facility will increase outpatient visits at NIH from 35,000 in 1975 to close to 200,000 in 1980. This as well as other budgetary actions indicate a decision to expand the intramural programs. The construction decision is important because of its long-term cost implications and because it reverses the trend of NIH funding toward extramural research.

INTRODUCTION

For the 20 years following World War II, biomedical research expenditures grew rapidly. These expenditures were directed at increasing our knowledge about the biological bases of diseases as well as our knowledge on how to prevent, diagnose, and treat diseases. While less than 1 percent of national health expenditures were spent on biomedical research in 1946, 4.8 percent was so allocated in 1966, 20 years later. Since 1967, however, biomedical research expenditures have not kept pace with the growth in other health expenditures, particularly personal health expenditures. As a result, the percentage of national health expenditures spent on biomedical research has fallen to about 3.6 percent.

Federal expenditures as a proportion of total national biomedical research spending doubled in the post-World War II period, from about 30 percent to over 60 percent in the mid-1960's. NIH, which is the major source of Federal expenditures, will spend over $2.2 billion in 1976.

While Federal expenditures on biomedical research have increased substantially, the growth has not been continuous. NIH expenditures grew rapidly throughout the 1950's and up until the mid-1960's. At that time, new Federal, social, and health programs, often of an entitlement nature, and the Vietnam war placed biomedical research in stiff competition for scarcer Federal dollars. These factors resulted in an abatement in the growth of Federal support for biomedical research.

As can be seen from table 1 below, NIH obligations in current dollars stayed almost constant between 1967 and 1970, but fell considerably in real terms, from $951.3 million to $813.4 million. These trends were reversed in the 1970's. Current dollar expenditures doubled between 1970 and 1975, and the growth in real terms was almost 50 percent. A major factor explaining this expansion in research support was the decision by the administration and the Congress to initiate the war on cancer. Roughly half, or $500 million, of the $1 billion increase in NIH spending between 1970 and 1975 has been by the National Cancer Institute. The remaining $500 million was distributed among the other 10 national institutes, the John Fogarty International Center, the National Library of Medicine, and the Research Resources Division of NIH.

TABLE 1.—NIH OBLIGATIONS IN CURRENT AND CONSTANT DOLLARS, 1965–75

[In millions of dollars]

	1965	1967	1970	1975
Current dollars	$831.5	$1,024.5	$1,029.8	$2,056.9
Constant dollars (1965=100)	831.5	951.3	813.4	1,189.0

[1] Based on NIH's biomedical R. & D. deflator.

The up-and-down nature of Federal biomedical research expenditures reflects the practical difficulties involved in determining how much should be spent on biomedical research. Furthermore, because of the lack of an analytical framework for determining the appropriate level and mix of support, the growth rates of the individual institutes involved in doing biomedical research have been determined in large part by the success of special interest groups. The disease specific nature of some of the institutes, such as those for cancer, heart, and arthritis, enhances the effectiveness of groups seeking funds for specific disease. The lack of an effective interest group helps to explain why the institute supporting general research, the National Institute of General Medical Science, experienced the smallest increase in funding over the 1968–75 period.

The President's fiscal year 1977 budget attempts to reverse the trends of the last few years. In particular, it reduces the NIH authorization below the 1976 appropriation level, redirects funds away from the cancer and heart institutes to the other institutes at NIH and includes funds for beginning the construction of a new ambulatory care clinical facility. These are all important budget issues and this paper will focus on them.

I. LEVEL OF FEDERAL SUPPORT FOR BIOMEDICAL RESEARCH

As stated above, there is no generally agreed upon method for determining how much should be spent on biomedical research, and there is unlikely to be one developed soon, if ever, because of the difficulty of linking up research advances with the level of expenditures. In order to develop this linkage many conceptual and quantification problems will have to be resolved. First, there are difficulties in relating individual research efforts or the total level of research to knowledge development. But, even if this relationship were understood and predictable, answers must be provided as to whether the new knowledge will yield desirable and safe therapies. Finally, once this is done, new treatments must be shown to provide benefits to society in excess of their costs.

The President's budget would reduce total NIH support in fiscal year 1977. While the 1976 appropriation level was about $2.25 billion, the President has requested $2.14 billion for 1977. Because of the higher costs to conduct biomedical research in 1977 than in 1976, this $100 million plus reduction will mean that the real level of Federal support will return to the 1972 level. Table 2 shows NIH appropriations in current and constant dollars for the last 5 years.

TABLE 2.—NIH APPROPRIATIONS IN CURRENT AND CONSTANT DOLLARS, 1972–76

[In millions of dollars]

	Current dollars	Constant dollars [1] (1965=100)
1972	$1,506	$1,072
1973	1,763	1,201
1974	1,790	1,144
1975	2,092	1,205
1976	[2] 2,248	1,208
1977 (President's request)	2,140	1,076

[1] Based on NIH's biomedical R. & D. deflator.
[2] Based on 1976 conference level plus unauthorized training programs and pay raises.

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As total NIH spending has doubled between 1970 and 1976, Congress could decide to maintain the fiscal year 1976 level, but require budget reallocations among institutes and programs. If Congress seeks to maintain the real level of biomedical research support in fiscal year 1977, as it did between 1975 and 1976, a budget of about $2.4 billion would be necessary in 1977. Alternatively, if a real increase were sought, perhaps arbitrarily set at 4 percent, this would mean an NIH appropriation of $2.5 billion in 1977 assuming that increased spending did not induce higher costs of conducting research.

Finally, some would argue for an even bigger increase on the basis that the Federal investment in biomedical research should be maintained as a fixed percentage of the gross national product (GNP) or national health expenditures. The arguments offered for this approach are that private firms dependent on new technologies for maintaining profits invest a certain percentage of their revenues in research and development and that a stable level of support would provide a better basis for research planning.

There are difficulties with these arguments. First, the Federal Government, unlike private firms, must consider widely different alternatives for investment; gains from more biomedical research must be compared to gains from other social investments, such as in energy. Similarly, when private firms are under pressure to reduce their costs, research expenditures suffer. Second, it is unclear what percentage (3 percent or 6 percent) or base (GNP or health expenditures) should be used in the fixed percentage approach. In particular, should we spend more on biomedical research because of rising hospital costs? Finally, the analogy to investments that produce higher profits may not be applicable to research expenditures that could raise health care costs without improving health status. This latter point is important because an implicit argument of those seeking a fixed percentage of support for biomedical research would seem to be that such expenditures will eventually reduce or restrain health care expenditures. However, if as some experts assert, substantial increases in biomedical research create pressures for more expensive treatments or control technologies, then this percentage approach could encourage a spiraling of health care costs.

II. THE BALANCE BETWEEN INSTITUTES

Since 1970, there has been a substantial shift in the distribution of NIH research support among the various institutes. Table 3, on page 75, shows the pattern over the 1967–77 period.

Cancer institute support has grown much faster than that of the other institutes. Whereas the expenditures for cancer grew close to fourfold between 1970 and 1975, the expenditures for the other institutes grew by about 50 percent. The result of these differing trends has been a doubling in the percentage of all NIH funds going to cancer, from 16.6 percent in 1967 to 34.0 percent in 1975.

A somewhat surprising fact is that despite all the discussion and emphasis on heart disease, the percentage of NIH funds going to the heart institute in the 1970's has not increased, but rather has been stable.

TABLE 3.—NIH OBLIGATIONS AND DISTRIBUTION FOR CANCER, HEART AND OTHER INSTITUTES[1]

[Dollar amounts in millions]

Institute	Year			
	1967	1970	1975	1977
Obligation:				
Cancer	$170.4	$181.3	$699.3	$687.7
Heart	163.6	160.3	327.8	342.9
Other	690.5	688.2	1029.8	1109.2
Total	1,024.5	1,029.8	2,056.9	2,139.6
Percentage distribution:				
Cancer	16.6	17.6	34.0	32.1
Heart	16.0	15.6	15.9	16.0
Other	67.4	66.8	50.1	51.8
Total	100.0	100.0	100.0	100.0

[1] 1977 figure is President's budget.

In considering what is a proper balance of support, a number of factors seem relevant. Among them are the cost or prevalence of the illness, the public's concern and fear of the disease, and the scientific readiness to use funds effectively. Some of these criteria appear to have been important in determining expenditures. Cancer is the most dreaded disease and heart disease ranks first in terms of deaths (accounting for over one-third), hospital days, and causes of limited activity.

However, the increase in specific disease-targeted funding is questioned by researchers for two reasons: (1) breakthroughs are more imminent in other areas and (2) the best research as measured by one's scientific peers should be supported regardless of the subject area because it is impossible to predict which basic research will provide the breakthroughs for understanding the causes of particular diseases. A reason offered for the limited successes of the "war on cancer" in improving the survival rates from the most prevalent cancers is that the basic scientific knowledge of the causes of this disease is still deficient.

The President's budget redresses the growing budgetary imbalance between the institutes by shifting funds to institutes doing research on neurological disorders, immunology and the cellular and molecular basis of disease. The proposed shift in funds would result in the cancer institute's share of NIH funds falling to 32 percent in 1977 from 34 percent in 1975. Some of this shift toward basic research could, however, provide significant findings with regard to cancer.

Congress could decide to maintain the current balance between the institutes. If the total fiscal year 1977 budget were set at $2.4 billion, then about $800 million would go to cancer, $400 million to heart, and the other institutes would share $1.2 billion.

Alternatively, Congress could act to redress the imbalance by increasing funds to all institutes except cancer. If all institutes were funded to keep their efforts constant in real terms, then the total NIH budget would be about $2.35 billion. In addition, the $50 million which is saved from holding the cancer institute's budget at its fiscal year 1976 level could be reallocated to the other institutes.

A larger budgetary shift toward other institutes could result by accepting the President's fiscal year 1977 level for the cancer institute of $688 million and by increasing the budget of the other institutes by about 5 percent in real terms; perhaps to $420 million for heart and $1,250 million for the others, for a total NIH budget of $2.36 billion.

Finally, while this discussion has focused on the distribution of support among institutes, it might be desirable to decide first on the overall level of support for NIH. If individual institute decisions are made first, the budget for those institutes that do not fare as well might be increased in order to bring about a better balance. The end result of this process is a higher total budget. This is one of the reasons why the administration has requested a one line appropriation for NIH rather than the 15 separate appropriations currently provided.

III. AMBULATORY CARE CLINICAL CENTER

A new initiative included in the President's fiscal year 1977 budget funds the initial construction phase of an ambulatory care facility at NIH in Bethesda, Md. This construction effort, which is projected to cost about $100 million, is three pronged: A new ambulatory care center, modernization of the existing clinical center at NIH, and a large parking facility. The fiscal year 1977 budget includes $22 million for the parking facility.

This initiative is important because it indicates a decision by the administration to upgrade the intramural programs at NIH and will mean greater intramural research costs and staff in the future. This construction will permit visits in the outpatient research programs to rise from approximately 35,000 in 1975 to close to 200,000 by 1980. This growth could alter the balance of NIH funding between intramural and extramural research. Another indication of the administration's decision to upgrade and expand the intramural program is that the budget request for intramural research and direct operations is increased by about $25 million in fiscal year 1977, while the budget request for new competitive project grants is $100 million below the fiscal year 1976 level.

The budgetary decisions made on the construction of the ambulatory center should be based on the desired future direction and role of the intramural research program at NIH. Since the establishment of NIH, intramural research as a proportion of the total research budget has fallen from 100 percent to the present levels of between 8 and 30 percent for the individual institutes. Over the last few years, a number of institutes have had a decline in their intramural research staff. In part, this decrease reflects the growth in the ability of the nongovernmental sector to conduct high quality biomedical research.

While there is a clear need for the Federal Government to continue to support biomedical research, it is not evident how much should be conducted at NIH itself with Federal employees. That is, is the current intramural effort too small, too large, or about right with regard to basic or clinical research? There are reasons for maintaining a strong intramural program. A strong intramural progam could yield better management of the extramural efforts, could mean higher quality research, or could be used to fill voids in research areas. However, these criteria do not seem to explain the current large variation in the

importance of intramural programs at NIH, or more particularly, why the heart and cancer institutes spend less than 10 percent of their research funds intramurally, while the institute for allergy and infectious diseases allocates 20 percent.

An alternative to the President's three-pronged construction effort to improve NIH's intramural clinical research capacity is to weigh the merits of three components separately. In particular, it might be appropriate to begin the renovations of the clinical center immediately, while deciding upon the desired future growth of the intramural program, that is, whether to build an ambulatory care center and, if so, of what capacity. The latter is an important decision which goes far beyond the allocation of $22 million or $100 million in construction funds in fiscal year 1977.

FEDERAL SUPPORT FOR HEALTH MANPOWER DEVELOPMENT

SUMMARY

The Congress is currently considering renewal of the Comprehensive Health Manpower Training Act of 1971. The 1971 legislation shifted the nature of Federal support from limited special projects and financial distress grants to basic operating grants awarded on a per student (capitation) basis. In return for this Federal support, schools were required to increase enrollments to meet what was then perceived as a national shortage of physicians and other health professionals.

The 1971 legislation expired on June 30, 1974. Since then Congress has been deadlocked on the issues, and the programs authorized in the 1971 legislation have continued to be funded under special provisions in appropriations bills. The House and Senate each passed separate bills in the 93d Congress, but could not resolve their differences. In this session, the House passed a bill in July and sent it to the Senate. The administration revised its position in testimony before the Senate last September with the most significant change being the maintenance of capitation grants subject to conditions. Previously, the administration had sought to phase out capitation grants. The Senate Health Subcommittee has scheduled markups for late March.

Current programs provide for capitation grants conditioned on a one-time enrollment expansion, construction support, financial distress grants, special project grants, a limited number of service scholarships, and direct loans for training of health professionals. Whereas the previous legislation was concerned with increasing training capacity to meet perceived national shortages, the changes in health manpower supply and distribution that have occurred in the past 10 years have altered the current legislative concerns.

The House and administration bills, as well as the bill that passed the Senate last session, concentrate on improving geographic and specialty distribution rather than merely increasing enrollments and aggregate health manpower supply. At the same time, there has been a decreasing emphasis on student financial assistance designed to increase student access and complement enrollment expansion. The current focus is on increasing substantially student assistance in the form of scholarships in exchange for a service commitment. The reason for the shift has been the widespread recognition that, because of previous efforts, there now appears to be an adequate training capacity to meet health care needs, The physician pool is expected to be between 495,000 and 520,000 by 1985, up from 323,000 in 1970. The physician to population ratio is therefore expected to rise from 159 per 100,000 in 1970 to between 207 and 217 per 100,000 in 1985.

While dramatic improvements are occurring with regard to overall supply, shortages of health manpower in rural and inner city areas have become more visible over the last 15 years. As a result of the rela-

tively small number of health professionals in these areas, residents often have inadequate access to health care. The second important maldistribution issue is that of physician specialty. Despite the increase in physician supply during the 1960's and 1970's, the absolute number of primary care physicians decreased sharply. The proportion of physicians in office-based primary care practices declined from 45 percent to 31 percent between 1950 and 1970. About one-third of students now take primary care residencies; however, many experts believe that 50 percent of medical students should be trained in primary care.

The legislative proposals may be evaluated according to their impact on (1) adequacy of supply, (2) specialty maldistribution, (3) geographic maldistribution, and (4) equality of access for students. Federal budget impact and efficiency should also be included among the criteria.

In exchange for capitation grants, the administration bill requires maintenance of enrollment; the Senate bill of last session requires an enrollment expansion; and the House bill makes an enrollment expansion optional. Both the Senate bill of last session and the administration bill require schools to set aside places for students who are willing to serve in shortage areas. Service scholarships are provided for such students. The House bill allows remote site training as an option, requires shortage area service for nonrepayment of capitation grants, and offers voluntarily accepted service scholarships. The administration bill and the Senate bill of last session require schools to ensure that residency positions under their control are allocated to primary care specialties in increasing percentages. All three bills also provide residency stipend support for primary care residencies.

The House bill and the Senate bill of last session maintain the health professions loan program, and the administration bill phases it out. The administration bill relies on the guaranteed student loan program to meet the demand for student financial aid.

Budget options for health professions training during fiscal year 1977 include:

—The administration bill of about $300 million, 36 percent less than the fiscal year 1975 appropriation. The decrease is achieved by maintaining capitation grants at present levels for medical, osteopathic, and dental schools and eliminating it for all others. Mechanisms aimed at distribution problems—service scholarships and primary care residencies—are increased slightly.

—The House bill of about $550 million, 15 percent over the fiscal year 1975 appropriation. Capitation is increased moderately from present levels, as are primary care residencies. Service scholarships are increased more significantly.

—The Senate bill of about $680 million, 42 percent over the fiscal year 1975 appropriation. Capitation, primary care residencies, and service scholarships are all increased substantially.

Alternatively, Congress could formulate other middle-range options that would maintain capitation at present levels for medical, osteopathic, and dental schools while expanding primary care residencies and service scholarships substantially. Thus, any expansion would be targeted on mechanisms aimed at improving distribution.

INTRODUCTION

The Congress is currently considering renewal of the Comprehensive Health Manpower Training Act of 1971. Health manpower legislation was first enacted in 1963 to provide health professions schools—schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy—with grants for construction, tied to increased enrollments, and students in schools of medicine, osteopathy, and dentistry with loans. Subsequent legislation provided special improvement grants conditioned on small enrollment expansions. In the late 1960's financial distress grants were initiated to aid health professions schools. These grants grew rapidly and became the predominant source of Federal institutional assistance.

In 1971, the Congress accepted the argument advanced by the health professions schools that they provide services of national importance, and decided to emphasize basic operating support awarded on a per student basis (capitation) rather than financial distress grants.[1] Capitation grants were tied to increased enrollments to meet what was perceived as a national shortage of physicians and other health professionals. This legislation increased Federal support of health professions training considerably, from $332 million in fiscal year 1971 to $489 million in fiscal year 1972. The 1971 legislation expired on June 30, 1974. Since then Congress has been deadlocked on the issues, and the programs authorized in the 1971 legislation have continued to be funded under special provisions in appropriations bills.

Current programs provide for capitation grants conditioned on a one-time enrollment expansion, construction support, financial distress grants, special projects, direct loans, and a limited number of service scholarships.

I. PROBLEMS ADDRESSED BY HEALTH MANPOWER LEGISLATION

The changes in health manpower supply and distribution that have occurred in the past 10 years have altered the legislative concerns. The bills now under consideration and the bills which passed the House this session and Senate last session concentrate on improving geographic and specialty distribution rather than merely increasing enrollments and the aggregate supply of health professionals.

Adequacy of supply

One reason for the shift has been the widespread recognition that, because of previous efforts, there now appears to exist an adequate training capacity to meet health care needs. Enrollments have increased significantly; first-year medical school places grew 70 percent between 1965 and 1974 and total medical school enrollments grew by 65 percent between 1965 and 1974. The results of this increase in training capacity are just beginning to be felt. The physician pool is expected, conservatively, to be between 495,000 and 520,000 by 1985, up from 323,000 in 1970. The physician-to-population ratio is expected

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[1] One problem with financial distress grants was that they discriminated against State institutions, which could not claim distress as long as they could draw upon State funds. Another was that they did not encourage long-range planning and institutional stability. However, there is evidence that even with the shift to capitation grants, schools did not make long-term spending commitments based on Federal funding.

to rise substantially from 159 per 100,000 in 1970 to between 207 and 217 per 100,000 in 1985.[2]

Specialty maldistribution

Despite the significant increase in total physician supply during the 1960's and 1970's, physicians are not distributed according to needs, in terms of the specialties or types of practice they choose. Availability of primary care—general prevention and maintenance of health usually provided in the physician's office—is important because it may obviate the need for more expensive care by narrowly focused medical specialists and decrease time spent in hospitals. However, the absolute number of primary care physicians decreased sharply between 1950 and 1970, and the proportion of physicians in office-based primary care practices declined from 45 to 31 percent. The decline may be more precipitous in the future because a larger proportion of such physicians are approaching retirement age. The average annual loss rate for physicians through death and retirement for the period 1972 through 1990 is projected to be 1.8 percent for all non-Federal, active physicians, compared with 2.5 percent for physicians in non-Federal primary care and 3.1 percent for those non-Federal primary care physicians who are general or family practitioners.[3]

Younger physicians seem to prefer non-primary-care specialties because of higher incomes, more peer prestige, increasing medical complexity, and the influence to specialize that exists in many medical schools. While about one-third of students now take primary care residencies, many professionals, including the American Medical Association, believe that 50 percent of medical students should be trained in primary care.

Geographic maldistribution

Shortages of health manpower in rural and inner city areas have become more visible over the last 15 years and are considered a major issue by the Congress. As a result of the relatively small number of health professionals in these areas, residents often have inadequate access to health care. However, there is disagreement as to the magnitude of the problem. Estimates of the ideal physician-to-population ratio for a given county vary from 40 to 100 per 100,000. These ratios yield vastly different estimates of additional doctors needed, as shown in table 1 below. To some degree, the differences can be explained by the type of physician the estimator has in mind. Low estimates are usually for general or family practitioners only, while high estimates are for the full range of specialists as well. Estimates in the middle

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[2] Figures from Department of Health, Education, and Welfare (HEW) Bureau of Health Manpower (BHM) 1974 report, *Supply of Health Manpower*, low and basic projections for physician supply. The lower figure in the range given for 1985 assumes no enrollment increases and a net increment of 3,800 Foreign Medical Graduates (FMGs) annually, which is consistent with the annual increment prior to 1970. The higher figure assumes enrollment increases of less than 1.5 percent annually after 1974 and a net increment of 5,200 FMGs annually, which is consistent with the increased influx of FMGs that occurred after 1970. Any increasing dependence on FMGs is open to criticism because the foreign trained physicians tend to score lower on national examinations than those trained in the U.S. Therefore, it is significant that the physician to population ratio is expected to exceed 200 per 100,000 even if FMG increments return to those of the last decade.

[3] From a 1976 BHM report on physician age and separation rates. This report also found that major differences in physician age distribution are the result of participation in primary care rather than urban-rural factors. However, it should be noted that the higher loss rate for primary care physicians may also exacerbate geographic maldistribution because there are more primary care physicians in rural than in urban areas.

part of the range would include primary care specialists like internists, obstetricians and general surgeons—a physician mix believed by many to be most appropriate for rural counties. However, even these estimates must be qualified for individual counties because of varying proximity to other areas with higher ratios whose physicians are sources of care.

TABLE 1.—MEASURES OF PHYSICIAN GEOGRAPHIC MALDISTRIBUTION

Desirable physician to population ratios	Number of counties below criteria	Number of additional physicians required nationally to meet criteria
40 per 100,000	966	1,800
50 per 100,000	1,396	3,800
67 per 100,000	1,982	9,500
83 per 100,000	2,349	17,700
100 per 100,000	2,591	29,400

Another problem is that these figures do not reflect most inner city shortages, which often occur within much smaller neighborhoods or communities. Access to care in poor urban areas can also be affected by social barriers and refusal of physicians to accept medicaid patients. Estimates of additional physicians needed to meet urban shortages are even less precise than for rural areas.

Equality of access for students

Medical students, in particular, have been drawn from wealthier families in the past. This situation was somewhat changed by the expansion of health manpower training capacity in the sixties, which was closely linked to Federal scholarships and subsidized loans for health professions students allocated on the basis of need. More recently, proportional gains by lower-income students may be threatened by rising educational costs and cutbacks in need-based financial assistance.

Which professions are included?

Most of the problems discussed above apply to training for careers in medicine and, to a lesser degree, osteopathy and dentistry. There is less evidence that significant health manpower problems exist in the fields of veterinary medicine, optometry, pharmacy, and podiatry. In many cases, student financial problems are also less severe because of lower tuitions and shorter training periods. Yet in fiscal year 1975, roughly 20 percent of all health professions education funds went to students and institutions in these other fields. This policy is defended by those who claim that the Federal Government should continue to subsidize the higher costs emanating from increased enrollments which were generated by the incentives of the 1971 legislation for all health professions schools.

II. PROPOSED LEGISLATION

The problems discussed above, plus cost considerations, suggest the following criteria to evaluate existing legislative proposals:

1. *Adequacy of supply.*—What training capacity would the legislation produce?

2. *Specialty maldistribution.*—How would the legislation address specialty maldistribution?

3. *Geographic maldistribution.*—How would the legislation address geographic maldistribution?

4. *Equality of access for students.*—How will the student assistance provisions affect students' ability to finance their education?

5. *Federal budget impact and efficiency.*—What is the Federal budget cost of the legislation and does it eliminate unnecessary subsidies?

This section summarizes three proposed health manpower bills—the House-passed bill, the administration's proposals, and last year's Senate-passed bill—and discusses them according to the above five criteria. Table 2 compares the bills according to the described criteria.

Description of proposals

The House and Senate each passed separate bills in the 93d Congress, but could not resolve their differences. In this session, the House passed a bill in July and sent it to the Senate. The administration revised its position in testimony before the Senate last September, with the most significant change being the maintenance of capitation grants subject to conditions. Previously, the administration had sought to phase out capitation. The Senate Health Subcommittee has scheduled markups for the end of March 1976.

TABLE 2.—COMPARISON OF HOUSE, ADMINISTRATION AND SENATE BILLS

	House bill (H.R. 5546)	Administration bill (S. 2748)	Senate bill (S. 1357)
Schools included for capitation support:	Medical, osteopathic, dental, veterinary medicine, optometry, podiatry, pharmacy, and public health.	Medical, osteopathic, dental..	Medical, osteopathic, dental, veterinary medicine, optometry, podiatry, pharmacy, public health, and graduate programs in health care administration.
Adequacy of supply:	Enrollment expansion (optional).	Maintenance of enrollment....	Enrollment expansion.
Geographic maldistribution:			
Schools.....	Remote site training (optional).	Required set aside of entering places for potential service scholarship recipients.	Required set aside of entering places and written agreement from those admitted to serve.
Students.....	Voluntarily accepted service scholarships for 20 percent of medical students. Shortage area service for nonrepayment of capitation.	Service scholarships for up to 25 percent of medical students, but authorizations for only 15 percent.	Service scholarships for 25 percent of medical students.
Specialty maldistribution:	Stipend support for family medicine residencies; support for family medicine departments.	Required establishment of a distinguishable academic unit responsible for primary care.	Required establishment of a distinguishable unit responsible for primary care.
		Required percentages of filled affiliated residencies in primary care.	Required percentages of filled affiliated residencies in primary care.
		Stipend support for family medicine/primary care residencies.	Stipend support for family medicine/primary care residencies.
Student assistance:	Maintains health professions loans.	Phases out health professions loans. Other legislation raises cumulative GSL borrowing limit from $10,000 to $25,000 for students in exceptional cost programs but maintains the annual $2,500 limit.	Maintains and expands health professions loans.
Authorizations:			
Fiscal year 1977.....	$556,000,000.....	$303,000,000.....	$682,000,000.
Fiscal year 1976 to Fiscal year 1978.[1]	$1,656,000,000.....	$908,000,000.....	$2,011,000,000.

[1] Proposed authorizations are added for 3 years to provide a very general comparison over time. Actual outlay pattern may differ depending on the specific programs in each bill.

The House bill (H.R. 5546).—The House bill provides capitation grants for schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health schools, subject to certain conditions. In return for capitation, medical, or osteopathic, and dental schools must either: (1) expand enrollments or (2) operate a remote site training program in which 50 percent or more of graduating students spend at least 6 weeks in off-campus training. In addition, as a condition of capitation, schools are required to enter into legally enforceable agreements with students to repay the capitation to the Federal Government, unless they agree to practice in medically underserved areas upon completion of training. The National Health Service Corps (NHSC)[4] is expanded, as are service scholarships for students who commit themselves to NHSC or other underserved area practice. If students volunteer for all available service scholarships—approximately 20 percent of medical students—and none buys out of the obligation, the fully implemented program might provide 12,800 physicians for shortage area service in any given year.

The House committee bill contained a medical residency regulatory commission which proposed to regulate: (1) the total number of residencies, (2) the specialty of every residency, and (3) the geographic location of every residency. This provision was defeated on the House floor. In the House-passed bill, support is provided to expand the number of family medicine departments and for stipends for family medicine residencies.

The existing health professions loan program, originally authorized in 1963 to provide subsidized need-based Federal loans, is continued and additional Federal contributions are provided.

The administration bill (S. 2748).—The administration bill provides capitation grants for medical, osteopathic, and dental schools, subject to certain conditions designed to correct geographic and specialty maldistribution. Capitation is phased out for schools of veterinary medicine, optometry, podiatry, and pharmacy. For medical, osteopathic, and dental schools not accepting the conditions, capitation is also phased out. In return for capitation, medical, osteopathic, and dental schools must: (1) set aside 25 percent of their entering places—phased in over 3 years—for applicants who agree, when applying for admission, to accept a service scholarship if offered one and serve in an underserved area upon graduation; (2) maintain a distinguishable academic unit responsible for primary care; and (3) assure that 50 percent of affiliated filled residency positions—phased in over 3 years—are in primary care. In addition, maintenance of enrollments is required for medical and osteopathic schools and a one-time 5-percent enrollment increase is required for dental schools.

The NHSC and service scholarships are expanded. If service scholarships are provided for all those who agree to accept them, and no graduate buys out of the obligation, then the fully implemented program might provide 16,000 physicians for shortage area service in any given year. However, at actual authorization levels, less than 15 percent of medical students could receive scholarships and a maximum of 9,600 physicians would be available for service. Stipend support for both

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[4] The National Health Service Corps is a program designed to alleviate problems of health manpower distribution by placing doctors and other health personnel in critical shortage areas.

family medicine and primary care residencies is provided, as is project grant support for schools and hospitals for faculty development, clinical clerkships, and supervised externships. A study committee is proposed to examine the distribution and financing of residencies.

The health profession loans program is phased out. Reliance for student loans is placed on the guaranteed student loan (GSL) program which subsidizes and insures commercial loans to students generally.[5]

The Senate bill.—(Reintroduced this session as S. 1357.) Last session, the Senate passed a bill providing capitation support for schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, and graduate programs in hospital administration, subject to certain conditions. The conditions for medical, osteopathic, and dental school capitation are: (1) an assurance that 25 percent of accepted students enter into an agreement to provide health services for 2 years in an underserved area, (2) increased enrollments, (3) creation of an identifiable academic unit responsible for primary care, and (4) having various percentages of residency positions in primary care. Project grant support is provided for family medicine and other primary care residency training and for grants to hospitals to develop family medicine and other primary care training programs. The NHSC and service scholarships are expanded. As with the maximum commitment under the administration bill, there would be 16,000 physicians available for service in any given year when the program is fully phased in.

The health professions loan program is continued and additional Federal contributions are provided.

Evaluation according to programmatic criteria

These health manpower legislative initiatives were directed at solving a number of problems simultaneously: Overall supply, the specialty and geographic maldistribution of health professionals, and student assistance needs. As the bills attempt to deal with these issues differently, it is important to assess their likely effectiveness.

Adequacy of supply.—The House bill allows enrollment increases as one of the options for receiving capitation support. The Senate bill of last session requires enrollment expansions. The administration bill requires maintenance of enrollments for medical and osteopathic students; a one-time 5-percent enrollment increase is required for dental schools.

It is difficult to pinpoint precisely future manpower requirements because of uncertainties about the growth of health insurance coverage—particularly national health insurance—and provider productivity. However, many believe that using reasonable ranges of demand and productivity estimates, the supply increases beginning to be felt from previous enrollment expansions will be sufficient to meet requirements. Some believe that the one profession where supply may not be adequate is dentistry. But even in this area any future shortage depends upon whether or not national health insurance, with dental coverage, is enacted.

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[5] The administration has submitted legislation to raise the GSL cumulative borrowing limit for both undergraduate and graduate years from $10,000 to $25,000 for students in exceptional cost programs. Thus health professions students who borrowed heavily while undergraduates could still retain their eligibility. However, the annual limit of $2,500 would not be raised.

Another rationale provided for expanding training capacity, but one that has little to do with adequacy of supply, is that thousands of qualified students are unable to gain acceptance to medical and dental schools.

Specialty maldistribution.—As a condition of receiving capitation grants, both the Senate and the administration bills require schools to establish academic units to provide undergraduate clinical instruction in primary care and to insure according to a phasein schedule that by 1980, 50 percent of residency positions under their control are allocated to primary care specialties.

The elimination of the medical residency regulatory commission from the House bill means that there is no absolute guarantee that a reallocation among specialties will occur. However, the House bill, like the Senate and administration bills, provides stipend support for family medicine residencies. These financial incentives will encourage students to enter this field. Moreover, stipend support for residencies will overcome hospitals' and medical schools' reluctance to establish primary care residencies, for which they have great difficulty getting reimbursed. While resident support is covered by insurance for inpatient services—that is, nonprimary care residencies—it is often not covered by insurance for primary care services. Thus, currently it is difficult for hospitals to recoup educational costs.

Geographic maldistribution.—All bills expand the NHSC but the numbers of service scholarships vary.[6] The Senate bill makes the most forceful attempt to address the geographic maldistribution problem by requiring schools to make agreements with 25 percent of the entering students to practice in underserved areas upon graduation whether or not they receive a scholarship. The administration bill requires schools to set aside entering places and requires shortage area service only if the student receives a scholarship. A rationale offered for linking the service obligation to admissions is that students from all family backgrounds will participate because of the difficulty in gaining acceptance to medical schools; service would not be limited to students from poorer families.

While the Senate and administration bills require some obligation from those offered preferential admission, the House bill seeks to expose students to other geographic areas during school, and relies on voluntary acceptance of the service concept. It also allows students to serve in shortage areas as an alternative to repayment of capitation. While capitation payback is unlikely to affect location decisions significantly, it reduces the inequity inherent in a capitation program.

Equal access for students.—None of the three bills would meet anticipated student needs for financial assistance. Aid available to students from all sources has not kept pace with expenses in the past.

Over the next 4 years, tuitions and therefore total expenses are expected to increase more rapidly—for medical students, from $7,252 per student in 1975 to $9,508 in 1979.[7] Even with expanded service scholarships and loans, a growing gap between financial aid and actual

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[6] Service scholarships in all three bills require a year of service for each year of scholarship, with a minimum obligation of 2 years.

[7] These estimates were derived from surveys conducted by the American Association of Medical Colleges of: (1) how medical students finance their education and (2) tuition projections for the next 4 years.

needs will occur. The GSL program is not likely to fill this gap because private lenders are already reluctant to increase the size or number of student loans.[8]

In addition, increased emphasis on large service scholarships not targeted on low-income students would result in lower income students receiving a smaller share of student aid because service scholarships are not awarded on the basis of financial need.

Finally, many believe that both health professions loans and GSL's, upon which students would be forced to rely, provide unnecessary interest subsidies for health professions students. Medical students in particular could pay close to market interest rates during school and after if some way were found to delay interest or to gear payments to income levels. None of the bills addresses this problem.

The rise in out-of-pocket costs and redistribution of aid would be least severe under the Senate bill because new capital funds for health professions loans would increase. It would be somewhat more severe under the House bill, which maintains new funds for health professions loans at a level slightly higher than at present. Problems would be most severe under the administration bill, with the smallest number of service scholarships and a phaseout of new funds for health professions loans.

Budgets for the three legislative proposals

Table 3 shows the yearly costs and total costs by major components of the House, administration, and last session Senate bills. (See p. 89.)

The three alternative bills have considerably different levels of authorizations for appropriations in fiscal year 1977 and rates of growth of authorizations thereafter.

The House bill authorizes spending in fiscal year 1977 at about $550 million or 15 percent above the fiscal year 1975 appropriation level of $480 million and rises to about $600 million in fiscal year 1978, a 24-percent increase. However, in the long run, the cost of the House bill could be reduced considerably because those students not serving in underserved areas must repay their capitation grant.

The administration bill starts at an authorization level of about $300 million, a level $180 million or 36 percent lower than the fiscal year 1975 appropriation and remains constant from fiscal year 1976 to fiscal year 1979.

The Senate bill of last session, assuming a delay in implementation of 1 year, starts in fiscal year 1977 at an authorized level of about $680 million—$180 million or 42 percent higher than the fiscal year 1975 appropriation—and rises another 8 percent to $729 million in fiscal year 1978.

In terms of total 3-year costs for fiscal years 1976 to 1978, the administration bill authorizes $908 million, the House bill $1,656 million, and the Senate bill $2,011 million.

In all categories of support, the administration's proposed authorization levels are considerably lower than the House and Senate bills. The House and Senate bills contain all the programs in the administration bill and add other provisions. The three major components—institutional assistance, student assistance, and special projects—are discussed below.

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[8] In an extreme example at the University of Michigan Medical School, only 50 percent of GSL loan applicants were able to receive loans.

TABLE 3.—HEALTH MANPOWER FUNDING UNDER ALTERNATIVE PROPOSALS

[Dollar amounts in millions; fiscal years]

	1975 [1]	1976	1977	1978	3-year 1976–78 total [2]	1979
HOUSE BILL—H.R. 5546						
Institutional assistance	$259	$252	$260	$257	$769	----------
Capitation	150	208	215	214	637	----------
Other	109	44	45	43	132	----------
Student assistance	82	85	125	165	375	----------
Health professions loans	36	30	30	30	90	----------
Service scholarships	23	40	80	120	240	----------
Other	23	15	15	15	45	----------
Special projects	139	154	171	187	512	----------
Total	480	491	556	609	1,656	----------
ADMINISTRATION BILL—S. 2748						
Institutional assistance	259	127	123	120	370	118
Capitation	150	127	123	120	370	118
Other	109	0	0	0	0	0
Student assistance	82	56	46	52	154	62
Health professions loans	36	20	9	1	30	0
Service scholarships	23	32	36	51	119	62
Other	23	4	1	0	5	0
Special projects	139	117	134	133	384	127
Total	480	300	303	305	908	307
SENATE BILL—LAST SESSION (INTRODUCED THIS SESSION AS S. 1357) [3]						
Institutional assistance	259	275	288	301	864	----------
Capitation	150	238	250	263	751	----------
Other	109	37	38	38	113	----------
Student assistance	82	120	147	174	441	----------
Health professions loans	36	30	50	50	130	----------
Service scholarships	23	80	85	110	275	----------
Other	23	10	12	14	36	----------
Special projects	139	205	247	254	706	----------
Total	480	600	682	729	2,011	----------

[1] Fiscal year 1975 figures are actual appropriations while fiscal years 1976–79 are authorizations.
[2] Total for general comparison only. Actual appropriations could vary, as could outlay patterns of specific programs in each bill.
[3] Assumes passage of the bill and beginning of operation for fiscal years 1976 through 1978. Fiscal years 1975 through 1977 authorization levels have each been delayed 1 year.

Institutional assistance.—All three bills maintain capitation for medical, osteopathic, and dental schools, though subject to different conditions. The administration bill phases out capitation for schools of veterinary medicine, optometry, podiatry, and pharmacy, premised on the argument that there are no demonstrated national shortage or specialty or geographic maldistribution problems for these health professions. The House and Senate bills maintain capitation for schools of veterinary medicine, optometry, podiatry, and pharmacy. The second major difference between the administration and House and Senate bills is the level of capitation. For example, grants of $1,500 per medical or dental student are proposed by the administration bill, $2,100 in

the House bill, and $2,500 in the Senate bill. Presently schools are receiving about $1,600 per medical or dental student.

Some argue that if capitation grants require little from schools, they come close to being simply a student subsidy because they retard increases in tuition and that consequently there may be inefficiencies in Federal subsidies for training professionals who will earn very high incomes. The three bills place different requirements on schools in exchange for capitation. The Senate and administration bills condition capitation on efforts schools must take to address maldistribution problems. While the House bill includes less stringent conditions, it also requires students to repay capitation.

Student assistance.—The differences in the three bills for student assistance are: (1) the number of service scholarships offered and (2) the treatment of the health professions loan program. The administration bill authorizes $119 million in service scholarships compared with $240 million in the House bill and $275 million in the Senate bill. The number of scholarships proposed in the administration bill would support only about 15 percent of medical students when fully operational, rather than the 25 percent set aside as a condition of capitation. An even smaller percentage of dental students would be offered scholarships. The administration bill proposes phasing out the health professions loan program, while the House bill maintains the program at about current levels and the Senate bill expands the program.

Special projects.—All three bills include support for family medicine residencies, area health education centers, and training of physician and dental assistants. However, the administration bill proposes funding these special projects at lower levels than the House and Senate bills. Unlike the administration and Senate bills, the House bill does not support graduate training in primary care fields other than family medicine. The House and Senate bills propose additional areas for special projects. Such areas include training in emergency medical services and bilingual health training.

III. BUDGET OPTIONS—1977

The more than 100-percent difference between the authorizations of the administration and last year's Senate bills could be regarded as the outside bounds of the budget choices for fiscal year 1977. Under this approach, the lowest budget option for health professions training would appear to be the administration's bill of $300 million.[9] This level would represent a decrease of 36 percent from the fiscal year 1975 appropriation level and would eliminate or substantially reduce several programs.

At the other extreme would be full funding of an authority that proposed support of health manpower programs at a level similar to that of the Senate-passed bill of last session—$680 million. This level would represent an increase of 42 percent from the fiscal year 1975 appropriation level, with all programs substantially expanded.

Between these extremes lies the House bill, at $550 million for fiscal year 1977, 15 percent over the fiscal year 1975 appropriation level.

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[9] This figure should not be confused with the administration's fiscal year 1977 budget request of $309 million which includes both health professions and nurses.

Capitation and primary care programs would be moderately expanded and service scholarships substantially expanded.

Alternatively, Congress might formulate different middle range proposals that would put less emphasis on capitation, since supply of health professionals has already increased, and more emphasis on the service scholarships and primary care programs that might solve distribution problems.

THE FEDERAL GOVERNMENT AND HEALTH MAINTENANCE ORGANIZATIONS: A CHOICE OF STRATEGY; A NEED FOR CONSISTENCY

SUMMARY

In recent years, increasing concern has been expressed about the quality and the rising cost of health services. Various proposals to deal with the health care system's problems have been considered by Congress, including rate setting, professional standards review organizations, use of physician extenders, overall cost controls, and various methods of reimbursing hospitals and physicians. Increasingly, however, the structure of the health care delivery system has come under scrutiny. The health maintenance organization (HMO) has been the structural reform which has received the most attention. An HMO assures to a voluntarily enrolled population the delivery of a comprehensive range of services in exchange for a predetermined, prepaid premium. Because HMO's agree to provide these services within a fixed budget, they have a strong incentive to limit care to that which is necessary, an incentive which does not exist in fee-for-service portions of the health sector.

In 1972, legislation authorized prepaid reimbursement to HMO's under the medicare and medicaid programs. In 1973, Congress passed the Health Maintenance Organization Act to promote the growth of HMO's. Because program operations under the act have not encouraged HMO development, the House recently passed significant amendments to the act. The Senate has held hearings to consider what changes, if any, need to be made.

This paper analyzes the major issues currently being discussed. It is not an all-inclusive analysis of HMO's. For instance, it does not evaluate the efficiency of HMO's or deal with the policy question of whether Congress should promote them. This paper does include: An analysis of the present shortcomings in the Federal HMO strategy, a presentation of the legislative options, and alternative strategies for amending the HMO Act. Emphasis is given the choice of a strategy, i.e., a consistent combination of objectives and mechanisms.

The problem

The basic goal of the 1973 HMO Act—accelerated HMO development and growth—has not been achieved. HMO growth, which had been increasing prior to the act's passage in 1973, has been abruptly halted.

The act's other major objectives which were aimed at correcting serious problems in the present health delivery system, included the provision of comprehensive health services and quality care to all HMO enrollees and the assurance of equal access to HMO's both for individuals who are high medical cost risks and for low-income people.

To achieve these additional purposes, the act specified requirements by which an HMO attained Federal qualification. Qualification is important for it is the precondition for HMO's eligibility for "dual choice," the provision that mandates employers to offer two health insurance options, one being a qualified HMO. Despite the powerful advantage dual choice could bring, few HMO's have applied for qualification. Thus, the act's goals to improve the comprehensiveness, access, and quality of health care through more HMO's are not being achieved.

Both the implementation of the act and the law itself are responsible for these shortcomings.

Implementation

The long delay in the issuance of virtually all the necessary regulations, especially the dual choice guidelines, has undermined HMO interest in qualification, dampened demand, and slowed HMO growth. While HEW has corrected past deficiencies, it is not clear that the necessary steps have been taken to minimize future problems. In particular, the program still appears to lack personnel with appropriate qualifications.

The HMO Act: The principal features

The primary weakness in the HMO Act is a "built-in" conflict between the law's objectives and the mechanisms to achieve them.

In 1973, there were primarily two strategies under consideration. One concept, herein titled the "competitive growth" strategy, entailed several measures to stimulate HMO growth. The dual choice provision, an override of restrictive State laws, and a 4-year grant program to provide HMO's with development funds were the most important provisions. Operating subsidies were not included. Under this strategy, HMO's were to become economically viable without ongoing Federal aid.

The other approach, best named the "social goals" strategy, also included provisions to encourage HMO growth. But this strategy encompassed other objectives as well, particularly the comprehensive care, access and quality assurance goals mentioned previously. To accomplish these aims, supporters of the "social goals" strategy required of HMO's an extensive "basic" services package, capacity to offer several "supplemental" benefits, open enrollment periods, pricing by community rating, maintenance of an enrollee population whose income characteristics parallel those of the area served, and the requirement that the HMO's physicians treat HMO patients as their "principal professional activity."

The mechanisms adopted by the "social goals" strategy meant additional cost for the HMO. Accordingly, financial aid was thought to be essential if HMO's were to compete effectively in the health insurance market. Three subsidies seemed in order: (1) an underwriting for the additional costs resulting from the "basic" services package; (2) a payment for the expected above-average health expenditures of high risk enrollees; and (3) a full or partial premium payment for poor people. While estimates of the cost for these subsidies are difficult and uncertain, the 4-year cost could range from $495 million to $1.48 billion, with a most likely estimate probably being $915 million.

The HMO Act passed by Congress was a compromise between the two strategies. All the objectives and mechanisms of the "social goals" strategy were adopted, but without the corresponding subsidies. They were dropped in deference to the advocates of the "competitive growth" strategy. Thus the objectives and mechanisms lost their consistency and led to the act's central dilemma. An HMO needs dual choice to generate more enrollment, yet bearing the extra $8 to $16 cost per family which qualification entails threatens an HMO's marketability.

Choosing an amendment strategy

The conflict written into the original act could be avoided by selecting one of the alternative, but consistent, development strategies. Among these options are the "social goals" and "competitive growth" strategies. A third alternative is a modification of the "social goals" approach, a fourth a modification of the "competitive growth" strategy. A fifth option calls for maintenance of the HMO Act in its present form, with grant support being targeted on a select number of HMO's.

(*1*) *The social goals strategy.*—This would entail the retention of most or all the original act's mechanisms and inclusion of the subsidies mentioned previously.

(*2*) *The competitive growth strategy.*—Under this approach only conditions applying to the rest of the health insurance industry would apply to an HMO seeking Federal qualification.

(*3*) *A modified social goals strategy.*—Because of the limited availability of Federal funds, an alternative approach would be to concentrate on one or more of the major social goals. One possibility would be to maintain coverage for high medical risks but to drop the goals of providing access to care for low-income people and of guaranteeing a full range of comprehensive services. Only a small subsidy would be needed for the extra costs incurred if HMO's are not to be placed at any kind of a competitive disadvantage.

(*4*) *A modified competitive growth strategy* (as reflected in H.R. 9019, the House-passed amendments, and S. 1926, the Senate bill).—The "competitive growth" strategy could be pursued by trimming the "basic services" requirements, dropping "supplemental services" and open enrollment, and excluding operating subsidies. Not all the objectives of the "social goals" strategy are surrendered, however. For example, community rating is delayed 5 years, not given up.

(*5*) *Keep the HMO Act as is.*—Under this option, none of the mechanisms would be changed and no subsidies would be included. This option would downplay the importance of HMO growth in favor of preserving the mode of care incorporated in the prototype HMO's.

Four-year total costs of each strategy

The choice of a development grant program level is the key to the total cost of each alternative. How many HMO's are funded has obvious cost implications itself, and the decision also affects the amounts of the various subsidies. The basic options appear to be whether to develop 60, 100, or 160 HMO's. The 4-year, fiscal year 1976–79 cumulative outlay for each of these program levels and strategies will most likely be:

[In millions of dollars]

	60 HMO's	100 HMO's	160 HMO's
(1) Social goals strategy	775	1,011	1,217
(2) Competitive growth strategy	41	87	150
(3) Modified social goals strategy:			
(a) All HMO's	99	162	261
(b) Experiment with 25 HMO's	48	94	157
(c) With no subsidy	41	87	150
(4) Modified competitive growth strategy, H.R. 9019 and S. 1926	NA	NA	170
(5) Keep the HMO act as is	41	NA	NA

Note: NA—Not applicable.

Impact of medicare and medicaid on HMO growth

The medicare and medicaid programs can be better utilized to increase the demand for HMO's. Two of the obstacles limiting the enrollment of both programs' beneficiaries are inadequate financial incentives for an HMO to seek out medicare and medicaid eligibles and beneficiaries' perceived lack of economic incentives to join an HMO.

Changes are available to meet each of these problems. While HMO's may find the about-to-be implemented prospective payment mechanism attractive, adjustments to the payment formula, such as deleting retrospective adjustments or permitting HMO's to keep a greater share of profits if benefits are expanded, might encourage greater HMO growth.

I. BACKGROUND

In recent years, the effectiveness and cost of health services delivery have generated increasing concern. Various proposals to deal with the health care system's problems have been suggested, including rate setting, use of physician extenders, health education programs, and various methods of reimbursing physicians. Increasingly, however, the structure of the health care delivery system has come under scrutiny. The health maintenance organization (HMO) has been the structural reform which has received the most attention in light of accumulating evidence that HMO's can save 5 to 30 percent on health costs compared with the fee-for-service sector.

HMO's accept responsibility to assure to a voluntarily enrolled population the delivery of a stated range of health services—including, at a minimum, inpatient and outpatient care, physicians services, out-of-area coverage, and laboratory and X-ray services. They do so in exchange for a predetermined, prepaid premium. Prepayment plays a central role in their ability to save money. It gives HMO's an incentive to halt inefficient and wasteful practices, especially the overutilization of expensive hospital care. The fee-for-service sector, on the other hand, does not have similar motivation. The more services a physician and/or hospital provides, the more they charge. There is thus an inclination to hospitalize people even when it may not be necessary. However, prepayment creates the opposite incentive, that is to provide less than the optimal amount of services.

Although HMO's had been in existence for over 40 years, by 1970 there were but 37 serving only an estimated 3.6 million enrollees. Thus, while HMO's looked like a good idea, there were not enough of them to have a major impact on controlling health care costs. Various barriers were slowing HMO growth. If HMO's were to become widespread, those barriers had to be lowered.

The foremost problem among HMO's was that of generating enough enrollment. Two aspects to this lack of demand stood out. First,

HMO's have had great difficulty achieving access to the health insurance market. Since 80 percent of insurance is purchased through one's place of work, having employers offer their workers health coverage through an HMO is crucial. However, because of established insurance relationships and/or unwillingness to complicate administrative arrangements, employers frequently refused to institute a dual choice health insurance arrangement, that is, allowing a union or employee to opt for either an indemnity carrier or an HMO. Second, in many parts of the country, the minimum HMO benefit package—the previously mentioned inpatient/outpatient care, physician services, out-of-area coverage, and laboratory and X-ray—was still too expensive to market. Many regions have very limited health insurance coverage and, in turn, low monthly premium payments. An HMO monthly premium substantially above people's present monthly insurance payment threatens an HMO's marketability. This is true despite the fact that HMO's cover more services, have less cost sharing, and may result in lower total health care costs than indemnity plans.

The other barriers to growth most often discussed were:

—Inadequate startup funding;
—Opposition from health care providers;
—Shortage of doctors willing to work in an HMO; and
—Restrictive State laws.

As Congress was beginning to consider how to help HMO's overcome these barriers to growth, Federal interest and preliminary HEW aid helped spur an impressive HMO growth rate. The number of HMO's increased by 11 percent in 1970, 27 percent in 1971, 52 percent in 1972 and 68 percent in 1973.[1] Enrollment jumped from 3.6 to 5 million.[2] Nevertheless, the six barriers remained a problem.

II. THE HMO ACT OF 1973

The 1973 congressional debate on HMO legislation produced agreement that the Federal Government should encourage the development and growth of HMO's. Consensus also formed on legislative provisions to remove HMO growth barriers. Restrictive State laws, such as those prohibiting the corporate practice of medicine or those requiring physician approval by a local medical society, were to be preempted by Federal law. Federal grants and loans would provide capital. To encourage nationwide expansion, 20 percent of those moneys would be reserved for rural HMO's and funding priority would be given to HMO's whose enrollment was over 30 percent from medically underserved areas. And to guarantee marketing access to employee groups, the legislation would mandate employers to offer a dual choice in health insurance, with one option being an HMO. Beyond the growth objective and these mechanisms, however, two competing strategies emerged, which can be described as "competitive growth" and "social goals."

The "competitive growth" advocates wanted to encourage HMO growth, but to do so in a manner consistent with fair market principles. It was believed important that HMO's prove their economic viability

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[1] McNeil, Richard Jr., and Robert Schlenker, "HMO's, Competition, and Government," *Milbank Memorial Fund Quarterly,* vol. 53, No. 2, Spring 1975, p. 198.
[2] U.S. Department of Health, Education, and Welfare, *Health Maintenance Organization Program Status Report,* May 1975, p. 43.

and efficiency with minimum Government intervention. It was feared that HMO's could become a continuing, inefficient Federal grant program. Consequently, there was substantial support for the limitation of Federal grants to planning and development only, for a 5-year limit to any such grant programs, and for Federal loans set at market interest rates. Operating subsidies were not considered an acceptable facet of this strategy.

The "social goals" viewpoint sought much more ambitious objectives. In addition to aiding HMO growth, proponents of this viewpoint wanted to use the HMO legislation to correct basic deficiencies in the health care system. To achieve these objectives, a series of requirements were developed, adherence to which became a precondition for an HMO's eligibility for the vital dual choice provision. HMO's were seen by some as an opportunity to provide the best kind of medical care—comprehensive health services—in one place or, at least, through one organizational entity in lieu of what was perceived as fragmented organization of medical care, with concomitant inconvenience, inaccessibility, and inefficiency. To attain this objective, the law established a mandated list of "basic services" and a list of "supplementary services" which a qualified HMO was required to offer to every enrollee who wanted to buy any of them. (See exhibit 1.)

Exhibit 1

Basic Services

Physician health care, including consultation and referral.
Inpatient and outpatient hospital services.
Emergency health services, if medically necessary.
Short-term (limited to 20 visits) outpatient services for mental health crises and evaluation.
Diagnostic laboratory and diagnostic and therapeutic X-ray services.
Home health services.
Preventive health services, including voluntary family planning and infertility services and preventive dental and vision care for children.
Medical treatment, including referral, for alcohol and drug abuse.

Supplemental Services

Services of facilities for intermediate or long-term care (such as nursing homes).
Vision care (excluding preventive care for children).
Dental care (excluding preventive care for children).
Mental health care not covered.
Physical medicine and rehabilitation (including physical therapy) on a long-term basis.
Prescription drugs required as part of care by an HMO.

Yet another "social goals" objective was to provide access to quality health care for high insurance risks and for low-income people. This is an effort to redress the widespread health insurance practices of "skimming" and experience rating, as these phenomena combine to make health insurance either unavailable or prohibitively expensive for less healthy or lower income people.[3] Additionally, this was an attempt to overcome low-income people's well-documented problems in either getting access to care or receiving inferior services. To achieve this access-to-quality care objective, three provisions were included in the law: A 30-day open enrollment period during which any applicant had to be accepted by the HMO; pricing by community rating, a system that establishes a premium based on a given area's recent

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[3] "Skimming" is the refusal to sell health insurance to people who have had a history of poor health.
Experience rating is the basing of a premium charge on past claims experience.

health experience and charges everyone the same rate; and enrollment of people whose income characteristics paralleled those of the surrounding area.

Finally, there was concern about the quality of medical care in general and, more specifically, about the possible disposition of prepaid HMO's to underserve their enrollees. There were several measures sought to insure quality: Continuing regulatory power for the HEW Secretary exercised through the qualification-for-dual-choice process; mandating doctors to have prepaid patients as their "principal professional activity" (51 percent of the medical group's practice); grievance procedures; continuing staff education; enrollees as one-third of the policy board; continuing reports from the HMO's to the Secretary on cost, health status, and other indicators; and a 75-percent ceiling on enrollment from medically underserved areas.

It was realized that these additional objectives meant higher costs for HMO's and, thereby, created a need for special, continuing Federal subsidies until adequate health financing existed for the general population. The Senate HMO bill (S. 14) authorized grants of $450 million over the succeeding 3 years.

In the HMO Act passed in December 1973, Congress did not choose one strategy over the other. The bill was a compromise. The major objectives and mechanisms of the "social goals" strategy were accepted—with one vital exception: The operating subsidies were dropped because of the incompatibility of continuing Federal subsidies with the "competitive growth" approach. This compromise has much to do with the disappointing results and present reappraisal of the HMO Act.

III. HMO INDEXES SINCE THE ACT'S PASSAGE

Measured against any of the HMO Act's objectives, HMO performance has been a disappointment. As chart I highlights, progress toward the consensus objective—growth—has faltered since the act's passage. Chart II detailing the overall number of HMO's tells a similar, if less dramatic, story. In 1974, the number of HMO's grew to 183, an increase of 50 over 1973. However, there had been 54 new HMO's in 1973. More importantly, the first 6 months of 1975 saw the number of HMO's decrease by two. Enrollment growth has also slowed. The 9-percent average annual increase since the act's passage is below the average of almost 13 percent of the 1970–73 period.

The congressional intent to encourage HMO development throughout the Nation has also been frustrated. There has been only limited HMO expansion into new geographic areas. Rural HMO's comprised only 12 percent of the HMO's established in 1974, up just slightly from the present overall proportion of 10 percent.[4] HMO movement into underserved areas has been similarly slight. Only 8.1 percent of HEW's limited grant funds have gone to HMO's serving such areas and no "for-profit" HMO's have utilized federally guaranteed loans for serving medically underserved populations.

The number of HMO's in the development pipeline also has been declining. From July 1974 to July 1975, the number fell from 201 to 164. There is evidence as well that a number of potential HMO's

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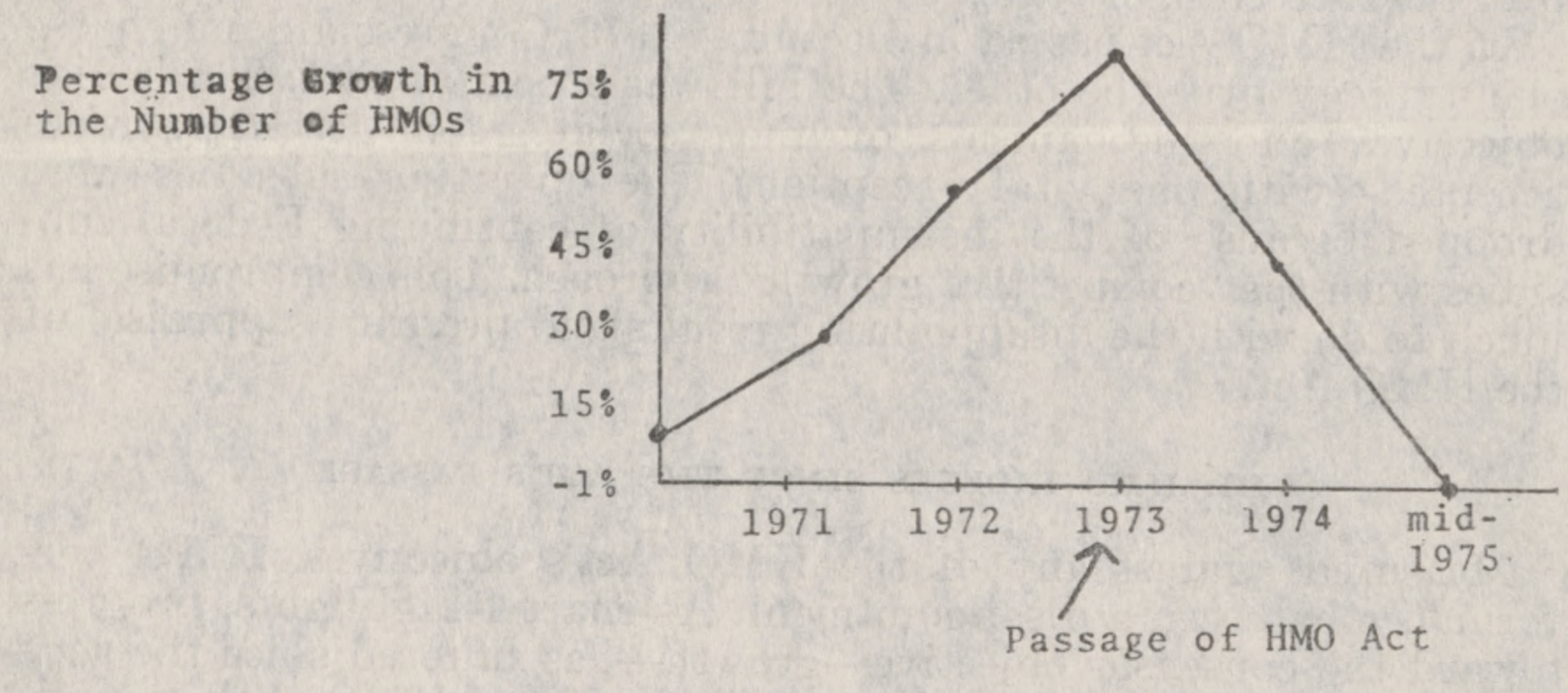
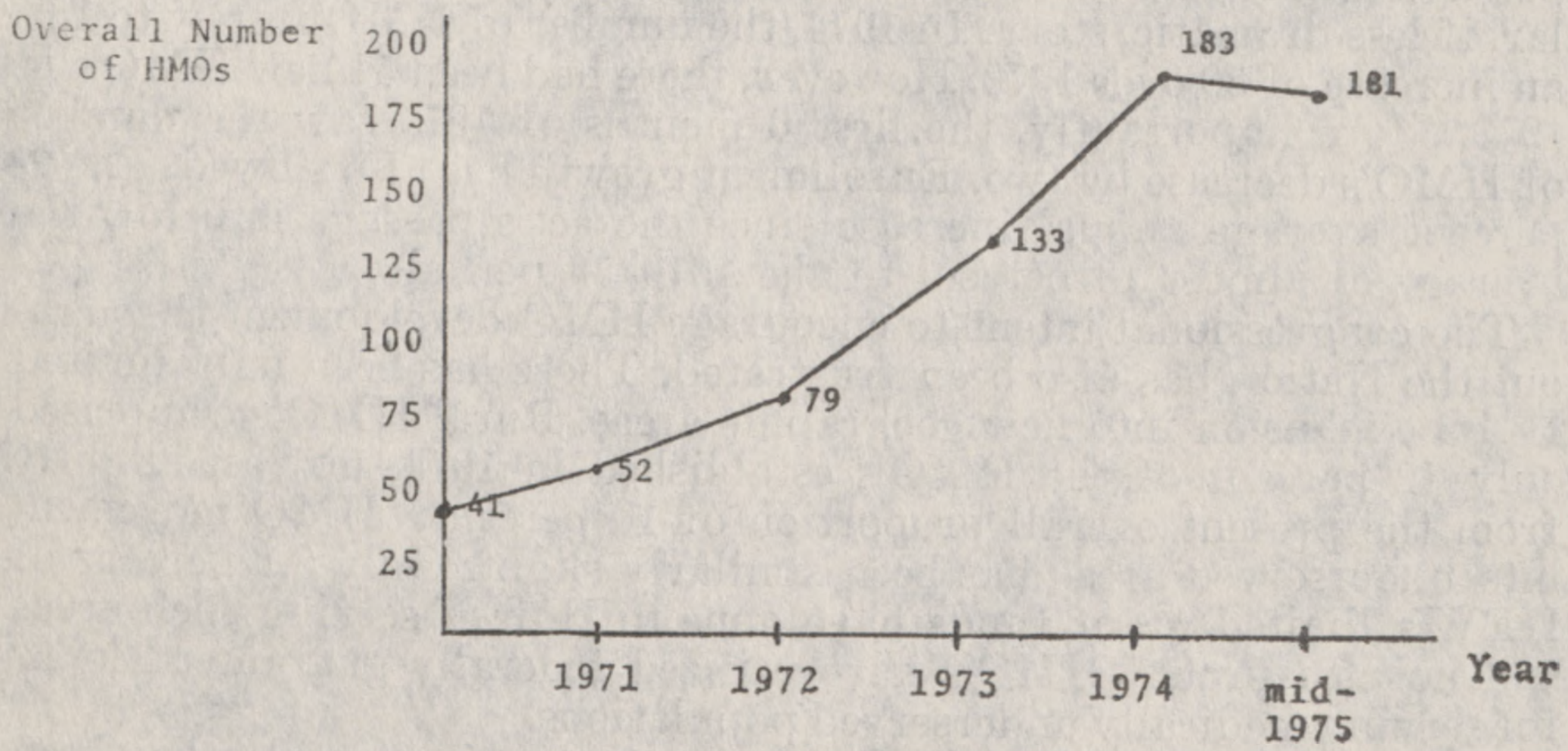
[4] Wetherille, Rhona L., "A Census of HMO's," Minneapolis: InterStudy. January 1975, p. 10.

are holding back from making the commitment. A GAO survey estimates 50 to 60 percent of potential HMO groups as presently hesitant.[5]

The additional objectives of the "social goals" strategy are not being realized either. Prior to the act's passage, provision of comprehensive services, access for high-risk individuals and low-income people, and effective maintenance of quality standards were not a reality in most HMO's. In fact, 71 percent of HMO's said that they would have to increase their minimum benefit package to be in accord with the HMO Act's "basic" services mandate. If measured by medicaid enrollment, only about 5 percent of total HMO membership was poor. In addition, a lack of uniformity in State regulation made effective quality control enforcement difficult.

In recognition of these shortcomings, the act made comprehensive services, access for high-risk and low-income people, and maintenance of quality standards a prerequisite for an HMO's qualification for dual choice. But only 7 of the 181 HMO's in existence have been qualified, and all of these are new and small. Established HMO's have not applied.





SOURCE: Ibid.

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[5] General Accounting Office, unpublished survey, fall 1975.

In summary, the progress to date toward either competitive growth or social goals appears to be negligible at best. The proponents of neither strategy can be satisfied with the current HMO situation. The HMO Act amendments recently passed by the House attempt to correct these deficiencies. To understand the failure to date of the HMO Act, an examination is needed of why the hopes of both groups have been frustrated.

IV. EXPLANATION OF CURRENT PROBLEMS

What has caused HMO growth to falter and why has there been little progress toward the additional social objectives? The answer lies partly with both the original act and its implementation.

The act

The objectives and mechanisms: Dual choice/qualification.—The lack of a consistent combination of objectives and mechanisms in the act seems to be central to the problem. To understand this causality, the connection between dual choice and Federal qualification must be fully understood. Dual choice is the mechanism Congress enacted to help HMO's overcome their difficulties in gaining access to the insurance market. It is the major tool in the attack on HMO's No. 1 difficulty—generating demand. However, in order to achieve the objectives of the "social goals" strategy, the act tied eligibility for the powerful dual choice provision to Federal qualification. Federal qualification requires that an HMO institute the various mechanisms—provide the "basic" services and offer the "supplemental" services listed previously, have open enrollment periods, community rate, etc.—which affect the "social goals" advocates' objectives. Since there are no subsidies in the act, HMO's have to bear the extra costs imposed by these mechanisms. The result of this dual choice/qualification tie is thus a contradiction. An HMO needs dual choice to generate more enrollment, yet bearing the costs entailed with qualification threatens an HMO's marketability. An examination of the nature of the health insurance market and the impact of the act's mandates will bring the dilemma into sharp focus.

HMO's compete in the health insurance market with private insurance companies offering health plans and with Blue Cross-Blue Shield. There are two prerequisites for success: flexibility and price competitiveness.

Flexibility is necessary because of the market's tremendous variability. The geographic differences in price and benefit levels are substantial. For instance, the average monthly health insurance cost per family in North Carolina is $35 to $45, while in northern California it is $60 to $65.[6] While some of this sizable margin is a reflection of geographic cost differences, substantial variations in benefit coverage are involved as well.

In addition to the geographic spread, there is great variation within every market. One area usually has families at various levels of purchasing power. Furthermore, even within the same price range, different groups have varying benefit preferences.

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[6] U.S. Department of Health, Education, and Welfare, Public Health Service, internal memorandum, February 1975.

Health insurers have adapted to this need for flexibility. One hallmark of commercial carriers is their willingness to tailor their plans to the price level and benefit preferences of the buyers.

HMO price competitiveness is essential because of consumers' sensitivity to monthly premium differentials. Most market planners believe that an HMO's monthly charge cannot exceed by more than $8 to $12 the monthly family premium of the competition.[7] This can be a very difficult constraint for an HMO since it generally covers more health services than its competitors. By offering fewer benefits, screening out high risks, and using heavy coinsurance and deductibles, the competition can offer lower premiums than an HMO.

An HMO's ability to meet the market's demand for flexibility and price competitiveness is clearly undermined by the act's qualification requirements. The mandated "basic services" inhibit an HMO's freedom to tailor a benefit package to a buyer's wants and purchasing power. This limitation is especially damaging to marketing success with lower income groups, who can afford only the minimum package or something close to it.

The monthly family premium increase resulting from the basic services, open enrollment, and community rating provisions will increase the cost of a minimum HMO benefit package by about $8 or 10 percent.[8] This increase comes on top of HMO premiums which may average $10 per month or 13 percent higher than the competition's because of HMO's wider benefit coverage and fewer deductibles or coinsurance provisions.[9] Moreover, all these estimates apply to large, mature HMO's. The costs to a small HMO could well be double. Clearly, an $18 to $26 monthly premium differential threatens many HMO's marketability. It is not surprising, therefore, that GAO found 50 to 60 percent of potential HMO's holding back from development, and several surveys documented existing HMO's belief that qualification would have anticompetitive effects.[10]

Other problems.—The Federal efforts, as embodied in the HMO Act, suffer from other weaknesses in addition to the dual choice/qualification contradiction. These problems involve the Federal attack on barriers to HMO growth. The mechanisms chosen have been uncertain, limited, and contravened by the quality assurance objective. These less obvious weaknesses have been overshadowed so far by the dual choice/qualification problems, but will contribute to less-than-optimal HMO growth in the future.

The level of funding for HMO planning and development grants has produced uncertainty and confusion. Because of administration and congressional budget actions to date, the amount of funding is uncertain. In fiscal year 1974, the appropriation for grants was $25 million, the total authorized. However, the fiscal year 1975 appropriation was $15 million and the fiscal year 1976 allocation is the same. These amounts are well below the authorized totals of $55 and $85 million for fiscal years 1975 and 1976. The result of this divergence is

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[7] U.S. Department of Health, Education, and Welfare, "Marketing of Health Maintenance Organizations." HEW technical assistance publication, vol. III 1972, p. 3.

[8] The development of this cost estimate and all other that follow are available in an appendix from the Congressional Budget Office, Health and Veterans Affairs Branch.

[9] McClure, Walter, "Expected Impact of the Heath Maintenance Organization Act of 1973." Minneapois: InterStudy, undated draft report.

[10] Lubalin, James, et al., "Analysis of Barriers to HMO Development (McLean, Va.: General Research Corp., Mar. 28, 1975), and GAO unpublished survey.

that the number of HMO's that can be funded is not clear. In addition, there is a strong inclination toward level funding (i.e., provision of the same amount of money each year of the program) when the development financing calls for varied spending patterns. This undercuts program continuity.

The HMO Act's mechanisms comprised only a limited attack on growth problems. As mentioned previously, the biggest difficulty HMO's have faced is generating enough demand. The dual choice provision was aimed at this problem. Yet two major Federal programs—medicare and medicaid—have not been effectively incorporated into the Federal HMO strategy. Less than 1½ percent of these programs' 47 million beneficiaries have joined HMO's. Nationwide HMO enrollment is only about 5.9 million; thus, it is clear that medicare and medicaid could significantly increase demand.

There have been at least three reasons why such a small percentage of the medicare and medicaid beneficiaries have joined HMO's.

First, HMO's have had little incentive to enroll these populations. With medicaid, most States do not cover enough services to make the recipients an attractive HMO enrollee. Medicare, on the other hand, does have adequate benefit coverage. To date, however, the required payment method has been reimbursement of costs—a mode at odds with HMO's prepayment philosophy. The 1972 amendments to the Social Security Act did authorize an alternative payment arrangement, one that incorporates elements of the HMO's preference for being paid prospectively and thus being at risk financially. But the Social Security Administration has not yet issued final regulations. Accordingly, it is difficult to assess what the new reimbursement method's impact will be.

Second, the beneficiaries themselves have not been attracted to HMO's. They have not perceived any economic incentive to join, since statutory benefits and cost-sharing arrangements are the same in an HMO as in a conventional setting. In fact, though, HMO's may well offer financial advantages to medical recipients. Only 52 percent of doctors now accept assignment, that is, participate in medicare's physician payment program. The 48 percent not accepting assignment often charge more for a service than the rate which medicare recognizes as reasonable. In such cases, the medicare recipient must pay more than 20 percent of medicare's prescribed service rate and thus incurs greater costs than he/she would in an HMO. This potential for savings in an HMO does not seem to be well known.

Third, the Federal Government-HMO relationship has been cumbersome with medicare and ineffective with medicaid. The medicare regulations concerning use of nursing homes, home health care services, and physician extenders can hinder an HMO's ability to use lower cost treatment and in addition impose expensive paperwork. The Government has just issued medicaid regulations because the lack of guidelines had permitted a number of HMO's to develop offering a scandalously low quality of care. The bad publicity which resulted has also slowed HMO growth.

Federal efforts to remove these constraints to medicare and medicaid enrollment in HMO's are complicated since the entitlement programs fall into different committee jurisdictions than the HMO development legislation.

The requirement that HMO patients must comprise 51 percent of the medical groups' practice stemmed from two "social goals" objectives: To insure quality care in HMO's and to extract from the physicians a full commitment to treat HMO patients in exchange for the dual choice provision. Unfortunately, the rule has another effect: It exacerbates the doctor shortage and probably inhibits HMO growth. Thus the 51-percent rule sets up a clash of objectives.

Implementation difficulties and recent progress

Compounding the weaknesses in the HMO legislation has been the act's slow implementation. The issuance of virtually all the necessary regulations has been long delayed. The critically important regulations implementing the "dual choice" offering of qualified HMO's by employers in health benefit plans were published on October 28, 1975. This was 22 months after the act's passage. Because of this delay, many employers, including 73 percent of the Fortune 500 companies in a survey,[11] have been refusing to contract with HMO's. Demand has obviously suffered as a result. In addition, regulations concerning the requirements for Federal qualification were published 19 months after the act's passage. And the final regulations outlining the form of HEW's continued regulation of HMO's qualified under the act are still awaited. Thus, it remains unclear exactly what qualifications will entail.

GAO has cataloged the causes of HEW's slowness in issuing the various regulations and its weaknesses in implementing the rest of the development program.[12] The source of the dual choice regulations' delay was the result of administration impasse over whether the union or individual employee has control of the dual choice provisions. The other regulations were held up because there has been only one attorney assigned to the program—and only for 70 to 80 percent of his time—and because the Office of HMO Qualification and Compliance has had only three professionals. Other program deficiencies, including weak technical assistance to prospective HMO's, have stemmed from a lack of the proper number of personnel with the appropriate qualifications as well as from a fragmented organizational arrangement which left "no single organizational unit within HEW . . . responsible for the entire HMO program." [13]

All of these factors have made HMO's more cautious because of the uncertainty over continuing regulation and their ability to receive a justified waiver.

It should be noted, however, that administrative improvements have been achieved in recent months. The dual choice controversy has been settled. Stronger organizational arrangements and more adequate levels of staffing are being provided.

Implementation problems do not appear, however, to be completely resolved. Continued concern is warranted in light of GAO's findings that "HEW does not have the number and type of personnel needed to implement the program." [14]

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[11] Stack, Ruth and William Polluck, "Survey of National Corporations on Health Maintenance Organizations," Minneapolis, Twin City Health Care Development Project, May 1975, p. 4.

[12] Statement, James D. Martin of the General Accounting Office before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, Nov. 21, 1975.

[13] Ibid.

[14] Ibid.

V. CHOOSING AN AMENDMENT STRATEGY

There are several possible courses of action available to Congress. In considering them, perhaps the most important guideline is the necessity to maintain a consistency between amendment objectives and mechanisms.

Five amendment options warrant consideration, two of them being the familiar "social goals" and "competitive growth" strategies and the package of mechanisms that go with each. The third and fourth alternatives are modifications of the "social goals" and "competitive growth" strategies. The fifth option calls for maintenance of the HMO Act in its present form.

(*1*) *The social goals strategy*

—"Basic services," "supplemental services," open enrollment, and community rating would be retained. Operating subsidies would be added.

—The options with respect to the 51-percent rule are to keep it, phase it in over 5 years, or phase it in with either the possibility of waivers or certain exceptions, such as for referral medical practices or rural HMO's. How much, if at all, the present provision is changed depends upon the relative weighting one gives to the rule's importance as a guarantee of quality care and as an essential aspect of the HMO concept versus its adverse impact on HMO growth.

—A choice of a level of grant support must be made. The options under most active consideration are to create 60, 100, or 160 HMO's through HEW financing.

—Four-year total costs could be $775 million, $1.01 billion, or $1.2 billion depending upon whether 60, 100, or 160 HMO's are created, respectively.

(*2*) *The competitive growth strategy*

—Drop the "basic" and "supplemental" services mandates as well as open enrollment, community rating, and the 51-percent rule.

—Make the same decision on a 60, 100, or 160 HMO level of grant support as faced by the "social goals" strategists.

—Four-year total cost could be $41, $87, or $150 million for the 60, 100, and 160 HMO's, respectively.

(*3*) *A modified social goals strategy*

—Objectives are HMO growth, access for high medical risks, and quality care assurance.

—Open enrollment is maintained, but "basic" and "supplemental" services, and community rating are dropped.

—Subsidies are added, but their cost depends upon whether the open enrollment requirement applies to all HMO's or to an experimental group of maybe 25.

—The same decision on 51 percent and the grant level must be made as faced by the "social goals" strategists.

—Four-year total cost depends again on the development grant level chosen and also on the extent of the open enrollment requirement:

(*a*) For all HMO's, the cost could be $99, $162, or $261 million for the 60, 100, and 160 HMO levels, respectively.

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(*b*) If 25 HMO's are selected for the open enrollment experiment, the cost again would vary with the grant level, the probable estimates being $48, $94, and $157 million, respectively.

(*4*) *A modified competitive growth strategy* [15]

—"Basic services" are trimmed, but not eliminated. "Supplemental services" and open enrollment are dropped. Community rating is delayed for 5 years. There are no subsidies.

—The 51-percent rule is delayed for 5 years, and then waivers are possible.

—About 160 HMO's could be created given the authorized amounts.

(*5*) *Keep the HMO Act as is*

—The "basic" and "supplemental" services, open enrollment, community rating, and 51-percent mandates are all maintained. No subsidies are possible.

—Objectives are revised, with HMO growth downplayed. The plan would lead to development of a small number, maybe 25 to 75, of prototype HMO's which offer a mode of care without many of the weaknesses in the current system.

—Grants would probably only be given to the small number of HMO's willing to accept the mandate, that is, probably no more than 60.

—Four-year total cost would probably be around $41 million.

Table 1 lists the mechanisms each strategy would choose, as well as the costs of each option. The costs, as well as a discussion of the various options, are included in the following sections of the paper.

The social goals strategy

The central decisions.—Provision of comprehensive health services, guaranteeing access to care for high-risk and low-income people, and assurance of quality care—the objectives of the "social goals" advocates—call for retention of the corresponding mechanisms in the HMO Act. Therefore, the qualification-tied requirements to provide "basic services," to offer "supplemental services," to have open enrollment periods, and to price by community rating are necessary.

The most significant addition to the mechanisms of the HMO Act are the continuing Federal subsidies. A three-pronged subsidy program would probably be needed. First, a $2 additional monthly premium price of supraminimum HMO services contained in the "basic" services package has to be underwritten for low- to middle-income HMO enrollees. Otherwise, HMO's could be priced beyond the reach of a very extensive market segment. Second, HMO's need reimbursement for the above average expenditures of high-risk enrollees. Estimates vary, but expenses 50 percent over the norm seems to be a reasonable expectation. Third, low-income people need full or partial help to meet the HMO premium.

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[15] This approach is reflected in H.R. 9019, the House-passed amendments and S. 1926, the Senate bill.

The costs of these subsidies cannot be estimated with much precision. The price tags depend upon the projected number of HMO's, their enrollment, and the number of subsidized individuals in HMO's—all of which are very uncertain. So any estimates must be tentative and accompanied by a range of possibilities.

The 4-year cost of these subsidies could run from $495 million to $1.48 billion, with the most likely estimate probably being around $915 million. A breakdown of these overall figures by type of subsidy and number of people served would be (costs in millions of dollars):

(*a*) $2 benefit: $99 to $247; $162 most likely; 1.2 million to 3.4 million people benefiting from subsidy in 1979.

(*b*) High risk: $99 to $345; $206 most likely; 243,000 to 945,000 people benefit in 1979.

(*c*) Poor people: $297 to $885; $547 most likely; 340,000 to 1.13 million receive partial subsidies in 1979; 191,000 to 638,000 receive full subsidies in 1979.

The $915 million estimate might be distributed annually in the following manner.

Fiscal year:	*Millions*
1976	$171
1977	202
1978	251
1979	291

TABLE 1.—MECHANISMS AND COSTS OF VARIOUS HMO STRATEGIES

Mechanisms	Original HMO Act	Competitive growth strategy	Social goals strategy	Modified social goals strategy	Modified competitive growth strategy H.R. 9019	Keep the act as is
(1) Mandated basic services	Yes	Only minimum services—those essential to be an HMO	Yes	Only minimum services	Yes, but drop a few.	Yes.
(2) Mandated capacity for supplemental services.	Yes	No	Yes	No	No	Yes.
(3) Open enrollment	Yes	No	Yes	Yes	No	Yes.
(4) Community rating	Yes	No	Yes	No	Delay 5 years	Yes.
(5) Subsidy	No	No	Yes	Possibly	No	No.
(6) Principal professional activity (51 percent rule).	Yes	No	Uncertain	Uncertain	Delay 5 years with waivers possible	Yes.
(7) Alternative grant program levels (in millions)	Authorized: FY 74 $25 FY 75 55 FY 76 85 FY 77 85 Total 250 (Enough for 250–300 HMOs).	60 HMO's / 100 HMO's / 160 HMO's FY 76 $22.5 / $28.5 / $30.7 FY 77 18.4 / 58.4 / 65.0 FY 78 / / 29.2 FY 79 / / 24.8 Total 41 / 87 / 150.0	Same as competitive growth: $41, 87, or 150	Same as competitive growth: $41, 87, or 150	Authorized: FY 76 $45 FY 77 45 FY 78 40 FY 79 40 Total 170 (Enough for some 160 HMO's)	Probably will fund 60 HMO's. Cost=$41.
(8) Total program costs [1] (outlays in millions)	Appropriations, less administrative costs, have been: FY 74 [2] $100 FY 75 15 FY 76 [3] 15 FY 77	Costs equal whichever grant level chosen.	60 HMO's / 100 HMO's / 160 HMO's FY 76 $175 / $200 / $221 FY 77 186 / 269 / 301 FY 78 196 / 251 / 306 FY 79 218 / 291 / 389 Total 775 / 1,011 / 1,217	60 HMO's / 100 HMO's / 160 HMO's (a) All HMO's $99.4 / $162.36 / $260.58 (b) Experimental group of HMO's: $48.3 / $94.3 / $157.1 (c) With no subsidy: Cost of grant level chosen.	Authorization totals, unless otherwise decided by Appropriations Committees.	Cost is that of grant program.

[1] Costs do not include administrative expenses.
[2] $75 to capitalize the loan fund.
[3] Most likely.

The choice of a grant level.—A decision is needed on whether Congress wants to provide capital to all qualified groups that want to become HMO's, whether funding of some representative number of HMO's is preferred, or whether a minimal program is in order. This choice of an objective for the Federal grant program is necessary to help clear up the uncertainty over the Federal development grant program and could form the basis on which to decide how many HMO's to help create.

(*a*) Create 60 HMO's:

Fiscal year:	*Millions*
1976	$22.5
1977	18.4
Total	40.9

(*b*) Create 100 HMO's:

Fiscal year:	*Millions*
1976	$28.5
1977	58.4
Total	86.9

(*c*) Create 160 HMO's:

Fiscal year:	*Millions*
1976	$30.7
1977	65.0
1978	29.2
1979	24.8
Total	149.7

As is obvious from the outlays just enumerated, this development effort, no matter what the level, has substantial variations in yearly funding needs. A constant budget level does not fit the programing realities of the grants program to develop new HMO's. So any tendencies to level fund this development program should be avoided.

These same grant options face all the strategies except the "keep the HMO Act as is" alternative.

The total costs of the strategy [16].—The decision to create 60, 100, or 160 HMO's determines, in part, the amount of the subsidies, as it affects the overall HMO enrollment population.

At the three grant levels discussed, the total program costs of the "social goals" strategy will most likely be:

[In millions of dollars]

	60 HMO's	100 HMO's	160 HMO's
Fiscal year:			
1976	175	200	221
1977	186	269	301
1978	196	251	306
1979	218	291	389
Total	775	1,011	1,217

[16] Total costs of this and all other strategies do not include administrative costs, which should be quite small.

The 51-percent rule.—The major options facing the "social goals" strategists on this issue are:

(*a*) Keep the rule as it is;

(*b*) Phase it in over 5 years; and

(*c*) Phase it in over 5 years and allow for some exceptions to the mandate, either through giving the Secretary of HEW the power to grant waivers, or through legislating some exceptions to the rule, such as for large referral group practices or for rural HMO's.

Which of these options are chosen depends upon one's view of the 51-percent rule's effect on the quality and quantity of HMO's, and the trade off one is willing to make between these goals.

Unfortunately these issues cannot be settled with adequate information on hand. The extent of the 51-percent rule's adverse impact on HMO growth is unmeasured. Its effect on the quality of care is also uncertain. The prime example cited as an example of HMO enrollees receiving poor quality care from physicians with primarily fee-for-service practices is the health insurance plan (HIP) of New York. Not only is the example unproven, but there are many cases of highly reputable fee-for-service groups which serve some minor percentage of prepaid patients. The other aspect of 51 percent's role in protecting quality—its importance as an essential component of the HMO concept—is based on a judgment of the overall quality-quantity trade off.

This same decision faces the supporters of the modified social goals strategy.

The competitive growth strategy

The central decisions.—As discussed earlier in the paper, the advocates of this option want to stimulate HMO growth, but without continuing Federal subsidies. Their position on subsidies demands that HMO's be self-supporting and, as a result, the act's mandates which do not apply to HMO's competitors are not acceptable. These requirements threaten HMO's marketability and growth. To be specific, the mandated "basic services" would be cut back to the minimum HMO benefit package, "supplemental services," open enrollment, community rating, and the 51-percent rule would be dropped.

Total costs of the strategy.—Since there are no subsidies, the cost is basically that of the development grant program. Depending upon whether a 60, 100, or 160 HMO level is chosen, the 4-year outlays would be $41, $87, or $150 million, respectively.

A modified social goals strategy

The central decisions.—This strategy is a more limited effort than the "social goals" plan discussed previously. HMO growth and guaranteed provision of quality care remain as objectives. Of the goals which lead to a need for operating subsidies, however, only access to care for high medical risks is retained. Comprehensive care and access for lower income people are dropped.

The motivating factor behind this scaling down of objectives would result from a desire to achieve social goals with limited Federal funds. Access for high risks is chosen because virtually nothing is being done for this group and, since there is no income test, the program should be easy to administer. Low-income people have medicaid, and even a

minimum HMO benefit package has the essentials of a comprehensive care system. Depending primarily upon the severity of this cost constraint, advocates of this modified strategy could push for one of two options:

(*a*) To subsidize all HMO's for providing care to people who are high medical risks.

(*b*) To limit the subsidy to a small, experimental group of perhaps 25 HMO's, with the idea of learning more about the costs, special medical arrangements, and organizational implications of enrolling high medical risks.

With this focus on growth, high risks and quality assurance, several of the mechanisms in the HMO Act are no longer necessary. Both "basic" and "supplemental" services requirements would be dropped, as would community rating. There would be subsidies for poor people.

An open enrollment would be essential to the strategy. With this mechanism, high risk people would be assured of admittance to HMO's. However, for several reasons, primarily budgetary, some limits to this open enrollment requirement may be in order. Several estimates indicate that 2 to 3 percent or some 4.2 to 6.3 million Americans have medical expenses twice those of the average citizen.[17] Such large numbers of people, who obviously have trouble buying health insurance, could potentially constitute a large percentage of HMO enrollment. However, given the desire to limit Federal spending, and to focus only on those most in need, a lid of 5 percent of an HMO's enrollment could be established. Additionally, to ensure that open enrollment is only economically attractive to people with very high medical costs, a 25 percent or so surcharge could be levied during this period. This extra cost should effectively deter other applicants.

Costs of subsidizing high risks.—The costs of subsidizing either the full or experimental effort, as with the costs of the various "social goals" subsidies, are difficult to estimate. Keeping in mind that there are several uncertainties in any calculation, it would seem that the 4-year costs of the subsidies and the number of people served might be as follows:

(*a*) If all HMO's must have open enrollment to qualify for dual choice, the 4-year cost might be between $46 and $113 million. A most likely estimate would be $75 million. Between 243,000 and 945,000 high risk people will be served.

(*b*) If an experimental program is instituted in perhaps 25 HMO's, with 5 percent of enrollment being high risk, the 4-year cost could be about $7.4 million. About 34,000 high risk people will be served.

If Congress decides that an operating subsidy is still inappropriate and therefore that the extra costs have to be passed on to HMO members, monthly family premiums would increase by $0.85 to $1.70 or 1.1 to 2.2 percent above the minimum HMO benefit package. Maintenance of this objective without funding would thus have an adverse effect on HMO growth, although not as much as one as the present act.

A modified competitive growth strategy[18]

Determining what the costs of this strategy might be depends heavily, as we have seen, on both the choice of a grant level and the

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[17] Conversation with Walter McClure (basis for his estimates in "A Critique of Health Maintenance Organization Act of 1973. Minneapolis, InterStudy. Feb. 7, 1974).

[18] H.R. 9019, the House-passed amendments, and S. 1926, the Senate bill.

decision on whether to require all HMO's to accept high risks or to limit the program to 25 or so HMO's.

If the full scale high risk program is adopted, the most likely 4-year costs of this strategy at the different grant levels are:

(*a*) 60 HMO's: $99 million.
(*b*) 100 HMO's: $162 million.
(*c*) 160 HMO's: $261 million.

If the experimental program is chosen, the 4-year costs will most likely be significantly lower:

(*a*) 60 HMO's: $48 million.
(*b*) 100 HMO's: $94 million.
(*c*) 160 HMO's: $157 million.

If there is no subsidy possible, the 4-year costs will be those of the development effort:

(*a*) 60 HMO's: $41 million.
(*b*) 100 HMO's: $87 million.
(*c*) 160 HMO's: $150 million.

The objectives and central decisions.—The House and Senate bills are directed at correcting aspects of the 1973 HMO Act which are thought to be undermining HMO growth. "Basic services" are trimmed, and the requirements to offer "supplemental services" and have open enrollment periods are dropped. There are no operating subsidies.

Yet some of the mechanisms of the "social goals" strategy remain. While two of the "basic services" requirements were deleted—preventive dental care for children and treatment for alcohol and drug abuse—several benefits beyond the minimum HMO offering were retained. Community rating and the 51-percent rule are delayed for 5 years, with waivers possible for the latter. Thus, while very concerned with the current lack of HMO growth, these changes indicate a desire to guarantee quality care and access to care for high medical risks.

The effect of these changes on HMO growth is unclear. While half of the extra monthly family premium costs in the 1973 HMO Act are dropped, the amendments still increase minimum HMO family prices by 6 to 12 percent. This $4.60 to $9.20 monthly, plus the possible difficulties of having to community rate while the competition has the superior marketing power of experience rating, and the problem of physician recruitment that may remain magnified as long as the 51-percent rule is not dropped, may cause HMO growth to continue to lag, especially in rural and medically underserved areas and among lower income groups.

The grant level and total costs of the strategy.—About 160 HMO's could be created through the authorized amounts in H.R. 9019 and S. 1926. Since there are no operating subsidies, the cost of these bills is the cost of this grant effort—$170 million over the 4-year period. The yearly levels are not as varied as they might be, however, and some program discontinuity would result.

Keep the HMO Act as is

Revised objectives.—As discussed in an early section of the paper, the HMO Act of 1973 encompassed the objectives of the "social goals" strategy but did not include the vital operating subsidies. The result has been that the act, along with the manner in which it has been implemented, has inhibited progress toward both the HMO growth objective and the additional aims of the "social goals" strategists. The reaction of many to this problem has been to push for changes in the HMO Act. There is, however, another possible strategy.

Great value is placed by some people on the new mode of care embodied in the HMO Act. Specifically, these advocates downplay the HMO growth goal and support a limited, experimental program in which the HMO's choosing to participate must continue to meet the HMO Act mandates in order to qualify for dual choice.

The position of these strategists as to the grant level is uncertain. While not opposed to HMO growth, they probably are only interested in helping create HMO's which will agree to the HMO Act's mandates. This may mean that funding needs would be closest to the 60 HMO level—$41 million.

Assessment of this strategy.—The underlying decision in choosing this strategy is that the creation of a small number of prototype HMO's which avoid the weaknesses of other health insurance and health delivery modes is very valuable. There is little basis on which to estimate how many HMO's will meet the qualification requirements. Perhaps 25 to 75 HMO's is a reasonable estimate.

There are costs, of course, in opting for this type of limited program. Those HMO's which do choose to qualify will no doubt be chiefly in higher income areas which have high insurance coverage and costs already. Without the dual choice provision, nationwide HMO expansion will proceed much more slowly, if at all. Lower to middle income groups will enroll less frequently because of the higher premium costs. And, coverage of high risk people will be minimal, under 2 percent.

VI. EMPHASIZING A DEMAND STRATEGY: MEDICARE AND MEDICAID

Underlying policy issues

To those interested in HMO growth, the medicare and medicaid progress could be used to increase substantially the demand for HMO's. As discussed previously, however, at least three obstacles have been limiting the HMO enrollment of both programs' beneficiaries: Inadequate financial incentives for an HMO to enroll medicare and medicaid eligibles; perceived lack of economic incentive by the beneficiaries; and unsatisfactory relationships between the Federal Government and HMO's.

Remedies are available to meet each of the three problems just mentioned. However, underlying how one would evaluate these possible changes are several basic questions:

1. What is the relative weight given to the HMO growth objective versus the goal of guaranteeing quality care for medicare and medicaid beneficiaries?

2. What effect will the alternative payment method authorized in the 1972 Social Security Act amendments have on HMOs' unwillingness to market to medicare recipients?

3. Should HMO's be given any marketing advantages over the fee-for-service sector or should HMO's be put on equal terms?

Where applicable, each of the possible changes will be discussed in terms of these policy questions.

Improving HMO's incentives to enroll medicare and medicaid recipients

Medicare's traditional method of payment, reimbursement of costs, has not been attractive to HMO's. HMO's prefer a prospective payment system. The 1972 Social Security Act amendments authorized a new payment method for HMO's. However, the new method has not yet been implemented. The unresolved question is whether HMO's will find the new arrangement attractive.

The new payment method will work as follows. Prepayment of a per capita amount on behalf of medicare enrollees is made to an HMO on the basis of the estimated average medicare payment in the area. This per capita total is subject to retroactive adjustment based on the cost experience of all medicare beneficiaries in the community. If, after that adjustment the HMO's costs are lower than the community per capita average, the HMO would share the first 20 percent of the savings resulting from that lower cost equally with the Federal Government. All further savings would go entirely to the Government. Any losses would be borne by the HMO.

This type of payment method reflects a deep concern for guaranteeing the provision of quality care to medicare beneficiaries. By limiting the profits made for enrolling medicare beneficiaries, it is felt that any tendency of HMO's to provide too few services would be significantly reduced.

HMO's have expressed serious reservations about this payment method. First, they prefer a straight prospective payment arrangement pegged at 100 percent of the expected community average cost per beneficiary. Second, they feel it is unfair to force HMO's to absorb all losses yet share any savings or profits with the Federal Government. In addition, HMO's fear that a retrospective readjustment could create severe cash-flow problems in cases where a substantial "pay back" to the Federal Government is required.

Despite the widespread HMO dissatisfaction with the 1972 amendment formula, it is too soon to say the HMO's will not find it acceptable. The method has, after all, yet to be implemented. On the contrary, there is some evidence that HMO's may profit from this arrangement. After the preliminary regulations were issued in July 1975, 30 HMO's, mostly smaller and newer ones, applied for the new method of payment. Others, including several of the well established HMO's, have expressed interest.

A recent Social Security Administration study shows that HMO's are likely to profit from the new arrangements. In this study, seven HMO's were compared in terms of medicare cost experience with the surrounding fee-for-service sector costs. Five of the seven spent less and three of the five would have received the maximum bonus. The two HMO's with above average costs would have had only moderate losses of 2 and 4 percent. Both of these plans had trouble controlling hospital costs and expenditures incurred in facilities outside the HMO area. These two HMO's, and others with similar problems, would not

necessarily incur financial losses because of the new payment scheme, since they have the option to remain on the traditional cost-reimbursement system.

Just as it is too soon to judge whether HMO's will find the 1972 formula acceptable, so is it premature to determine whether or not the continuing option of reimbursement of costs makes sense from a Federal perspective. If the 1972 formula does prove successful, or if a straight prospective payment system is substituted, perhaps the reimbursement option should be phased out. This step might well result in greater Federal savings, since medicare beneficiaries could then join only the more efficient HMO's. Only these HMO's would accept the risk inherent in any prospective payment system.

In summary, it is premature to judge whether the 1972 amendments' formula will facilitate greater enrollment in HMO's by medicare beneficiaries. Whether one is willing to accept this uncertainty probably depends upon one's objectives. If the guarantee of quality care to the beneficiaries is the paramount concern, then maintaining the new payment scheme, at least until evidence of its acceptability or unacceptability to HMO's accumulates, is probably the best course of action. If one is less concerned about the threat to quality care and thinks HMO growth is vitally important, change may be in order. The options available are:

(*a*) To modify the present provision by dropping the retroactive adjustment aspect and making payment simply on a prospective basis. Profits would continue to be shared, and a sharing of losses could possibly be added; or

(*b*) To change the present formula more extensively. Payment for medicare enrollees would be simply on a prospective basis, but rather than the amount being the expected community average cost per beneficiary, it would be 90 to 95 percent of that amount or an amount negotiated between an individual HMO and the Social Security Administration. Furthermore, neither profits nor losses would be shared. A cap on the amount of profit possible per beneficiary would be considered.

The problem of insufficient benefit coverage by medicaid plans to attract HMO's is not easily solved. Since those States covering fewer services usually have high Federal matching rates already, options short of federalizing medicaid would probably not solve the problem. Obviously, federalizing medicaid is a major policy change of which the importance of HMO development is a minor element.

Improving beneficiaries' incentives to join HMO's

Medicare recipients have not perceived any economic advantages in joining HMO's. As discussed in a previous section, this is not true for many of the medicare recipients whose doctors do not accept assignment because of the levels of reimbursement. These steps are thus possible:

(*a*) Encourage the Social Security Administration both to contract with qualified HMO's so medicare enrollees will have a dual choice option, and to publicize the potential savings to their beneficiaries.

(*b*) Allow qualified HMO's to keep a greater share of their savings if they will use the extra funds to either increase the number of benefits offered to the beneficiary or lower his/her out-of-pocket costs.

The latter step would, of course, give the qualified HMO an advantage over the competition. The extra amounts, however, need never put the Federal payments to an HMO above the average cost per beneficiary in the fee-for-service sector.

Medicaid recipients currently lack any economic incentive to join HMO's. To encourage interest, HMO's must offer coverage of more services. Such wider coverage depends, of course, on the States either increasing the prospective reimbursement amount or allowing greater savings retention in exchange for more benefits. The Federal Government could encourage this wider coverage by increasing the Federal match as the percentage of medicaid recipients enrolled in HMO's rises. This kind of a change would give a distinct financial advantage to HMO's over other providers and would create an inequity between providers.

Improving the Federal Government-HMO relationship

A key to HMO cost savings is the substitution of lower for higher cost treatment. The medicare regulations with regard to home health care, nursing homes, and physician extenders can encumber an HMO's ability to effect this cost-saving substitution. Loosening these regulations, for example by allowing physician extenders to operate with less physician supervision and to perform a wider range of medical procedures, or by waiving the 3-day hospital requirement before an enrollee can enter a skilled nursing home, could make HMO's more enthusiastic about serving the medicare population, and could augment HMO growth prospects.

The recent HMO scandals in California, where many HMO's failed to provide care to State medicaid recipients, have hindered HMO growth. More effective regulation of HMO's could have reduced or avoided many of these problems and the resulting damage to the HMO reputation. Federal regulations have now been issued. While legislative action may not be in order, rigorous oversight by Congress to guarantee strong HEW enforcement of the new HMO-medicaid regulations may be the most appropriate step.

CONCLUSION

HMO growth appears to have been stymied, if not retarded, by the passage of the 1973 HMO Act. A major reason appears to be the added costs imposed on HMO's by the requirements of the act that attempt to attain specific social goals. These additional costs have adversely affected the competitive position of HMO's.

If a high growth rate for HMO's is to be maintained as a major objective of the act, amendments to the act appear necessary. The amendments could provide the necessary operating subsidies to allow HMO's to be competitive or eliminate their need by dropping some or all of the requirements that add substantially to HMO costs. If all of the requirements of the act are maintained, operating subsidies approaching $250 million annually would be needed. If requirements are dropped, particularly that of assuring access to low-income people, the necessary subsidies fall off rapidly. Alternatively, if no amendments are adopted, HMO growth will be dampened, perhaps substantially; but those HMO's emerging will meet the social objectives specified in the law.

PROSPECTS FOR MEETING HEALTH CARE NEEDS OF CHILDREN ELIGIBLE FOR MEDICAID UNDER EPSDT

SUMMARY

This report attempts to provide the following information on medicaid's early and periodic screening, diagnosis, and treatment program (EPSDT) : A description of the program and the problem it was intended to deal with, constraints on program effectiveness, the benefits of dealing with the problem, and alternatives for dealing with it.

Background, purpose, and current status of the EPSDT program

The EPSDT program was enacted by Congress in 1967, as an amendment to the existing medicaid law. It is an attempt to provide comprehensive and preventive health care for the 13 million persons under 21 annually eligible for medicaid, a group with disproportionately greater illness and disability than other American children. Under EPSDT, States are required not only to reimburse for, but also to insure the provision of periodic screening, diagnosis, and treatment services to those eligible.

To date, the EPSDT program has fallen far short of its potential, prompting widespread criticism from Congress. Implementation was delayed until final regulations were promulgated in November 1971. In 1974 and 1975 only 1.3 and 1.5 million, respectively, of the 13 million eligibles were screened. Even this level of performance was credited largely to the impact of a penalty for noncompliance imposed on States by Congress in 1972, and to increased implementation activity by the Department of Health, Education, and Welfare (HEW). The 1976 screening target is 2 million eligibles; approximately 60 percent of those screened and subsequently identified as needing treatment may actually get it. Costs for all activities directly attributable to EPSDT during fiscal year 1976 can be estimated very roughly at $140 million—5 percent over and above the $2.6 billion medicaid might otherwise be expected to spend on those under 21.

Constraints on program effectiveness

Several constraints have contributed to EPSDT's difficulties. First, a slow and ineffective administration response was cited by the General Accounting Office (GAO) as a reason for delayed implementation. Second, EPSDT works through medicaid, which was established to pay providers' bills and does not operate its own health care delivery system. Thus each of the steps mandated is provided separately, which necessitates costly management services to insure coordination, yet offers little assurance that all of a child's health care needs will be met. Furthermore, EPSDT often relies on private providers of health care, who may be inadequate in number or unwilling to participate. A third problem is that under medicaid, States, which are reluctant to bear

EPSDT's added cost, are relied upon to implement the program. A fourth is an emphasis, perhaps unintentional, on screening as a necessary first step, even though it is not needed for some conditions and may not be followed up with diagnosis and treatment.

Benefits of dealing with health needs of children eligible for medicaid

Available attempts to quantify the benefits of dealing with medicaid eligible children's health needs through EPSDT in terms of improved earnings and decreased welfare dependency are unreliable. Those based on medicaid expenditures are not relevant to EPDST. Assuming that the personal costs of untreated illness and disability are significant, the Congressional Budget Office (CBO) has estimated the number of children eligible for medicaid with various health problems whose needs are currently met by EPSDT. Based on data from EPSDT demonstration projects, up to 6,500,000 eligible children may need medical care, and up to 11,700,000 dental care. Through fiscal year 1976, 9 percent of those who may have medical problems and 3 percent of those who may have dental problems are expected to be treated by EPSDT. This does not mean that all other eligible children remain without care. A much larger proportion of the 13 million eligibles—approximately 85 percent—will be medicaid beneficiaries in fiscal year 1976. But those outside the EPSDT system are believed much less likely to have their health problems uncovered and dealt with routinely.

Options for meeting health needs of children eligible for medicaid

Two options involve working through EPSDT as it now exists. The first, proceeding as currently projected by the program, provides incentives and requires some increases in outreach and case management efforts. It might result in 3 million children screened in fiscal year 1977, with 70 percent of those screened and requiring treatment getting it. Thus 16 percent of eligible children who may need medical care and 7 percent of those who may need dental care would be treated by EPSDT. Little improvement could be expected in later years. Program costs could be expected to rise to roughly $250 million, with a Federal share of $140 million and a cost per child in the EPSDT system of $84.

The second option, full implementation, would involve substantially greater program activity, especially in outreach, and 90 percent Federal payment for dental treatment. By fiscal year 1979, 80 percent of the eligible population might be screened and 90 percent of those screened who need treatment might get it. Thus, 72 percent of the eligible children who may need medical and dental care that year would be treated by EPSDT. Without allowing for inflation beyond 1976 levels, annual costs could be $1.4 billion, with a Federal share of $1 billion, and a cost per child in the EPSDT system of $132.

However, even if it were possible to implement EPSDT with the present reluctance of States to commit funds, the previously mentioned constraints relating to the nature of medicaid—reliance on episodic, not comprehensive care, and high administrative costs—would remain. And if one adds the cost of a fully implemented EPSDT program to other public expenditures for medicaid eligible children's health care, the total—approximately $4.5 billion in 1976 dollars, or over $340 per

child—rivals the cost of the most expensive continuous comprehensive health services.

Alternatives exist which might help insure that funds for the health care of medicaid eligible children are spent more efficiently and effectively. They include limiting EPSDT objectives to age groups and conditions where preventive care is most effective; altering EPSDT's program design, regulating health manpower and offering financial incentives to providers so as to improve the accessibility, continuity, and comprehensiveness of care; and providing continuous, comprehensive care through mechanisms that control health service delivery. While it was not within the scope of this report to fully develop these additional options, some basic considerations for future exploration have been raised here.

I. BACKGROUND, PURPOSE, AND CURRENT STATUS OF THE EPSDT PROGRAM

Several trends contributed to an awareness of low-income children's health problems and the origin of EPSDT in the mid-1960's. Anti-poverty programs were helping build an interest in and constituency for the poor—particularly poor children. Medicaid and medicare became law, as did a number of new categorical health services programs aimed at the poor and emphasizing disease prevention and health maintenance.

Finally, a Selective Service study produced the startling findings that more than 15 percent of 18-year-olds examined were rejected for military duty because of chronic handicapping conditions. These included orthopedic problems; internal conditions such as heart disease; dental, eye and ear conditions; and a large percentage of emotional and developmental disorders.

HEW figures suggested that potentially disabling conditions were far more prevalent among children from low-income families, many of whom lacked effective access to care:

—Two-thirds had never been to a dentist; 60 percent of those with chronic conditions were not being treated. Physician visits were less frequent, although there was nearly twice as much hospitalization as among higher income children.

—Compared to more affluent children, the prevalence of heart disease was three times as great. Seven times as many low-income children had visual impairments, six times as many had hearing problems, and five times as many had mental illness.

Program origins

A 1966 HEW program analysis estimated from a review of medical literature that 62 percent of the chronic conditions responsible for Selective Service rejection were preventable or correctable through continuous and comprehensive child care and 33 percent were preventable or correctable with only periodic screening and treatment. Both these health figures may have been high in view of the many other factors affecting health status and the difficulties in achieving good treatment even for specific conditions using the existing health care system. Nevertheless, the report strongly recommended a very limited screening and followup program (only 12 percent of those screened were assumed to need treatment) as being far more "cost effective" than continuous care.

The following year, President Lyndon Johnson delivered a message on the welfare of children in which he proposed doubling the crippled children's program, which was part of title V (maternal and child health programs) of the Social Security Act, to reach disabled children who were not being aided. He also stressed the need for preventive child health care, asking that such services be made reimbursable under title XIX of the Social Security Act (medicaid). The distinction between the limited screening and followup program envisioned by the HEW analysts and comprehensive preventive care was blurred. Moreover, the new proposal was not only broad in scope, but it had the potential for reaching far greater numbers of children than believed possible with existing categorical service programs.

Legislation reported by the House Ways and Means Committee in response to the Presidential message included not only the reimbursement provision and a larger crippled children's program, but considerable expansion and reorganization of all maternal and child health programs, which might have provided a programmatic base from which to implement the new preventive care initiative. Discussion in both Houses indicated that the proposal was seen as a centrally directed effort with funding and authority to insure widespread implementation. However, wording that applied specifically to preventive care in the final legislation consisted only of minor clauses to insure coordination between titles V and XIX, and the inclusion among required and reimbursable medicaid services, effective July 1, 1969, of:

> . . . such early and periodic screening and diagnosis of individuals who are eligible under the (State medicaid) plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations by the Secretary.

Thus, the legislation was nonspecific with regard to administrative responsibility and virtually open-ended with regard to scope, cost, and target population within the eligible group. While it is not unusual for details of a new program to be left to the executive branch, some believe the vagueness of the laws was a special problem for EPSDT because of the strong and opposing pressures involved. In a 1974 report for the Yale School of Medicine's health policy project, Anne-Marie Foltz noted that HEW was left ". . . with the difficult, if not impossible, task of drawing up a set of regulations and guidelines which would satisfy administrators, State officials, interest groups, and Congress."

Implementation

There are an estimated 13 million persons under the age of 21 eligible annually for medicaid, between 3 and 4 million of them new to the pool during any given year.[1] Despite the fact that 11.1 million, or 85 percent of the 13 million, will receive some medicaid benefits during fiscal year 1976, and that average expenditures for these child

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[1] Some believe that the original estimate of 13 million was overstated in the past. However, even those who estimate the figure at 11 or 12 million in 1974 and 1975 predict that the number of eligibles will be close to 13 million by 1977. The proportion newly eligible is based on the fact that 30 percent of all aid to families with dependent children (AFDC) cases in a January 1973 survey were new to the rolls during the preceding 12 months. A precise figure is not yet available for more recent years, but there are some indications it may be slightly lower. Ninety percent of EPSDT's target population are AFDC recipients.

The low-income and medically indigent children who may share many of the health problems listed above but are not covered by medicaid because of varying State eligibility requirements are not subjects of this report. However, this group should be considered in formulating alternatives.

medicaid beneficiaries are approaching per capita health care expenditures for children in the general population, there are serious problems with distribution and type of care. In a 1975 report on the provision of health care to low-income families, Karen Davis of the Brookings Institution found disparities in medicaid benefits to the rural poor and members of minority groups. In addition, medicaid benefits to children exclusive of EPSDT are believed to be primarily episodic and to include little comprehensive screening or preventive care.[2]

EPSDT's progress even toward its initial objective of screening the 13 million children eligible during a given year has been slow. A period during which administrative authority for the program was unclear followed passage of the legislation. Later in 1968, HEW's Medical Services Administration (MSA) assumed the responsibility. However, final regulations were not promulgated until November 1971—17 months after the program's effective date. These regulations reflected the broad mandate of the law but according to the GAO, HEW was not aggressive in seeking compliance.

The number of children screened during fiscal year 1973, EPSDT's first full year of operation, was less than 500,000. This figure jumped to 1.3 million in fiscal year 1974 and 1.5 million in fiscal year 1975. The increase is credited largely to enactment by Congress in 1972 of a 1-percent penalty for State noncompliance to be charged against Federal AFDC matching funds during each quarter and to more vigorous implementation by HEW during the last 2 years. However, 1.5 million was still only 12 percent of the target population.[3] Of those found to require treatment in fiscal year 1975, approximately 60 percent received it, according to responses from nine States in a survey by the House Subcommittee on Oversight and Investigations.[4]

The penalty

According to regulations implementing the original law and the penalty amendment, each State must now:

—Inform all AFDC families at least once a year in writing of what EPSDT services are available, and how and where to obtain them;

—Inform all recipients who request screening of where and how to receive it, provide transportation, insure that screening is provided normally within 60 days;

—Inform recipients needing treatment of where and how to obtain diagnosis and treatment, provide transportation where necessary, and insure that the services are provided normally within 60 days of screening; and

—Provide services that are within the scope of the State medicaid plan, and include, in all cases, treatment for vision, hearing, and dental services.

Enforcement is still at the stage where available information, and therefore official action, involves primarily the first two items. Nine States have been assessed the penalty for failing to meet the basic re-

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[2] 95 to 98 percent of all conditions discovered at screening in four EPSDT demonstration projects were either new or untreated previously.

[3] To add the numbers screened each year since EPSDT's inception would be misleading, since an unknown number are repeats and even the total of 3 million is smaller than the estimated annual turnover of between 3 and 4 million in the eligible population.

[4] The 60 percent may be high if only those States with followup systems responded. Previous State averages reported to EPSDT ranged from 25 to 69 percent.

quirements during the first quarter of fiscal year 1975 and one of the nine has also been assessed the penalty for the second quarter of 1975. Enforcement action continues but the process leading to a decision by the Secretary to penalize is time consuming. Thus, no penalties have been assessed for any subsequent quarter. In addition, those penalties that have been assessed are subject to a formal reconsideration process established by HEW, and none has yet been collected. Table 1 provides information on reasons for the penalty and numbers of children eligible for medicaid in the States penalized. It is significant that New York and California, States with 1.5 million eligibles each—the highest numbers in the Nation—were both penalized for failing to notify and provide screening for large proportions of children. Other States with major infractions were Indiana, North Dakota, and Montana.[5]

TABLE I.—PENALTY PROVISIONS

State	Number of eligibles	Approximate amounts of penalties (millions)	Cause of penalty
A. Major infractions:			
1. California	1,524,007	$1.9	Failed to inform 14 percent of the eligibles, to make screening available to all, and to assure provision of treatment services on a timely basis.
2. New York	1,519,855	2.2	Did not inform all eligibles in New York City, or insure availability of screening services or treatment services.
3. Indiana	180,038	.14	Did not inform where EPSDT screening available, provide for appropriate screening, or refer for preventive health services.
4. Montana	21,117	.03	Failed to describe what EPSDT services were as well as where to obtain them.
5. North Dakota	12,808	.03	Failed to describe what EPSDT consists of, and how and where to receive the services.
Total impact	3,257,825	4.3	
B. Lesser infractions:			
1. Hawaii	51,462	.08	Failed to inform all eligible families on time and to tell how and where EPSDT services were available.
2. Minnesota	118,287	.03	5 counties did not inform families what EPSDT consisted of and where the services were available; 2 counties did not tell where screening could be received or arrange for such services.
3. New Mexico	59,246	.07	2 counties did not provide screening facilities; 1 county did not provide screening on a timely basis.
4. Pennsylvania	551,814	1.0	Did not inform eligibles in Dauphin County (Harrisburg) of the availability of EPSDT services.
Total impact	780,809	1.18	

Current status

There are four major steps in completing an EPSDT case: Outreach, screening, followup (taking the child whose screening showed the presence of disease through diagnosis and treatment) and actual treatment. During the current fiscal year, EPSDT estimates that 2 million children, or 15 percent of the eligible population, will be screened. The increase over fiscal year 1975 is due to States' increased outreach and notification activities.

[5] There are legitimate problems with the penalty, despite its apparent success in stimulating State action. It takes money away from AFDC, an area where State governments and recipients may need it most, and it may be unfair to penalize States for a situation that may be related to a shortage of resources that is not entirely their fault.

Results of demonstration projects indicate that approximately 50 percent require some additional medical treatment. If this percentage can be applied to the 2 million projected to be screened, roughly 1 million should be referred for medical care. Ninety percent of those in demonstration projects require dental treatment. However, only 25 percent, or 500,000 of the 2 million projected to be screened, may actually be referred for dental care, probably because some States are reluctant to "find" dental problems they would be required to treat. If it is assumed, based on the survey data from nine States, that of those referred for treatment 60 percent receive it, then in fiscal year 1976 600,000 children may be treated for medical conditions and 300,000 for dental conditions.

Any EPSDT cost estimates must be of extremely questionable reliability since the program has no independent cost reporting and it is impossible to separate EPSDT treatment costs from other medicaid reimbursements. However, a very rough approximation of annual program costs at the current level of implementation from data provided by EPSDT staff would be $136 million, with a Federal share of $75 million and a cost per child in the EPSDT system of $68.[6] The total is approximately 5 percent over and above the $2.6 billion expected to be spent on those under 21 under the current medicaid program without EPSDT in fiscal year 1976. Thus, in terms of expenditures, EPSDT's magnitude is considerably less than the Federal Government's nonmedicaid health services programs that some of its original proponents believed it would surpass. Taken together, these categorical programs account for perhaps $500 million in additional, nonmedicaid public expenditures for low-income children's health care.[7]

II. CONSTRAINTS ON PROGRAM EFFECTIVENESS

A number of factors have contributed to the failure of EPSDT to provide comprehensive and preventive health care for all medicaid eligible children, and some may continue to do so. They include HEW's lack of speed and effectiveness in implementing the program, the difficulties in providing comprehensive care through the existing financing system, problems raised by the Federal-State medicaid relationship that leaves policy matters to the States, and an emphasis on screening, perhaps unintentional, that may result in inefficient resource allocation.

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[6] The estimate is comprised of screening costs of $21 per child screened, averaged from State estimates; medical treatment costs of $35 per child (the increment attributed to EPSDT from reports of eight States on total medicaid vendor payments per child before and after the program was implemented) and the following costs for other components estimated by EPSDT's central office based upon data from four demonstration projects and a few States developing their own reporting systems: outreach at $1 per eligible child, administration at $10 per child in the EPSDT system, followup at $10.40 per child with referral, and dental treatment at $90 per child actually getting it. Detailed costs at current levels of program implementation as well as those projected for a fully implemented EPSDT program are provided in tables 3A and 3B.

[7] These other programs, which are distinguished from medicaid because they organize and operate their own delivery systems rather than financing care, include community and migrant health centers, the maternal and child health and family planning programs, health maintenance organizations, the National Health Service Corps and Indian Health Services. The figure of $500 million is very imprecise, since accurate data on the financial status of children in such programs are not available. It includes nonreimbursable care for medicaid eligible children but also some care for children from low-income families who are not medicaid eligible.

The administration's response

While confusion over who was to administer EPSDT may have contributed to early delays in implementation, the aforementioned January 1975 GAO report placed the major blame for lack of progress on HEW. The report said the agency was "slow in developing EPSDT regulations" and that it had "not taken effective action to insure that States fully implement EPSDT." In testimony before the House Subcommittee on Oversight and Investigations, HEW officials agreed substantially with this finding regarding the first 5 years of EPSDT's existence. Many observers believe that HEW's real action on the program did not begin until after Congress enacted the penalty provision in 1972.

Staffing was and is another problem. HEW's staff commitments have been low even for a program that left much administrative responsibility to the States. Today, after recent and substantial increases, HEW's official commitment to EPSDT is for the equivalent of 33 full-time staff members in the central office and 56 in regional offices. However, the program has little control over regional office employees, so that staff members may devote considerably less than the allocated time to EPSDT. While the categorical service programs operate differently, a comparison of staff may be useful. The maternal and child health program, similar in its Federal-State nature but with a much more limited target population, employs the equivalent of 160 full-time staff members.

One indication that more staff may be needed is that existing staff have been preoccupied with checking on basic penalty clause compliance and have been unable to provide intensive technical assistance to States or to develop an independent EPSDT data base. In the case of the former, it may not be appropriate to have the same persons providing technical assistance and enforcing the penalty. The latter is a particular problem, since medicaid reporting of even aggregate costs is more than a year behind. Because of the data deficiency, it is not possible to separate services received as a result of EPSDT, let alone track individuals from screening to treatment or identify EPSDT-type services received elsewhere.

Difficulties in working through medicaid

With the exception of EPSDT, medicaid is essentially a bill-paying program. It does not operate its own delivery system. Eligible persons see existing, often nongovernmental providers, usually on their own initiative. The providers are subsequently reimbursed with State and Federal funds. Care delivered in this way may be episodic and crisis oriented, with little continuity from one encounter to another. This lack of continuity is a serious deterrent to the success of EPSDT, which attempts to provide care that is preventive (physical exams and screening for a well child) and comprehensive (dealing with all the child's health needs). Because the eligible population is constantly changing, often mobile and possibly wary of health professionals, EPSDT's objective is difficult to achieve even in a single setting like a neighborhood clinic. The program's reliance on the existing, fragmented network of providers necessitates extensive outreach and followup services to arrange a logical sequence from screening to diagnosis to treatment even for specific conditions, according to reports from EPSDT demonstra-

tion projects. Such management "glue" is costly and it has not been conclusively demonstrated that it insures comprehensiveness.

In addition to fragmentation of services, lack of resources is a problem. In some areas there are simply no health care providers. Elsewhere, EPSDT has to depend on private pediatricians, school health programs, public health departments, hospital outpatient clinics, and federally supported grant programs. Serving medicaid children is not the primary goal of many of these providers, and some may be actually resistant to treating the target population.

In commenting on EPSDT's new penalty regulations, published but not yet finally promulgated, 20 of 33 States and 10 of 15 localities responding attested to provider problems related to shortages in certain geographic areas and/or medicaid participation. Both the American Medical Association (AMA) and HEW report that of 335,000 non-Federal physicians, approximately 55 percent are medicaid participants. While most State percentages are similar, participants may be unevenly distributed within States, especially in urban areas. For example, the percentage of physicians participating in medicaid falls to 35 in the District of Columbia. In addition, a small number of providers may actually service the majority of recipients. In New York City, 60 percent of all medicaid physician billings are attributable to 10 percent of the participating doctors.

Finally, the fact that medicaid is administered as a welfare rather than a health program has been a barrier to achieving EPSDT's objectives. Successful implementation means creating and reorganizing health resources as well as providing health education. Yet State medicaid agencies are mostly welfare departments whose relevant experience is limited. Where the agency or its contractor is a health department, the pertinent division is often one that pays vendors rather than one that organizes care.

Federal-State relationships

Within requirements established by law and Federal regulations, States control the mechanisms through which EPSDT is implemented. They have discretion in precisely what services are provided, who can provide them and how much is paid. They also bear from 22 to 50 percent of EPSDT expenditures. Thus they have been reluctant to move ahead with a program whose additional cost could be high and whose benefits in terms of improved health status or cost savings have not been clearly demonstrated.

Nearly all States have problems with the cost of new treatment services. When HEW's proposed regulations attempted to mandate treatment of any condition found at screening regardless of whether it was previously covered by the State medicaid plan, the States protested vigorously. After a year of discussion, the Federal requirement was limited to hearing, vision, and dental problems plus all others previously covered. Even these additional services, some of them for children who would not have otherwise entered the medicaid system, entailed substantial costs. As discussed later, it is unclear whether provision of such services through the existing EPSDT-medicaid system will ever result in dollar savings to States. If such benefits do accrue, long-term savings would be a questionable selling point when State budgets are being squeezed by medicaid now, and even short-

term savings through preventive care may require a degree of comprehensiveness in EPSDT that would take several years to develop.

Emphasis on screening

Some States have acted on their own to insure followup care for those screened. But in many others, effective operation of EPSDT is limited to screening. This is partly due to efforts at forcing States to implement at least the first step of a program they were resisting. In turn, it has proven easier for States to mobilize the medical community for mass screening efforts than it has to insure physicians' participation in the ongoing care of eligible children.

However, the emphasis on screening appears also to be the legacy of past HEW policy. Many believed that once a child's health care needs were identified, the availability of financing through medicaid would insure the provision of treatment. HEW policy now reflects an understanding that financing is not enough—that barriers to case completion are posed by lack of treatment capacity and discontinuity of care. But although the agency plans to require States to report routinely on followup care, mandated information is still currently limited to screening data. And despite HEW's urging to the contrary, screening may persist as a separate step even where it is duplicative and wasteful—for example, with dental problems, where 90 percent of the children have been found to require some treatment; or immunization, where the treatment is simply to give the shots.

III. BENEFITS OF DEALING WITH HEALTH NEEDS OF CHILDREN ELIGIBLE FOR MEDICAID

The long-term benefits of dealing with medicaid eligible children's health problems through EPSDT are very difficult to quantify. On a theoretical level, the dollar costs of illnesses and disabling conditions can be calculated, usually in terms of subsequent medical care, earnings lost to morbidity and mortality and increased welfare dependency. It is quite another thing to link decreases in these costs to EPSDT. The many conditions EPSDT deals with are too varied in kind and degree and amenability to treatment to assign dollar values to their improvement, and the program is too unspecific to predict its impact. There are probably significant, albeit nonquantifiable benefits, such as increased awareness, from the outreach and educational efforts of a program like EPSDT. However, even preventive and comprehensive medical care may have a minor impact on some measures of low-income children's health status.[8] More and more frequently such measures are linked by public health experts to factors outside the control of medical care—housing, sanitation, work environment, lifestyle, and genetics.

A more reliable, though narrower, method for assigning dollar values to program benefits, and one with more practical fiscal impact, would be to demonstrate reductions in total health expenditures for a particular group of persons who received preventive and comprehensive services simultaneously or immediately prior to the test period. There is some spotty evidence that such savings are achievable in con-

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[8] This is less true of vision and hearing problems which are easily correctable.

tinuous care settings. For example, according to a controlled study in Portsmouth, Va., reductions of 20 percent in total medicaid expenditures for AFDC recipients were achieved during 1 year. All of the experimental group received intensive outreach and complete physical exams; most received followup care in a health department clinic. Despite the additional costs of community case management workers and screening for the experimental groups, the cost of physician visits was 25 percent less than for a control group left to seek care on their own; prescription drug costs were 27 percent less and there were 35 percent fewer hospital days. Unfortunately, however, similar studies have not been conducted for a screening program that makes use of a fragmented health care system. It is unclear whether the same savings can be expected without knowing how comprehensive such a program can be. On a very preliminary basis, these figures only provide an idea of the short-term benefits of some kind of preventive and comprehensive health care for low-income children.

The fact remains that the personal costs of untreated illness and disability can be high. Thus, as a first step in calculating EPSDT's benefits, table 2 provides estimates of the program's impact in providing treatment for the number of medicaid eligible children who may have medical conditions (50 percent, or 6,500,000) and dental conditions (90 percent, or 11,700,000), as well as its impact on more specific problems.

Up to 1.6 million medicaid eligible children may have respiratory problems, 1.7 million may have vision problems, 520,000 may have hearing problems, and 1.95 million may have genito-urinary conditions; 3.25 million might be lacking one or more important immunizations. Since EPSDT is expected to deal with 600,000, or 9 percent, of all those believed to have some medical condition in fiscal year 1976, this proportion was applied to numbers with specific problems. Thus the program might reach and treat 150,000 with respiratory conditions, 150,000 with vision problems, 50,000 with hearing problems, and 200,000 with genito-urinary conditions; 300,000 might receive needed immunizations. Children outside the EPSDT system are believed far less likely to have their problems uncovered and dealt with.

IV. OPTIONS FOR MEETING HEALTH NEEDS OF CHILDREN ELIGIBLE FOR MEDICAID

Five options are suggested here for dealing with the health care needs of children eligible for medicaid. Two would involve no major changes in the design of the EPSDT program: Accepting the current strategy for modest improvement, or pushing hard for full implementation. Their costs are itemized in tables 3A and 3B. A third, still within the general structure of EPSDT, would scale down the objectives considerably, concentrating on age groups and conditions where such a program can be most effective. A fourth would involve possible changes in resource controls, financial incentives and EPSDT's operational procedures so that the program could meet its objectives more effectively and efficiently. A fifth would be the provision of continuous health care to all medicaid eligible children through mechanisms that exert direct control over the organization of service delivery.

TABLE 2.—ESTIMATED TREATMENT NEEDS OF MEDICAID ELIGIBLE CHILDREN FOR SPECIFIC CONDITIONS AND NUMBERS REACHED AND TREATED BY EPSDT FOR 3 LEVELS OF PROGRAM IMPLEMENTATION

Percent needing referral	Estimated treatment needs in target population of 13,000,000	Number treated at current EPSDT levels, fiscal year 1976	Number treated as anticipated with new penalty regulations, fiscal year 1977	Number treated with optimal program, fiscal year 1977	Number treated with optimal program, fiscal year 1978	Estimated treatment needs in target population of 10,000,000 [1]	Number treated with optimal program, fiscal year 1979
A. Dental, 90 percent	11,700,000	300,000	800,000	6,300,000	7,400,000	----------	8,400,000
B. Medical, 50 percent	6,500,000	600,000	1,050,000	3,500,000	4,100,000	5,000,000	3,600,000
1. Immunization, 25 percent	3,250,000	300,000	500,000	1,750,000	2,050,000	2,500,000	1,800,000
(a) Diphtheria, 18 percent	2,340,000	200,000	350,000	1,250,000	1,450,000	1,800,000	1,300,000
(b) Tetanus, 18 percent	2,340,000	200,000	350,000	1,250,000	1,450,000	1,800,000	1,300,000
(c) Polio, 19 percent	2,470,000	200,000	400,000	1,350,000	1,550,000	1,900,000	1,350,000
2. Other conditions:							
(a) Anemia, 16.8 percent	2,184,000	200,000	350,000	1,200,000	1,400,000	1,700,000	1,200,000
(b) Heart and circulatory, 3.5 percent	455,000	50,000	50,000	250,000	300,000	400,000	300,000
(c) Respiratory, 12.2 percent	1,586,000	150,000	250,000	850,000	1,000,000	1,200,000	850,000
(d) Genito-urinary, 15 percent	1,950,000	200,000	300,000	1,050,000	1,250,000	1,500,000	1,100,000
(e) Hearing, 4 percent	520,000	50,000	100,000	300,000	350,000	400,000	300,000
(f) Vision, 13 percent	1,690,000	150,000	250,000	900,000	1,050,000	1,300,000	950,000
(g) Sickle cell, 6 percent	780,000	100,000	100,000	400,000	500,000	600,000	450,000

[1] By fiscal year 1979 the numbers due for medical screening should fall to 10,000,000 eligibles: 4,000,000 repeats according to age-adjusted periodicity schedule, 2,000,000 not previously reached and 4,000,000 new eligibles.

Source: Projected from prevalence of conditions found in EPSDT demonstration projects.

TABLE 3A.—ESTIMATED PROGRAM COSTS, CASELOADS AND NUMBERS NOT SERVED UNDER CURRENT EPSDT POLICY

	Current level, fiscal year 1976 [1]				Projected impact of minimal improvements, fiscal year 1977 [2]				
		Caseloads		At risk and not served by EPSDT of 13,000,000			Caseloads		At risk and not served by EPSDT of 13,000,000
	Program cost	Percent	Number		Cost at—	Program cost	Percent	Number	
Outreach at $1 per eligible child	$13,000,000				$1.50	$19,500,000			
In EPSDT system		15	2,000,000	11,000,000			23	3,000,000	10,000,000
Screening at $21	42,000,000		2,000,000		21.00	63,000,000		3,000,000	
Medical referrals		50	1,000,000				50	1,500,000	
Dental referrals		25	500,000				40	1,200,000	
Followup at $10.40 per child with referral	13,000,000		1,250,000		11.40	23,900,000		2,100,000	
Administration at $10 per child in EPSDT system	20,000,000				11.30	33,900,000			
Treatment (includes referral for diagnosis and immunizations):									
Medical at $35	21,000,000	60	600,000	5,900,000	35.00	36,800,000	70	1,050,000	5,450,000
Dental at $90	27,000,000	60	300,000	11,400,000	90.00	75,600,000	70	800,000	10,900,000
Total	136,000,000					252,700,000			
Cost per child in ESPDT system	68					84			
Estimated Federal share (at 55 percent)	74,800,000					139,000,000			

[1] Derivation of costs as estimated by EPSDT:
Outreach: Current estimate of $1 per eligible child.
Screening: Averaged from 1975 estimates reported to EPSDT.
Followup: Current estimate of $10.40 per child with referral.
Administration: Current estimate of $10 per child in EPSDT.
Medical treatment: Current estimate of $35 per child treated.
Dental treatment: Current estimate of $90 per child treated (most children require full workup).

[2] Derivation of costs as estimated by EPSDT:
Outreach: Current estimate of $1 per eligible child plus 50 cents per child added to reflect impact of new penalty regulations and intensive methods in some States.
Screening: Averaged from 1975 estimates reported to EPSDT.
Followup: Current estimate of $10.40 per child with referral plus $1 added to reflect impact of new penalty regulations.
Administration: Current estimate of $10 per child in EPSDT plus $1.30 per child added to reflect impact of new penalty regulations.
Medical treatment: Current estimate of $35 per child treated.
Dental treatment: Current estimate of $90 per child treated.

TABLE 3B.—ESTIMATED COSTS, CASELOADS AND NUMBERS NOT SERVED WITH A FULLY IMPLEMENTED EPSDT PROGRAM

	Projected impact of optimal program, fiscal year 1977[1]				Projected impact of optimal program, fiscal year 1978[1]				Projected impact of optimal program, fiscal year 1979[1]			
		Caseloads		At risk and not served by EPSDT of 13,000,000		Caseloads		At risk and not served by EPSDT of 13,000,000		Caseloads		At risk and not served by EPSDT
	Program cost	Percent	Number		Program cost	Percent	Number		Program cost	Percent	Number[2]	
Outreach at $5.75 per eligible child	$74,800,000				$74,800,000				$74,800,000			
In EPSDT system		60	7,800,000	5,200,000		70	9,100,000	3,900,000		80	10,400,000	2,600,000
Screening at $21	163,800,000		7,800,000		191,100,000		9,100,000		168,000,000		8,000,000	
Medical referrals		50	3,900,000			50	4,600,000			50	4,000,000	
Dental referrals		90	7,000,000			90	8,200,000			90	9,360,000	
Followup at $13.20 per child with referral	92,400,000		7,000,000		108,200,000		8,200,000		123,600,000		9,360,000	
Administration at $11.30 per child in EPSDT system	88,100,000				102,800,000				117,500,000			
Treatment (includes referral for diagnosis and immunization):												
Medical at $35	122,900,000	90	3,500,000	3,000,000	144,900,000	90	4,100,000	2,400,000	126,000,000	90	3,600,000	1,400,000
Dental at $90	567,000,000	90	6,300,000	5,400,000	664,200,000	90	7,400,000	4,300,000	757,800,000	90	8,400,000	3,300,000
Total	1,109,000,000				1,286,000,000				1,367,700,000			
Cost per child in EPSDT system	142				141				132			
Estimated Federal share (dental at 90 percent; all other at 55 percent)	809,400,000				939,800,000				1,017,400,000			

[1] Derivation of costs: Outreach: Current estimate of $1 per child for all eligible children plus additional personal contact cost of $5.60 per child for 85 percent of eligible children not responsive to basic methods (2.5 children per family; 2 caseworker hours at $7 per hour for each family).

Screening: Averaged from 1975 State estimates reported to EPSDT.

Followup: Current estimate of $10.40 per child with referral plus $2.80 additional personal contact and referral cost (2.5 children per family; 1 caseworker hour at $7 per family).

Administration: Current estimate of $10 per child in EPSDT plus $1.30 per child added to reflect new penalty regulations.

Medical treatment: Current estimate of $35 per child receiving treatment.

Dental treatment: Current estimate of $90 per child receiving treatment.

[2] Outreach, case management, automatic dental referral for those who have not seen a dentist in last year and dental treatment calculated for all 13,000,000 eligibles. (If 80 percent or 10,400,000 respond to outreach then 90 percent of those, or 9,360,000 would be referred for dental treatment.) Medical screening and treatment calculated for 10,000,000 eligibles (by fiscal year 1979 the numbers due for medical screening should fall to 4,000,000 repeats according to periodicity schedule, 2,000,000 not previously reached and 4,000,000 new eligibles).

Because the last three options depart from the existing EPSDT program, it is not within the scope of this report to develop them fully. Much additional research and analysis is needed. However, some of the questions that should be considered in formulating a health care policy for medicaid eligible children are raised here. Some of these questions are also relevant to the handling of children's health problems under national health insurance.

Current EPSDT strategy

EPSDT's current strategy might be expected to produce modest improvements over fiscal year 1976 levels by means of new penalty regulations specifying more vigorous outreach, followup, and recordkeeping activities and by persuading States to increase their own staff investment even further in return for a 75-percent Federal match for these activities.

An increase from $1 to $1.50 per eligible child in outreach expenditures, reflecting some personal contact, might raise the number screened during fiscal year 1977 from 2 to 3 million. If dental screening is partly amenable to enforcement efforts, 40 percent rather than the current 25 percent of those screened might be found to have conditions requiring treatment. The $21 unit price of screening would remain unchanged, as would treatment costs incremental to non-EPSDT medicaid expenditures ($35 per child for medical and $90 per child for dental treatment). Roughly $1 would be added to the current followup unit price of $10.40 per child with referral, and $1.30 to the administrative unit price of $10 per child in the EPSDT system, reflecting initiation of a data system. Optimistically, the percentage of those needing treatment and getting it might rise to 70.

Annual program costs for fiscal year 1977 would then be estimated at $250 million—$84 per child in the EPSDT system. The Federal share of program costs would be estimated at $140 million. Again, these costs could vary tremendously and are only meant as a guide to the magnitude of increases if the program is implemented more fully.[9]

With this strategy, in fiscal year 1977 the number of eligible children with dental problems treated by EPSDT might be 800,000. The number with medical problems treated by EPSDT might be 1.1 million. Assuming no additional investment in outreach or followup, numbers screened and treated might increase somewhat due to word of mouth in subsequent years, but it would be quite some time before an appreciable dent is made in unmet needs.

Full implementation

Full implementation of EPSDT—defined as providing all services now legally required to the maximum possible number of eligible children—involves three steps, at a minimum. First, ensuring that most low-income children are screened requires a much greater invest-

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[9] It should be noted that only two major variables are reflected in these and subsequent projections—investment in outreach, which should yield higher initial response rates, and investment in followup, which should result in a higher proportion of those needing treatment who get it. Increased administrative investment, particularly in recordkeeping, should facilitate both. Numbers of eligible children and medical and dental care unit prices are assumed constant over time. The numbers do not reflect variations in kind and quality of screening, since EPSDT is accepting the packages States say they provide, and they do not reflect problems of inadequate resources except to assume that with more followup, treatment providers will be found. Such variations may be revealed when a data system reports actual tests administered to individuals and the proportion of test results confirmed at diagnosis, as well as tracking individuals to treatment.

ment in outreach. Based on experimental reports, an 80-percent response rate may be possible with some kind of personal contact with families not now responding, probably over a period of 2 to 3 years. (Increased outreach can—and does now, on a limited basis—take other forms, such as mobile screening centers, and supplying transportation for patients as a program initiative rather than on request.) Second, raising the proportion of referrals actually treated to an acceptable level (for example, 90 percent) requires an increase in followup activities. These increases could be pursued administratively or through congressional action that would further specify outreach and followup requirements and perhaps mandate certain levels of State investment. Third, ensuring that States refer all children needing dental treatment—closer to 90 percent than the 25 percent referred—might be possible by increasing the Federal match for dental treatment to 90 percent, at least for several years.

With the aid of EPSDT staff, CBO has estimated the costs of a full implementation strategy. Such a strategy would provide, in addition to present services, personal contact with the family of every child unresponsive to current efforts—bringing the outreach unit cost to $5.75—and for every child with referral—bringing the followup unit cost to $13.20. Very roughly, such a program might cost $1.1 billion in fiscal year 1977, $1.3 billion in fiscal year 1978, and $1.4 billion in fiscal year 1979, with a Federal share of $1 billion by the third year because of the 90-percent dental treatment match. Cost per child in the EPSDT system would be $142 in fiscal year 1977 but would fall to $132 by fiscal year 1979 because outreach costs would remain constant as the response increased and less medical screening and treatment would be required.

After fiscal year 1978, 80 percent of prior eligibles are assumed to have been screened once and the annual target population for medical screening would fall to 10 million—a maximum of 4 million new eligibles, 2 million previously unreached, and 4 million to be rescreened according to the schedule recommended by the American Academy of Pediatrics.[10]

The target population for dental treatment, however, would continue yearly to be the entire 13 million eligibles. With this full implementation strategy, numbers of eligible children who may have dental problems treated by EPSDT might be increased to 8.4 million by fiscal year 1979. Those who may have medical problems treated by EPSDT might be increased to 3.6 million.

However, there are a number of serious questions that can be raised with regard to a full implementation strategy. First, it may be extremely difficult to enforce, despite the steps described, because of States' reluctance to make further investments. More important, even if States accept the required level of investment, or if full implementation is forced through federalization of medicaid, those constraints on program effectiveness related to the nature of a financing scheme would remain.

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[10] The eligible population would still be 13 million, but 3 million of the children over-5 would not be scheduled for screening in any given year because they will have been screened once and rescreening is recommended on an average of once in 3 years.

Reasons for considering other options

Before taking steps that may lead to major increases in medicaid expenditures, it may be useful to step back and examine federally aided health care for low-income children in general.

Costs of a fully implemented EPSDT program were estimated as increments to the $2.6 billion medicaid might be expected to spend on those under 21 in fiscal year 1976 and to the rough estimate of $500 million in additional public funds for low-income children in Federal categorical health service programs.[11] Thus, without allowing for inflation, the total annual expenditure could be approximately $4.5 billion—over $340 per eligible child, or $275 without dental care—a sum that compares with the most expensive continuous care programs in the Nation. Yet, for the majority of eligible children, care would not be continuous and probably not comprehensive, since followup would be likely only to insure that particular conditions are treated. Resources might still be inadequate. The EPSDT component would be expensive and possibly inefficient because of some unavoidable duplication and the continued need for administrative and case management expenditures of at least 25 percent. Finally, EPSDT has not been tested in order to demonstrate its benefits compared with those of other options.

With certain changes, EPSDT might be a potential lever for spending much of the $4.5 billion more efficiently and effectively. This might be accomplished by limiting objectives and concentrating resources, or by reforms in various Federal programs aimed at enabling EPSDT to reach its broader goals. If it is not possible to achieve efficiency and effectiveness using EPSDT as a lever, then a national system of continuous comprehensive health care for eligible children may be an option.

A less ambitious program

There are some who believe that EPSDT's mission of comprehensive care for all eligible children is far too ambitious, given the constraints of medicaid and the organization of health services in the private sector, as well as sparse knowledge of what works. They suggest concentrating the program's resources and available providers on conditions and age groups where preventive care can be most effective—in some ways returning to the program envisioned by the original HEW analysis but with much more careful planning and a sense of how limited the benefits might be. This might keep the required investment low, but still achieve the desired response rate and raise the proportion treated for the conditions selected. However, such an alternative would not resolve the basic problem of fragmented care and it would be open to criticism as a retrenchment from broader objectives, however difficult to achieve.

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[11] In fiscal year 1973, before widespread implementation of EPSDT, 17.5 percent of total medicaid expenditures were attributable to those under 21. Applying this percentage to the $14.9 billion in total medicaid expenditures for fiscal year 1976 results in the figure of $2.6 billion for those under 21. EPSDT costs for outreach, screening, followup and administration would be incremental to existing medicaid expenditures. Costs for medical treatment attributable to EPSDT were estimated on an incremental basis from reports of eight States on total medicaid cost per child before and after the program was implemented. Costs for dental treatment are believed largely incremental because little was provided in fiscal year 1974. (Again, the accuracy of these treatment estimates must be questionable until EPSDT and other medicaid costs can be separated.)

Answers to the following questions are needed for purposes of setting priorities whatever EPSDT policy is adopted, but they are particularly important if one must choose some objectives and discard others:

—For which age group has preventive care been shown most effective?

—For which conditions is screening effective? The condition should be of sufficient prevalence and potential severity to make mass screening of consequence, yet not so prevalent that screening is an unneeded step (for example, if dental treatment is known to be needed by 90 percent of poor children, the program could routinely refer all eligibles directly to a dentist). There should be simple screening tests available with a high degree of validity, and the conditions should be amenable to early treatment.

—To what degree would beneficiary services already instituted or in the process of being instituted as a result of EPSDT be cut back if objectives are limited?

Reforms in resource control, financial incentives and EPSDT's operations

This option would accept the ambitious objective of comprehensive care for all eligible children and identify changes in EPSDT itself and various other Federal programs that might deal with remaining problems.

A problem that relates both to provider shortages and discontinuity of care is the lack of involvement of existing organized health service delivery programs in implementing EPSDT. Some States will not reimburse Federal programs such as maternal and child health projects and community health centers, or other clinics, with medicaid funds. In other States, school health programs are not fully utilized. The Federal Government might require States to reimburse for clinic services, including those offered by Federal programs, and establish more stringent guidelines for utilizing existing facilities.

The shortage of treatment providers in a particular area might be ameliorated through the National Health Service Corps, other resource development grants, or through reimbursement incentives. If there are sufficient providers in an area but they reject medicaid patients, it may be because medicaid reimbursement for primary care is often not competitive with rates charged private patients. (If national health insurance provided less attractive reimbursement plans for poor patients than for others, the problem of rejection would be likely to continue.) Finally, if medicaid children are seen as undesirable patients, particularly on an ongoing basis, the Federal Government might consider methods of assuring provider participation.

To increase efficiency and effectiveness, the Federal Government could require, rather than urge, the elimination of duplicative steps and further integration of services in a number of ways, through State jurisdictions or, if necessary, a combined Federal-State programmatic base. (Federalizing medicaid would make implementation of these steps easier but would not obviate the need for a programmatic base.) For the bulk of medical care, which may require a sequence of screening, diagnosis, and treatment steps, the model of EPSDT as a clearinghouse already in use in a few localities could be implemented on a

more widespread basis. The program would coordinate treatment resources, assigning each child to a single source of screening and treatment and following his status. If the assigned provider were reimbursed by EPSDT on a capitation basis, the program would come very close to funding continuous care.

A less preferable alternative in terms of comprehensiveness, but one that might be easier to implement, would be to mandate a better division of tasks between screening and treatment providers. Simple services, such as immunization, could be routinely provided at screening. Those services where need is obvious from patient histories, such as dentistry, screening could be bypassed.

More programmatic control might also maximize the use of less expensive personnel and delivery methods. For example, one EPSDT demonstration project found that 54 percent of the medical conditions for which children were referred could be treated by school nurses. (In some States laws restricting activities of less expensive personnel would have to be repealed.)

Questions that should be answered to formulate this option are particularly relevant to low-income children's needs under national health insurance, since most insurance proposals are simply financing schemes that, like EPSDT, would depend on the existing system of care. They include:

—What is the extent of the shortage of treatment resources and how can it be dealt with? A great deal more data are needed to specify the nature and distribution of resources available to EPSDT. This is especially true for dentists, since a fully implemented EPSDT program would stimulate a large increase in demand for dental care and there are already shortages of dental manpower in some areas.

—To what extent does fragmentation of care hamper EPSDT's efficiency and effectiveness and how can this be remedied? Again, information is needed on numbers getting needed care, short-term cost savings and, ultimately, improvement in some health status indicators in EPSDT programs. It is significant that the benefits that have been demonstrated have been in continuous comprehensive care programs that involve a very different organizational mechanism.

—To what extent can and does EPSDT maximize use of less expensive health care delivery methods?

Continuous comprehensive care for all eligible children

Continuous care in HMO's that enroll medicaid children, or categorically funded programs like maternal and child health or community health centers, or with closely monitored private providers on a capitation basis, provides a standard against which other, more fragmented alternatives must be evaluated. For example, in a 1976 report on child health care, the Children's Defense Fund pointed out that while medicaid costs have risen steeply, the costs of programs providing services in comprehensive, organized settings have gone down for children. Costs per child in such programs, including hospitalization, range from $122 in the Portsmouth, Va., health department program that showed a 20-percent decrease in total medicaid costs, to $263 for AFDC children in Kaiser HMO's.

If the comparatively costly EPSDT-medicaid combination, at a cost of $275 per child without dental care, shows significantly lower efficiency and effectiveness despite all the tinkering with the existing system, one way of increasing the cost benefit ratio may be to move toward categorically funded and continuous comprehensive care for all eligible children. This final alternative would have major implications for the current system of health care, representing as it does a fundamental shift from reliance on the private fee-for-service sector rather than the limited Federal involvement in actual delivery of care that now exists. It would also take a great deal of time and effort to implement. There would be problems in arranging prepaid continuous care for a group with a 25- to 30-percent turnover in eligibility annually.

In addition to extensive comparative evaluations, the following questions would be relevant in formulating a continuous care option:

—Given fairly complete programmatic authority, what are the most efficient and effective ways of organizing care? The benefits of small programs may not be achievable through a massive Federal effort. On a continuum between contracting for services through States and direct Federal provision, what are the tradeoffs between sufficient control, on one hand, and bureaucratic inflexibility, on the other?

—What would be the loss in benefits if care for parents and children were provided separately?

—What would be the impact on the private sector, and how could private providers best be integrated into a comprehensive system?

—Are there regional differences that would indicate the adoption of a continuous care strategy in some States but not in others?

CONCLUSION

EPSDT is an ambitious effort to provide comprehensive preventive health care for all children eligible for medicaid that is seriously constrained by its dependence on the existing Federal-State medicaid program. A small proportion of eligible children are currently being reached and an even smaller proportion treated. If intensive efforts were made to implement the program fully, it might be possible to reach and treat many more children, but costs would be high and major problems of fragmented care and lack of resources might remain. Before taking steps that will lead to additional expenditures, Congress may wish to examine EPSDT in tandem with other programs and consider how all publicly financed health care for low-income children might be organized more efficiently and effectively. Extensive evaluation is needed, including controlled comparisons between the existing medicaid system alone, with a limited screening program, with EPSDT as currently conceived, and continuous comprehensive care programs. The alternatives only briefly mentioned here indicate some areas for future exploration.

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