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STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
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MEMORANDUM

TO: Joint Fiscal Committee members

FROM: Virginia Catone V. Catone

DATE: July 19, 2004

SUBJECT: **September Joint Fiscal Committee meeting and special meeting**

As agreed at the end of last week's meeting, the JFC will meet next on Wednesday, September 15, for lack of a mutually acceptable alternative. Please plan on a full day, starting in Room 11 at 9:30 a.m. and probably lasting until late afternoon.

The morning will be devoted to regular Joint Fiscal Committee business, while the afternoon schedule starting at 1:30 p.m. will consist of a special meeting on the sustainable health care study authorized in Sec. 290 of Act 122 of 2004. For your easy reference, a copy of that provision is attached. The other parties whose participation is required are being notified via copy of this memorandum.

As usual, about a week before the meeting we will send you agenda materials. If any material relating to the special meeting is available at that time, we will send it to everyone involved.

Please let the JFO know as soon as possible if you cannot attend the meeting.

cc: Rep. Koch, Chair, HAOC
Sen. White, V. Chair, HAOC
AHS Secretary Smith
Administration Secretary Smith
BISHCA Commissioner Crowley

Act 122 (FY 2005 Big Bill)

Sec. 290. SUSTAINABLE HEALTH CARE STUDY

(a) The general assembly recognizes that state supported health care programs face major financial issues in the coming years. These financial issues will require changes in financing and program design. In that state sponsored programs are an integral part of the state's health care system, the financial solutions need to take into account system-wide impacts.

(b) It is imperative that the administration and the general assembly work together to develop strategies to address these financial issues. The administration and the joint fiscal office shall work collaboratively in developing analyses and policy alternatives.

(c) In coordination with the joint fiscal committee meetings in September and November of 2004, there shall be special committee meetings which shall include the joint fiscal committee, the chair and vice chair of the health access oversight committee, the secretaries of the agency of human services and agency of administration, and the commissioner of the department of banking, insurance, securities, and health care administration.

(d) At these special meetings, the legislative fiscal office, legislative council, and the administration staff shall present analysis and findings including information on the following:

(1) Specific alternatives to address the health access trust fund shortfall in fiscal year 2006 and in subsequent years;

(2) A review of activities of other states, health care literature and other public policy information on sustainable financing and content of state health care programs. For the purposes of this section, health care programs include tax credits and other financing incentives. The review shall include strategies for health care financing alternatives and allocation of health care resources, universal coverage options, and issues of program operational efficiency; and

(3) The impacts various approaches will have on costs, quality, and access to health care in the public and private health care markets and the fiscal impact on other state funds and programs.

FINAL AGENDA
Joint Fiscal Committee
Meeting of September 15, 2004
10:00 a.m.
Room 11, State House

10:00 a.m. 1. Call to order

2. Approval of minutes of July 15, 2004

10:05 3. Administration items
   a. Fiscal Year 2005 – revenue update and spending pressures *[Rob Hofmann, Commissioner of Finance and Management]*
   b. Fiscal Year 2006 budget instructions *[Comm. Hofmann]*
   c. VEDA write-off *agreement [Comm. Hoffman and Jeb Spaulding, State Treasurer]*
   d. Human Services caseload reserve *update [James Reardon, Deputy Commissioner of Finance and Management]*

10:40 4. Vermont State Hospital update [requested at July 15 meeting]
[Susan Wehry, Deputy Commissioner of Health, Mental Health Division]

11:00 5. Medical transportation issues
Becky Walsh, representing FAHC *[by phone: 802/847-0467]*
Camille George, representing Agency of Human Services
Chris Cole, General Manager, Chittenden County Transportation Authority
Patricia McDonald, Secretary of the Transportation Agency

11:20 6. Agency of Transportation inflation index report
[Patricia McDonald, Secretary of the Transportation Agency]

11:35 7. Update: Vermont Hydroelectric Power Authority
[John Sayles, Deputy Commissioner, Public Service Department]

11:50 8. Joint Fiscal Office report
[Stephen Klein, Chief Fiscal Officer]

11:55 9. November meeting date [proposed: Wednesday, November 17]

10. Item(s) for information (no action required)
   a. Secretary of State update on funding for HAVA

Recess for lunch; reconvene in special meeting* at 1:00 p.m.

***See separate agenda for afternoon special committee meeting on health care financial issues**

FINAL AGENDA

Special Committee of Joint Fiscal Committee and Others
On Health Care Program Financial Issues

Wednesday, September 15, 2004
1:00 p.m.
Room 11, State House

1:00 p.m.	Overview of cost containment methodologies Steve Kappel, Joint Fiscal Office
1:30	Medicaid cost containment: how are other states doing? Vernon Smith, Health Management Associates
2:15	Vermont Medicaid perspective Joshua Slen, Director, Office of Vermont Health Access [OVHA]
2:30	BISHCA perspective Herb Olson, General Counsel
2:50	Medicare legislation impacts (prescription drug coverage) Vernon Smith
3:30	Preliminary effects of legislation on Vermont Joshua Slen, OVHA Steve Kappel
4:00	Discussion and follow-up
4:30	Adjournment

JFC 9/15/04

Prelim. agenda mailing 9/07

07/08/04

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MP, NS, ST			
Other legislative:			
Speaker Freed	1		
Bill Russell	1		1
Rachel Levin	1		1
		1	
Administration:			
Secretary of Administration	2		
F&M Commissioner	1		1
Otto Trautz	1		1
Brad Ferland			1
Human Resources Commissioner		1	
Rossi Conklin (@ 110 State Street)			1
Molly Ordway (@ 144 State Street)			1
Raylene Jacobs, VTrans		1	
State Auditor	1		
State Treasurer	1		
Agencies/department(s)		1	On request
VTrans (agenda)		1	
AHS - full pm packet + a.m. agenda			
S. Weary, Mental Health Waterbury (agenda)			
D. Markowitz Sec of State		1	
C. Cole CCTA (agenda) - via Email			
Josh Sleeper		1	
Commission on Women		1	
VSEA		1	
Extras (press & meeting)	8		
TOTAL	36	Extra agendas	37

PRELIMINARY AGENDA

Joint Fiscal Committee
Meeting of September 15, 2004
10:00 a.m.
Room 11, State House

10:00 a.m. 1. Call to order

2. Approval of minutes of July 15, 2004 *[enclosure]*

10:05 3. Administration items [Rob Hofmann, Commissioner of Finance and Management
   a. Fiscal Year 2005 – revenue update and spending pressures
   b. Fiscal Year 2006 budget instructions
   c. VEDA write-off agreement *[written information may be mailed separately closer to meeting date]*
   d. Human Services caseload reserve update *[enclosure]*

10:40 4. Vermont State Hospital update [requested at July 15 meeting]
   [Susan Wehry, Deputy Commissioner of Health, Mental Health Division]

11:00 5. Medical transportation issues
   Fletcher Allen Health Care representative [by phone]
   Camille George, representing Agency of Human Services
   Chris Cole, General Manager, Chittenden County Transportation Authority

11:20 6. Agency of Transportation inflation index report *[written report may be mailed separately closer to meeting date]*
   [Patricia McDonald, Secretary of the Transportation Agency]

11:40 7. Joint Fiscal Office report *[enclosure]*
   Stephen Klein, Chief Fiscal Officer

11:45 8. Item(s) for information (no action required)
   a. Secretary of State update on funding for HAVA *[enclosure]*

November meeting date [proposed: Wednesday, November 17]

Recess for lunch; reconvene in special meeting* at 1:00 p.m.

***See separate agenda for afternoon special committee meeting on health care financial issues**

MINUTES

Joint Fiscal Committee
Meeting of July 15, 2004

Representative Richard Westman, Vice Chair, called the meeting of the Joint Fiscal Committee to order at 10:30 a.m. in Room 10, State House.

Also present: Senators Bartlett, Bloomer, Cummings and Sears
Representatives Marron, O'Donnell, Rusten and Schiavone

Others attending the meeting included Legislative Fiscal Office and Legislative Council staff; Administration officials and staff; and representatives of various organizations.

APPROVAL OF MINUTES:

1. Representative Marron moved approval of the minutes of the November 6, 2003 and May 14, 2004 meetings, as submitted. Representative O'Donnell seconded the motion, which was adopted.

DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION (BISHCA) TRANSFERS:

2. Commissioner John Crowley presented estimated final figures for fiscal year 2004 receipts available for transfer to the General Funds from the Insurance, Captive Insurance and Securities Regulatory and Supervision Funds.

Firm final figures were unavailable at the time of the meeting; thus, the Committee's action allowed for the amounts to be adjusted after the meeting. *[Note: The final figures were in fact precisely the amounts estimated; the amounts below are in fact correct.]*

Fund name	Amount
Insurance Regulatory and Supervision Fund	$2,226,579.86
Captive Insurance Regulatory and Supervision Fund	577,960.29
Securities Regulation and Supervision Fund	1,924,037.86
Total	$4,728,577.59

As required by Section 71(a)(2) of Act 80 (fiscal year 2004 budget adjustments) of the 2004 legislative session, Commissioner Crowley certified that the transfer of the unencumbered balances in these funds would not impair BISHCA's ability "...in fiscal year 2005 to provide thorough, competent, fair, and

effective regulatory services, or maintain accreditation by the National Association of Insurance Commissioners...."

On a motion from Senator Bartlett, the Committee accepted the Commissioner's certification relating to the transfer of the balances, with the understanding that if the amounts presented at this meeting were to change slightly, the adjusted figures would be relayed to the Joint Fiscal Office after the meeting and reflected in the minutes. *[See note previous page.]*

SECTION 8 FEDERAL HOUSING CHOICE VOUCHER PROGRAM UPDATE:

3. At the request of Senator Welch, Committee Chair, the members heard from several individuals pertaining to the impact of recently announced reductions by the U. S. Department of Housing and Urban Development (HUD) in housing assistance payments for low-income households.

First, Joanne Troiano, Director of the Montpelier Housing Authority, described the extent of the problem facing Vermont. Of the nearly 6,100 households in the state, which received housing assistance under the Section 8 program, 63 percent are elderly or have a disability and 24 percent are working families, while 13 percent receive TANF (Temporary Aid to Needy Families) or other monthly benefits from the State. She described several aspects of the crisis facing the program, including whether the state's eleven housing authorities will be able to provide housing to the same number of households currently enrolled; if HUD's proposal for a flexible voucher program for FY 2005 will mean either that fewer households can be assisted or tenants' share of rent and utilities will increase; and that the lack of new incremental vouchers for two years and a dim prognosis for the future has resulted in several Vermont housing authorities' closing their waiting lists.

Ms. Troiano was followed by Vermont State Housing Authority's (VSHA) Director of Finance, Thomas Peterson, and Kathleen Berk, Director of Section 8 Programs for VSHA. Mr. Peterson elaborated on the housing organizations' perception of the crisis, pointing out that although HUD initially 3promised to fund the rental assistance program at its cost, the agency now advises that it will not provide assistance that reflects true inflationary housing costs. Unless HUD changes its current position, program reductions will ensue.

Ms. Berk described the clientele served by VSHA, the size of the clientele, the critical situation in Vermont in terms of high rents and the number of families on the waiting list who are in need of rental assistance. At present there are over 3,000 such families. Effective July 1 the State Authority has closed the waiting list for the first time in its history.

The presentations were followed by questions from the Committee members, many of them focused on the need to cap the waiting lists and prioritization within those lists.

Mr. Peterson and Ms. Berk promised to provide additional information asked for by the Committee. Those requests included but were not limited to a fact sheet recapping information presented, including the total dollars involved; categories of people on the priority list for assistance, by county; and projections for the next two years on outcomes reflecting possible Congressional action on the Section 8 program funding.

DEPARTMENT OF ENVIRONMENTAL CONSERVATION REQUEST TO EXPEND $300,000 FROM THE ENVIRONMENTAL CONTINGENCY FUND (ECF):

4. Jeffrey Wennberg, Commissioner of the Department of Environmental Conservation, requested Committee authorization for the expenditure of $300,000 from the Environmental Contingency Fund for the purpose of assisting with the emergency stabilization at the Elizabeth Mine in Strafford. Acidic drainage at the site, an abandoned copper mine, has caused serious environmental degradation of downstream waters for many years.

The members were informed that about a year and a half ago, federal Environmental Protection Agency (EPA) site investigations identified an immediate, serious problem of potential failure of a dam at the site. Estimated construction cost are now expected to increase construction costs by $600,000, one-half of which EPA has requested the State contribute because of limited federal funding.

Commissioner Wennberg described what is needed to remediate the site, which is on the federal Superfund National Priority List, as well as the cost factors.

After discussion, the Committee adopted a motion by Representative Marron, seconded by Representative O'Donnell, to authorize the $300,000 ECF expenditure for the purpose described.

STATE HOUSE SECURITY:

5. Sergeant at Arms Kermit Spaulding recapped a written report on security coverage in the State House for fiscal year 2005. The report, required by Sec. 53 of Act 122 (fiscal year 2005 appropriations) of 2004, was mailed to the members prior to the meeting and is on file in the Joint Fiscal Office.

As stipulated in the act, the report included the hours and number of persons to be on duty for the proposed hours of coverage, both during the

legislative session and the non-session months. Considerations for scheduling were also outlined. Mr. Spaulding told the Committee that three officers seem adequate to cover the State House 24 hours a day, 365 days a year, with some overlap and overtime. The schedule presented attempts to minimize overtime. The likelihood of one current officer being sent to Iraq, however, is high. The resulting coverage problems might be addressed through hiring certified officers on a part-time basis.

Senator Bartlett, referring to a conversation she had with a legislative staff member about concerns for individual safety in the State House, wondered about the possibility of installing a buzzer or similar system to help allay some of these concerns. Mr. Spaulding expressed willingness to work with Tom Torti, Commissioner of State Buildings and General Services, to make an emergency system available.

LEGISLATIVE FISCAL OFFICER'S REPORT:

6. Chief Legislative Fiscal Officer Stephen Klein addressed certain areas in his written report on Joint Fiscal Office activities mailed in advance of the meeting. He also distributed copies of an updated list of summer studies, reflecting legislative appointments.

SUSTAINABLE HEALTH CARE STUDY:

7. Steve Kappel, Joint Fiscal Office health care analyst, made an informational presentation on the sustainable health care study called for in Sec. 290 of Act 122.

Mr. Kappel distributed graphs and other data and written commentary to depict the magnitude of the major financial problems facing state supported health care programs in the coming years and factors contributing to the problem. His presentation consisted primarily of a review of the information contained in the written material, although he also gave some history of the Health Access Trust Fund. He also made some tentative observations to consider in beginning the process of finding solutions.

In considering the data on the very substantial shortfall projected in the Health Access Trust Fund beginning in fiscal year 2006, Mr. Kappel cautioned the members to be aware of several points. Among them were that even seemingly minor changes in assumptions have a huge impact on the bottom line estimates, and that the information presented makes no assumptions about the impact of reorganization of the Agency of Human Services.

Senator Sears asked that the Joint Fiscal Office to obtain and share with the Committee the impact of all federal budget reductions. Although Chief Fiscal Officer Stephen Klein pointed out that Congress has not yet acted on all, the

Senator nevertheless wanted as much of that information as possible. Mr. Klein promised to try to amass figures on at least the larger impacts of the potential reductions.

Senator Bloomer observed that in assessing federal cuts, new programs also must be taken into account. Also, later in the discussion he asked for information on total health care spending in the state, to show the amount of private health care spending separate from that encompassed in the Medicaid program.

As his presentation drew to a close, Mr. Kappel suggested that to start the discussion of solutions to the problem facing Medicaid programs, the Legislature and Administration will have to look at what is allowed by federal policy; e.g., there are mandatory populations and mandatory benefits; optional populations and optional benefits. The largest area of spending in Vermont is in optional services to mandatory populations.

ECONOMIC REVIEW AND REVENUE FORECAST UPDATE:

8. Tom Kavet, economic and revenue consultant to the Committee, presented revenue information, which he planned to present also to the Emergency Board later in the day. His presentation consisted of an oral summation of information contained in a written report distributed at the meeting, entitled "July 2004 Economic Review and Revenue Forecast Update."

Because the economy has performed well and at a considerably brisker pace than earlier expected, Mr. Kavet will recommend to the Emergency Board an upgraded revenue estimate for fiscal year 2005 by $27.4 million over the prior forecast. For the following fiscal year, when he predicted a possible slowing in economic growth and related tax revenues for reasons outlined in his written report, he proposed an upward revision of $19.4 million in the revenue projection.

Mr. Kavet's presentation was interspersed with and followed by brief questions and discussion.

FISCAL YEAR 2004 CLOSEOUT:

9. Rob Hofmann, Commissioner of the Department of Finance and Management, first commented briefly on the status of the fiscal year 2003 Comprehensive Annual Financial Report (CAFR). That delay was related to the much more severe delay in closeout of the State's financial books for fiscal year 2002.

The Commissioner also mentioned that to be in compliance with Governmental Accounting Board Standards, for the first time in the state's history fixed assets have to be addressed as part of year end closeout.

As for fiscal year 2004, the Commissioner mentioned that $27 million is the recently-announced General Fund revenue surplus figure, although final figures are not yet available. Direct applications of approximately $2 million higher than expected will be added to the $27 million figure.

Mr. Hofmann observed that the strong revenue results for 2004 mean available funding for a great many of the items included in the "waterfall" provision of the fiscal year 2005 appropriations bill (Sec. 288).

Much of the Commissioner's time before the Committee was devoted to a $2 million closeout issue that has surfaced pertaining to Vermont Economic Development Authority (VEDA) receivables. He explained that it has been brought to the Administration's attention that there is an asset on the State books relating to VEDA for a loan program dating back approximately 30 years. It is inaccurate, however, to reflect that amount as an asset on the balance sheet, and Mr. Hofmann said the Administration plans to collaborate with VEDA, the Joint Fiscal Office, and the State Treasurer to resolve this issue.

After discussion of the VEDA issue, Senator Bartlett moved that the Joint Fiscal Committee request that:

> (a) the Commissioner of Finance and Management to hold off making accounting adjustments for the Mortgage Insurance Program operating expense and the Financial Access Program operating expense pending resolution with the Commissioner, the State Treasurer, VEDA, and the Joint Fiscal Office to ensure a positive impact on the State's overall financial position and related State bond ratings; and
>
> (b) a report as to the recommended strategy and any adjustment to be made be presented at the September meeting of the Joint Fiscal Committee.

The motion was seconded by Representative Marron and adopted.

Responding to a request from Commissioner Hofmann, the Committee gave its tacit recognition that the $2 million is not a valid asset.

Finally, Mr. Hofmann mentioned two significant budget issues that will have to be addressed in the relatively near future. One is the mandatory upgrade of the VISION system, and the other relates to requirements of new GASB retirement plan accounting rules requiring carrying as a liability on State balance sheets the estimated future costs of retired employees' health care.

UPDATED FISCAL YEAR 2004 BALANCE SHEETS:

10. Legislative Fiscal Analyst Stephanie Barrett distributed and discussed updated balance sheets reflecting the revised revenue forecasts presented by Mr. Kavet.

SEPTEMBER MEETING:

11. Wednesday, September 15 was set as the date for the next meeting. The members agreed that at that time a November meeting date would be established.

Senator Bartlett expressed the hope that an in-depth discussion on health care, including future options, can take place in September. In the meantime, she suggested that Joint Fiscal Office staff meet with federal officials and members of Vermont's Congressional delegation on the subject. Mr. Klein reminded the Committee that Act 122 requires that in coordination with the Joint Fiscal Committee in September and November meetings, special committee meetings on health care program financial issues shall be held, to include the Secretaries of Administration and the Human Services Agency, the BISHCA Commissioner, and the Chair and Vice Chair of the Health Access Oversight Committee

Senator Bartlett also asked that the September agenda include a report on the status of recertification of the Vermont State Hospital.

Senator Sears brought up the matter of a directive in Sec. 243(a) of Act 122 of 2004 requiring the Secretary of Transportation to file with the Joint Fiscal Office prior to the July 2004 meeting a status report on discussions with Pownal Fire District #5 concerning allocation of costs and financial arrangements regarding movement of a water line. The Senator remarked that to date no Transportation Agency representatives have met with Pownal officials on this matter, and he asked that at the September meeting there be a report on progress in negotiations. The Vice Chair proposed that the update be provided in written form.

The meeting was adjourned at approximately 2:10 p.m.

Respectfully submitted:

Virginia F. Catone

Virginia F. Catone
Joint Fiscal Office

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MICHAEL K. SMITH, SECRETARY

STATE OF VERMONT

AGENCY OF ADMINISTRATION

To: Joint Fiscal Committee

From: Michael K. Smith, Secretary of Administration MKS

Date: August 30, 2004

Subject: Human Services Caseload Reserve

Pursuant to 32 V.S.A. Sec. 308b(b), I am reporting that there was no transfer of General Fund carry forward directly attributable to Temporary Assistance to Needy Families (TANF) caseload reductions. However, the amount of $3,000,000 was transferred to the Human Services Caseload Reserve as part of the State fiscal year 2004 closeout procedures. The balance of this reserve at June 30, 2004 is $18,543,422.

This amount was transferred in accordance with the fiscal year 2004 designated balance (Waterfall--Act 122 of 2004, Sec. 288(a)(6)).

The summary of changes in the reserve for State fiscal year 2004 is as follows:

Reserve balance at July 1, 2003	$17,243,422
Transfer from FY2004 surplus pursuant to Act 122 of 2004, Sec. 288(a)(6)	3,000,000
Appropriation from Reserve pursuant to Act 122 of 2004, Sec. 120a	(1,700,000)
Reserve balance at June 30, 2004	$18,543,422

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STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Senator Welch, Chair
Members of the Joint Fiscal Committee

From: Stephen A. Klein, Joint Fiscal Officer

Date: September 3, 2004

Subject: September Fiscal Officer's Report

1. Fiscal 2005 Revenue tracking:
Revenues continue to exceed forecasts. With two month of tracking the general fund is $9.3 million over targets and the transportation fund is $2.3 million over targets and the education fund is $2 million over targets. Revenue strength is across most categories indicating strength in the underlying economy. Again, it is too early in the fiscal year to identify any long term trends.

Tobacco settlement revenue projections have been adjusted downward for FY 2006. We are now expecting $19.7 million or $7 million less than FY 2005 spending. This will be a challenge in the FY 2006 budget.

2. Fiscal Year 2005 Budget Pressure update:
The State Hospital remains a potential FY 2005 budget pressure as federal support continues to be in jeopardy. Vermont faces two distinct issues. First, we are in the process of regaining certification for federal funds. That process should be completed this fall. The budget assumed October1 as a recertification date; the budget will require an estimated $330,000 per month beyond this date. Second, federal support for independent state mental hospitals may be diminishing due to a change in federal policy direction. This could reduce or eliminate state hospital federal funds in the long term.

Corrections caseload and the medical services contract are also items that are anticipated to require additional funding this year. Implementation costs of the changes in the corrections report could also be up for consideration. Childcare costs are again a potential budget hot spot as well, as they are running above estimates.

In the Agency of Natural Resources lagging receipts in the Forest and Parks and Fish Wildlife special funds combined with previous year deficits in these funds indicate potential budget needs for both programs up to $1.6 million.

3. Federal Funds:
The FY 2005 federal budget is not yet resolved, creating a lot of uncertainty in levels of federal funds. We have received word that Section 8 housing funds may be coming in at a higher level than expected in the current year, temporarily addressing the shortfall.. Another bright spot is federal elections funding. Vermont has received substantial federal Help Americans Vote Act (HAVA) funds. As of June 30, 2004 $16.6 million has been received. The money substantially exceeds Vermont's election funding needs and will provide a resource that can be used into the future. A memorandum on this funding from the Secretary of State Markowitz is in the package.

4. Transportation Infrastructure Funding:
Last session's transportation bill created the Vermont Transportation Infrastructure Funding Working Group, a joint legislative, executive and private sector committee to analyze the gap between the present and future costs of maintaining the state's transportation system and the projected level of available resources, and to assess alternative methods for funding the state transportation system, including the possible use of GARVEE bonds. The working group convened on August 27 to discuss the legislative charge. The agency of transportation presented background materials on the transportation budget and the condition of the transportation system infrastructure. The group agreed that more hard data was needed. A presentation on GARVEE bonds is also being planned as well as a meeting at which the public will be invited to participate.

The legislatively mandated transportation inflation rate is still being developed. The agency hopes to have a presentation for the September 15th meeting.

5. Sustainable Health Care:
In the afternoon, following the September meeting of the fiscal committee, we will be having the first sustainable health care special meeting. As the fiscal committee requested we will focus on cost containment efforts. Steve Kappel will be presenting an approach for developing a Vermont response to the costs. Vernon Smith, a national expert on State Medicaid programs and former director of Michigan's program, will be presenting other states' cost containment efforts and the impact of the Federal Medicare law on state pharmacy programs. Joshua Slen, Director of OVHA, will be commenting on Vernon Smith's presentation with a Vermont perspective. Herb Olson from BISCHA will also be making comments. There will be time for committee discussion. Based on Committee requests we expect a more detailed menu of options to be developed for the November meeting.

6. Legislative Information Systems:
We are close to completing the hiring process of information system personnel. About 120 applied and we interviewed 21. We have made two offers, to two outstanding candidates. One will replace the new position and one will replace Lisa Wilcox who left.

The two candidates chosen are Peter Keenan, the information systems director of the City of Watertown, New York, and Dawna Lee Attig of Barre who has been working with Fletcher Allen in information technology systems. Amy Storti of the Legislative Council will be working with the legislative technology staff in a help desk capacity.

7. Congressional Staff meeting:
As mentioned in the July meeting we had a very successful meeting between Joint Fiscal Office health staff and staff from the three members of our congressional delegation. Senator Leahy, Senator Jeffords and Representative Sanders each had two staff participate in a meeting concerning Medicaid funding and other state federal health concerns. Josh Slen, Director of OVHA (State Medicaid) and David Yacavone of AHS joined Steve Kappel, Sam Burr and I for the discussion which took place her in Montpelier in August. We agreed upon a number of specific follow up actions.

8. JFO Staff/Office Updates:
Legislative evaluation: We have received 59 office evaluation responses as compared to 24 in 2000 and 71 in 2002. We expect to receive a few more in the coming weeks. Those received display the highest overall evaluation for the office since we have been evaluated. On a scale of 4 the responses are averaging 3.7. Two years ago it was 3.55 and four years ago it was 3.47. 98% of respondents felt we were impartial in our service between chambers. 94% felt the service was equal between minority and majority parties, the respondents who had a concern in this area included one democrat and one republican and one unidentified member. A number of written respondents indicated that non-money committees would like more interaction with the office. As part of our response to the survey we are discussing the implementation of a committee liaison system. A joint fiscal staff person would be assigned to each non-money committee to check in on needs and answer questions as they arise. We hope this would provide for a greater information flow and improved interaction.

Internal staff evaluations are underway and the process should be completed this month.

Budget process review: Vermont is hosting the NCSL Legislative Information Systems staff section conference the week of September 6th. We have invited one of the attendees, Jonathan Ball, an information technology fiscal staff person from the Utah fiscal office to meet with us on the Monday following the conference to discuss technological improvements to the budget process. Utah has an integrated system which has allowed increased accuracy and faster turnaround of legislative fiscal documents.

JFO newsletter: We will be sending out the second newsletter "The Fiscal Focus" in September after the Joint Fiscal Meeting.

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State of Vermont
Office of the Secretary of State

Deborah L. Markowitz
Secretary of State

William A. Dalton
Deputy Secretary

Jessica G. Porter
Director, Professional Regulation

TO: Joint Fiscal Committee

FROM: Deb Markowitz, Secretary

RE: Update on Funding for HAVA (federal election reform)

DATE: August 23, 2004

The Help American Vote Act (HAVA 2002) enacted by Congress authorized 4 payments to each of the fifty states and territories to improve the administration of federal elections and to meet the requirements set out in Title III of the act. In order to receive any payment, each state was required to set up a special "Election Fund", certify that all payments will be deposited in the special fund, certify that all funds will be used only to improve the administration of federal elections, and certify that all interest earned on the fund will be deposited in the fund.

The first payment, termed "early out, no match, no year money" was received in the spring of 2003 and placed in the Vermont Election Fund. This $5 million payment can be used most broadly to "improve the administration of federal elections." The next three payments authorized by HAVA 2002, termed "requirements payments", were set up to be appropriations in federal FY 2003, FY 2004 and FY 2005 to be used to meet the requirements of Title III. The FY 2003 appropriation was delayed so that the FY 2004 payment of $7.46 million and the FY 2003 payment of $4.15 million were both deposited in the Vermont Election Fund in June 2004. The terms of these requirements payments include maintenance of effort for federal elections at the same level as in FY 2000(called "MOE"), 5% matching state appropriations for all federal requirements payments, compliance with all federal election laws, and using the payments to meet the requirements of Title III.

Although the Vermont State Plan, developed with an advisory committee and four working groups of local officials; provides an overview of how we anticipate needing to spend the Election Fund to meet the requirements of the federal law, we will also continue to provide a detailed spreadsheet of the budget proposal for each Vermont fiscal year to the General Assembly in order to have the funds appropriated from the Election Fund. We will also update the Vermont State Plan within in the next six to nine months so that the updates can be published in the federal register prior to the federal FY 2005 requirements payment.

As of June 30, 2004 (FY 2004) we have deposited $16.61 million in the Vermont Election Fund.

We have spent approximately $600,000 of these funds. The majority (just under $500,000) was used to purchase new optical scanning machines for some towns and to upgrade the existing optical scanning voting machines used by a total of 70 municipalities. (The purpose of this expenditure was to standardize and streamline the ballot creation and ballot counting process.) Approximately $50,000 has been used for voter education and approximately $50,000 has been used to purchase some of the hardware, software and IT training needed to develop the electronic statewide voter registration checklist that is required by HAVA to be in operation by January 1, 2006. We had initially requested larger budget amounts because we had anticipated that we would have had to purchase more equipment, training, and software sooner rather than later.

In December of 2003, we requested that the Office of the State Treasurer take action to maximize the interest earned on the funds in the Vermont Election Fund. The Treasurer's office has assured us that it will continue to do all it can to maximize the interest on this fund while investing in risk free products such as certificates of deposit. Federal law mandates that all interest on these funds be deposited in the fund so that the fund can grow and continue to pay for improvements to federal elections well into the future.

It is impossible to predict exactly what the federal FY 2005 appropriation will be for Vermont. We have heard that the President's budget included a very low number; but there are a number of U.S. senators that continue to want to fully fund election reform.

The Elections Division staff have worked with and will continue to work with local election officials to plan for the best uses of these funds to improve federal elections, meet the mandates of HAVA 2002, and minimize local government expenditures for our primary and general elections. We have used an open and inclusive process that has involved local officials serving on an advisory committee and four working groups to help us develop a plan for meeting the requirements of the federal law, improving federal elections, and assisting local election officials with education, training, and voting equipment. We will continue to work with local officials as we develop a budget request for each fiscal year. We will continue to bring our budget proposal to the General Assembly each year to receive authorization for expenditures from the Election Fund.

The purpose of the three requirements payments is to provide funds to allow states to meet the Title III requirements (some by January, 2004 and all by January, 2006) without serious financial impact on the state or municipalities that administer elections. Without detailing all of the requirements, the five areas where Vermont will need to spend the most to comply are:

- Computerized statewide checklist accessible to all town clerks in real time;
- One voting system (machine?) in each polling place (280) that is accessible to voters who are blind or visually impaired to cast his or her ballot privately and independently;
- Replacement of outdated voting machines in municipalities to bring all polling places using machines to a standard optic scanning machine that can reject a ballot that contains overvotes;
- Voter education;
- Election official training.

We anticipate requesting sufficient funding for FY 2005 and FY 2006 to be able to complete the statewide voter registration checklist and to place one voting system in each polling place that will allow voters who are blind or visually impaired to vote independently and privately. Unless there are some new developments in technology, we expect this to be the largest expense required to comply with HAVA. The statewide checklist project will have a total budget between $600,000 and $1 million.

A voting system for voters who are blind or visually impaired could cost $6000 to $10,000 (including programming and audio tapes) per unit, times 280 units for a total of between $1.6 and $3 million.

We are continuing to work with the Vermont Association for the Blind and Visually Impaired, the Center for Independent Living, Vermont Protection and Advocacy, Inc, venders, and other organizations to try to find or develop the best technology to meet this requirement at a more reasonable price. We are hoping that there will be better technology developed in the next two years. So we are postponing any purchase until the latest possible date (November or December 2005). Therefore we expect that the largest request for appropriation from the Fund for one year will be in FY 2006.

It is our overriding purpose and goal to request and expend the HAVA funds as sparingly as possible so that this resource will be available for continuing to improve the administration of elections in future years.

C: Robert Hofmann, Commissioner, FinMan
Steve Klein, Director, JFO
Beth Pearce, Deputy Treasurer

PRELIMINARY AGENDA

Special Committee of Joint Fiscal Committee and Others
On Health Care Program Financial Issues

Wednesday, September 15, 2004
1:00 p.m.
Room 11, State House

1:00 p.m.	Overview of cost containment methodologies Steve Kappel, Joint Fiscal Office
1:30	Medicaid cost containment: how are other states doing? Vernon Smith, Health Management Associates
2:15	Vermont Medicaid perspective Joshua Slen, Director, Office of Vermont Health Access [OVHA]
2:30	BISHCA perspective Herb Olson, General Counsel
2:50	Medicare legislation impacts (prescription drug coverage) Vernon Smith
3:30	Preliminary effects of legislation on Vermont Joshua Slen, OVHA Steve Kappel
4:00	Discussion and follow-up
4:30	Adjournment

Rising Health Care Costs: State Health Cost Containment Approaches

Ellen Jane Schneiter
Trish Riley
Jill Rosenthal

National Academy for State Health Policy
June 2002

ACKNOWLEDGEMENTS

The authors wish to thank Scott Leitz, director of the Health Economics Program within the Minnesota Department of Health, for reviewing this paper and for his extremely helpful insights and comments.

EXECUTIVE SUMMARY

The rapid growth of health care spending is once again of deep concern to payers, purchasers, providers, the public, and policymakers. Efforts to control previous increases in health care costs have focused on the supply of services (Certificate of Need programs), the pricing of services (hospital rate setting), and the demand for services (managed care). In addition, states have often employed strategies aimed at controlling the price and business of health insurance. This paper focuses on lessons learned from cost containment efforts.

Controlling supply: Certificate of Need (CON)
States use CON to promote cost containment by decreasing both service duplication and investment in excess capacity. Under CON, certain health care providers must obtain state approval for substantial changes in their scope of services or for capital investments.

CON was one of the earliest attempts at cost control and characterized an era when governmental intervention was viewed as a necessary element of any cost containment effort. While some states allowed their CON programs to lapse when the federal enabling legislation expired, many chose to continue the program as one device in a range of cost saving strategies. Today, 38 states administer CON programs. Among the paper's key findings:

- Little data exists to demonstrate that CON helps curb overall health care costs. While it does have a demonstrated impact on the number of patient beds, intensity of services appears to counteract any cost savings realized;
- There is a demonstrated correlation between CON and the availability of indigent care, redirecting funds from investments in capital to subsidization of care; and
- CON may be useful in promoting regionalization of services, with a concomitant improvement in patient outcomes for selected, high-risk services.

Controlling costs: hospital rate setting
Most hospital rate setting systems were implemented to control the rate of cost increases in hospital care. Research reflects broad-based agreement that while rate setting was able to exercise considerable control over the cost per admission and over per capita hospital costs, it has not constrained the rate of growth in health care costs per capita. At the same time, the degree to which substitution of unregulated outpatient services for regulated inpatient services has occurred as a direct market response to cost containment is debatable.

The success of rate setting systems is dependent on several factors:

- statutory flexibility appears vital to the long term viability of any regulatory system, which must be able to adapt to a rapidly changing environment;

- rate setting systems must have the authority to limit payer discounts in order to avoid an erosion of the system created by the lopsided negotiating power of a few influential payers;
- there must be solid political support for the system; and
- the inclusion of all payers – including Medicare – under the rate setting scheme provides great strength to the system by minimizing cost shifting and maximizing equity among payers.

Controlling demand: managed care

Evidence of managed care's ability to constrain health care costs is mixed; it is not clear whether today's rising health care costs reflect a failure of managed care or simply the correction of a competitive insurance market flooded by underbidding.

Among the lessons that may be gleaned from the managed care experience:

- Managed care plans tend to provide comprehensive benefit packages with less out of pocket cost to the consumer, at a more attractive price;
- Consumers are generally satisfied with the financial aspects of managed care plans, but are less satisfied with the administrative features of the plan designed to control access to services;
- Managed care plans do impact utilization of certain services, but it is not clear that these plans adversely impact the quality of care;
- Privately insured (nonelderly) HMO enrollees generally have lower incomes than non-HMO enrollees, increasing their price sensitivity.

Because managed care consumers are attracted to and satisfied with their plans' financial characteristics and relatively dissatisfied with the organizational aspects of those plans, increased enrollee cost sharing will likely fuel growing frustration with managed care.

Other levers: insurance regulation

Controlling the cost of insurance is, like other regulatory strategies, a lever policymakers may employ as part of a comprehensive cost containment program. While this approach may not exercise a direct impact on the cost of care, it carries with it the possibility of a substantial indirect effect on the cost and viability of the current system. It is also important to bear in mind the possibility that market reforms have prevented or slowed erosion of coverage. While not proven, the importance of this potential cannot be ignored.

Where to now?

Today's cost containment strategies (increased cost sharing and limited benefit defined contribution plans, for example) mirror those of the past in that they tend to address only price or supply or demand. The key lesson we can take from the past is that a haphazard approach to cost containment will not achieve or sustain its objectives. Policymakers need methods to integrate supply, price, and demand, building a comprehensive, tripartite strategy that is sensitive to the

complexities and idiosyncrasies of the health care marketplace. Such a comprehensive approach to health care cost containment may well require a re-thinking of the entire health care delivery system to assure that clear goals are set and that incentives are properly aligned to reach them.

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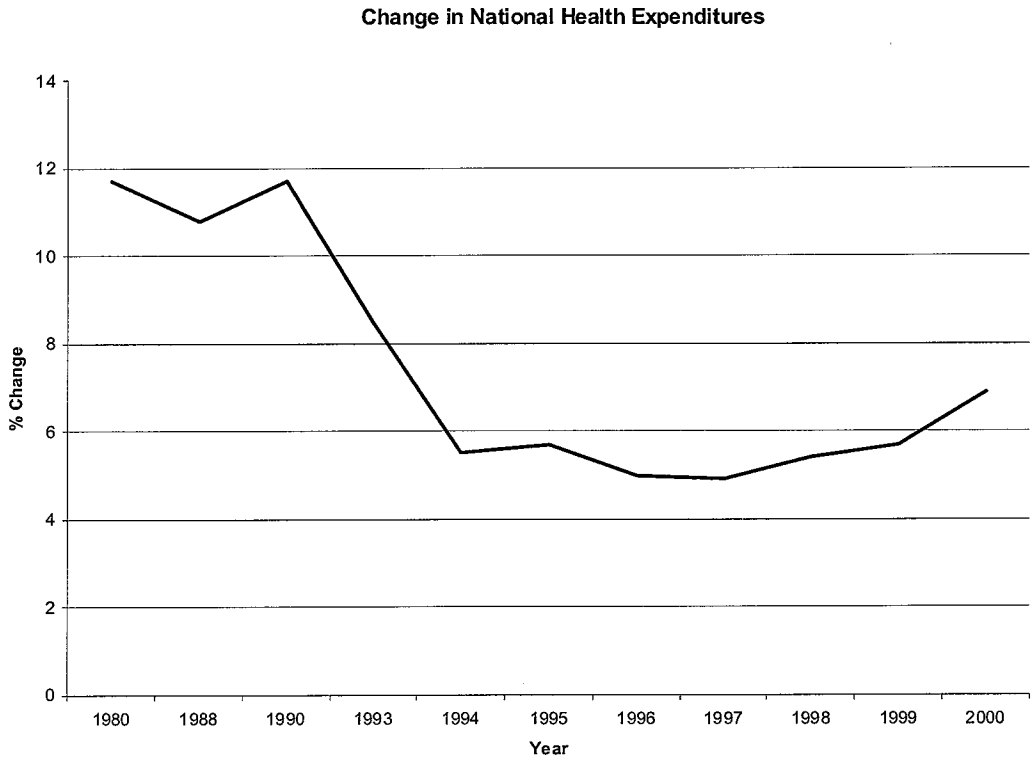
SETTING THE STAGE: THE CASE FOR COST CONTAINMENT

The growth in health care spending is a topic of growing concern for payers, purchasers, providers, the public, and policymakers. National health expenditures increased at a rate of almost 7% in 2000, as compared to 5.7% in 1999, edging out the growth in gross domestic product by a slim margin, a reversal of a nine-year trend.[1]



Data Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis

In total, health care spending in the US reached $1.3 trillion in 2000, with higher than expected growth in public spending and growth in private spending below what had been expected by the federal government.[2] The Centers for Medicare and Medicaid Services anticipate sharp growth in public sector spending for Medicare, Medicaid and public health, in the near term; this growth is attributed to changes in Medicare/Medicaid law, increased Medicaid enrollment due to a

[1] *Highlights - - National Health Care Expenditures, 2000.* HCFA website. http://www.hcfa.gov/stats/NHE-OAct/hilits.htm.
[2] Heffler S, Smith S, Won G, Clemens MK, Keehan S, Zezza M. Health Spending Projections for 2001-2011: The Latest Outlook. *Hlth Aff.* Vol 21(2):207-218. March/April 2002.

slow economy, and investments in bioterroism defense.[3] The government also projects a marked acceleration in real private expenditures for health care as the result of rising household income, the loosening of restrictions traditionally imposed by managed care plans, and rising price inflation.[4]

Milliman USA projects even more striking growth, estimating an increase in per capita health care costs for all payers of 44% by 2006.[5] Consumers are expected to shoulder the lion's share of this growth, seeing their costs increase by 55% between 2001 and 2006[6] as employers – faced with a slowing economy and rising unemployment – become less inclined to absorb future increases in the cost of benefits.[7]

While the government is projecting an eventual slowing in the rate of growth in national health spending – reflecting slower increases in utilization, intensity of services, and input prices – that growth is still expected to outrun real economic growth.[8] Health care will continue to consume a growing proportion of our fiscal resources. To simply maintain health care expenses at the 13.2% level of GDP observed in 2000[9], we will have to spend approximately 4% less each year than projected.[10] This presents an obvious challenge to state policymakers who strive to meet the needs of their citizens while preserving fiscal integrity and maintaining a balanced budget. Medicaid represents 20% of state budgets at a time when states are having to face the reality of slowing growth in tax revenues, forcing budget crises across the nation.[11]

Where is the Growth in Costs Coming From?

The cost of hospital care exhibited marked growth in 2000, with the cost of inpatient care increasing by 2.8% and outpatient care by 11.2%. Taken together, inpatient and outpatient care comprised 43% of the cost increases in 2000.[12] Physician services comprised 28% of total growth - a smaller proportion that that observed in the prior year's rate (34%), but still substantial. Similarly, growth in

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[3] *id*
[4] *id*
[5] Diede ML, Lilledahl R. Health Care Cost Control: Getting on the Right Track. *Mgd Care.* 24-33. February 2002.
[6] *id*
[7] Dunks PJ. Will Consumerism Lead to More Price-Sensitive Patients? *MGM J.* March/April 2001. www.mgma.com.
[8] *id*
[9] *Trends and Indicators in the Changing Health Care Marketplace, 2002; Chartbook.* Kaiser Family Foundation. May 2002.
[10] *supra* at 5
[11] Riley P. *State Health Policy Responses to Recessions (1970-2002).* May 2002.
[12] Strunk BC, Ginsburg PB, Gabel JR. Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000. *Data Bulletin No 21- Revised.* Center for Studying Health System Change. September 2001.

spending on prescription drugs made up 29% of the increase, down from 35% the previous year.[13]

Levit and colleagues from CMS' National Health Statistics Group dissect the growth factors in a recent *Health Affairs* article.[14] They cite systematic changes in public policy as significant cost-push factors. These changes include the creation of the State Children's Health Insurance Program (SCHIP), which provides expanded access to health coverage for low income children. SCHIP spending increased from $1.8 billion in 1999 to $2.8 billion in 2000; a portion of these increases is funded by the states. Medicaid expenditures rose as well.

At the same time, states have made use of the federal disproportionate share hospital provision, more commonly known as DSH. The DSH program was created in the late 1980s as a means of providing supplemental revenues to hospitals serving large numbers of low income patients, on the premise that such patients carry with them inherently higher costs. States were able to use the program to boost federal Medicaid spending without concomitant expenditures of state funds[15] – provider "taxes" could be used to seed federal match. Although the DSH provisions have now been limited, states were able to temper the growth in their Medicaid spending by using DSH payments to supplant state funds. Still, total Medicaid expenditures increased by over 8% in 2000.

After a brief but significant downward turn in the rate of spending growth for nursing home care between 1995 and 1999, spending on long term institutional care rebounded in 2000; much of the spending for these services is attributable to Medicaid programs.

Medicare spending for hospital services climbed 4.5% in 2000, exhibiting the greatest increase since 1997.[16] According to Levit, *et al,* this level of spending may be traced to legislative changes enacted as part of the Balanced Budget Refinement Act, which softened reductions in disproportionate share payments, reduced the gravity of cuts to graduate medical education funding and which temporarily boosted reimbursement to sole community provider hospitals. At the same time, the severity of illness exhibited by Medicare inpatients fell, pushing case mix adjusted reimbursement down. While hospital revenues overall grew in 2000, so did the cost of producing hospital services. These costs include wage pressures – particularly wages for nurses – increased sharply, as did energy costs. The cost of technology was also a major contributor to the increased cost of care.[17]

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[13] *id*

[14] Levit K, Smith C, Cowan C, Lazenby H, Martin A. Inflation Spurs Health Spending in 2000. *Hlth Aff.* Vol 21(1):172-181. January/February 2002.

[15] Coughlin TA, Ku L, Kim J. *Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s.* Urban Institute. January 2000.

[16] *id*

[17] Okunade AA, Murthy VNR. Technology as a "Major Driver" of Health Care Costs: A Cointegration Analysis of the Newhouse Conjecture. *J Hlth Econ.* Vol 21:147-159. 2002.

Accelerated growth rates in health insurance premiums have also characterized the past several years. Premium increases were attributable to the rising costs of benefits (driven primarily by prescription drugs) and a shift in enrollment to higher-cost benefit plans. A continued upward swing in the underwriting cycle also contributed to premium increases, as insurers sought to recover prior years' losses and build profitability.[18]

The recent build-up in dissatisfaction with restrictive managed care plans also contributed to spending increases. Not only have providers grown less willing to negotiate capitation rates that favor payers, but consumers increasingly opted for more expensive benefit designs that allow more choices.[19] Seeking broader, more open provider networks, the number of individuals enrolled in health maintenance organizations began to decline for the first time in 2000.[20]

What Can Be Done?

There is some evidence that growth in health care spending is the collective result of three factors: inefficiencies in the provision of health services; continued large returns to providers; and investment in new technology.[21]

Total spending includes both growth in the volume or units of service produced and the cost paid per unit. Payments are a function, at least in part, of the cost of inputs and resources used to produce the service. These dimensions of spending serve as the targets for cost containment strategies. That is, policymakers have focused on the supply of services, the pricing of services and the demand for services.

Efforts to control the **supply** of services are well demonstrated by state Certificate of Need programs, which seek to limit the acquisition and dissemination of substantial investments in technology and capacity. These limitations are imposed in an effort to promote the rational, planned development of health services and, most often, to hold down the volume of services provided and the cost (as related to intensity of service).

Hospital rate setting is a good example of a cost containment strategy designed to control the **price** of services provided, focusing on promoting the efficient production of services in one of the most costly sectors of the health care market. Rate setting is designed to impose limits on hospital revenues, making hospitals operate within a constrained budget. While individual programs vary a good deal,

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[18] *supra* at 12
[19] *id*
[20] *HMO Enrollment Continues to Decrease.* Interstudy Publications. May 7, 2001. http://www.hmodata.com/Pdf/ir111pr.pdf. June 6, 2002.
[21] Altman SH, Wallack SS. Health Care Spending: Can the United States Control It? In *Strategic Choices for a Changing Health System,* S. Altman and U. Reinhardt (ed.). Association for Health Services Research. 1996.

the overriding objective is to control hospital *charges* while striving to maintain a viable hospital system.

Managed care has grown to be the predominant cost containment strategy. Aimed at influencing the **demand** for health services, managed care is a blend of the financing and delivery of care. Comprehensive benefits are available to enrollees seeking care from a proscribed, limited provider network, with which the managed care organization MCO) has established contractual relationships. Enrollees seeking care outside the approved network either receive reduced benefits or no coverage at all, depending on the plan's design. The MCO seeks to enter into provider contracts that allow for discounts from charges and which subject providers to certain parameters and standards for utilization and quality of care, set out by the payer. These plans may exercise considerable influence on the manner in which patients seek care as well as the manner in which care is provided to them.

Importantly, "demand" is driven not only by the introduction and utilization of new technologies and interventions, but by the demographic character of the population, as well. Shifts in the age, gender, race, prevalence of chronic illness, income, and education composition of the population exercise considerable impact on demand for – and use of – services. It is possible to exert influence over these factors through benefit design (limiting coverage of certain individuals or of certain services) and through the pricing of products.

Finally, states often employ strategies aimed at controlling the price and business of health insurance. These efforts are designed to assure that policies – particularly those sold in the small group and individual markets – meet certain minimum standards for access to coverage and care.

In this paper, we examine the history of these broad categories of cost containment initiatives, with an eye toward lessons learned.

Certificate of Need Regulation

One of the earliest regulatory strategies employed to promote cost containment by decreasing service duplication and investment in excess capacity is Certificate of Need (CON).[22] Although cost containment has been the primary objective of CON, it also has been used, at least implicitly, as a strategy for encouraging hospitals to provide increased levels of indigent care.[23]

First enacted by New York in 1964,[24] CON is a governmental program requiring certain types of health care providers to obtain state approval to make substantial capital investments in new equipment or facilities, to change bed complement (in hospitals) and to add or, sometimes discontinue, a patient service.[25] The National Health Planning Act, passed in 1974,[26] established the original federal statute relating to Certificate of Need; it was subsequently amended and expanded in 1979.[27] The law established a formal health planning process, including the SHPDAs (State Health Planning and Development Agencies) to attempt to exert some influence over the health care market, which was beginning to grow rapidly. This growth resulted in greater cost exposure for both the federal and state governments as they took their place among major payers following the enactment and implementation of the Medicare and Medicaid programs.

The National Health Planning Act contained a provision commonly known in health planning circles as "Section 1122." That provision authorized states to establish CON programs and specified that capital investments that did not receive prior approval from the state health planning agency were not eligible for full reimbursement under the Medicare, Medicaid or federal Maternal and Child Health programs.[28] The provision set up minimum criteria for CON review: any project that would result in a change in hospital bed complement required CON review and approval, as did any project that would entail a change in the scope of services offered or that involved a capital investment of more than $100,000. The 1979 amendments modified the minimum review criteria, applying it to the rental, lease or purchase of any diagnostic or therapeutic equipment costing

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[22] Campbell ES, Fournier GM. Indigent Hospital Care. *J Hlth Pol Policy Law.* Vol 18(4). Winter 1993.
[23] *id*
[24] McGinley PJ. Beyond Health Care Reform: Reconsidering Certificate of Need Laws in A Managed Competition System. *FL St Univ Law Rev.* 1995.
[25] Antlitz AM, Boyer E. Certificate of Need: A Physician Concern. *MD State Med J.* June 1979.
[26] Pub L No. 93-641
[27] Pub L No. 96-79
[28] Davis K, Anderson GF, Rowland D, Steinberg EP. *Health Care Cost Containment.* Johns Hopkins University Press. 1990. Baltimore and London.

$150,000 or more, to be used in the treatment of hospital inpatients, regardless of where that equipment would be located (inpatient, outpatient or non-hospital settings). It also required prior notification to the health planning agency of investments exceeding the dollar threshold, even if the project would not be used in the care of inpatients.

The program reflects a perspective on the health care economy as representing an imperfect market – almost monopolistic in some respects – necessitating the intervention of government in order to improve its functionality and performance.[29] The lack of ability on the part of patients and payers to play a meaningful role in the performance of the health services market was prevalent until relatively recently, leaving the market power in the hands of the providers.

The CON regulatory approach is predicated on "Roemer's Law" which implies that a built bed is a filled bed is a billed bed – alternatively, "if you build it, they will come."[30] This economic view of the hospital market, in particular, sees hospital beds (and other resources) as generating their own demand. In order to compete effectively, hospitals invested in the newest technologies and developed new services (particularly high margin services such as heart centers) to attract physicians and patients.[31] This imperative resulted in excess capacity – especially in areas that are hospital dense[32] where they were least needed. Excess capacity must be supported financially, resulting in higher costs. The use of fee for service as the primary reimbursement strategy established an incentives for the provision of more services, especially if they had large profit margins. Under a cost-plus payment system, there was little risk related to the acquisition of new, expensive capital. At the same time, commercial payers simply passed the costs associated with capital expansion on to consumers through increased premiums.[33]

A desire to do something to rein in the growth in health care expenditures stimulated the interest in regulation, although precise answers to this challenge were unknown. The federal government began to encourage state "experimentation" with different types of strategies to meet this challenge and states took up the call. As hospitals represented the major category of health care expense[34] and as technological expansion was recognized as a major driver

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[29] Smith MD. Seeking Common Ground. *HSR.* Vol 29(1):33-34. January/February 1996.
[30] Sloan FA, Steinwald B. Effects of Regulation on Hospital Costs and Input Use. *J Law & Econ.* Vol 23(1):81-109. 1980.
[31] This is a good example of non-price competition, which is characteristic of the health care market.
[32] *supra* at 29
[33] *id*
[34] Strunk B, Ginsberg PB, Gabel JR. *Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000. Center for Studying Health System Change.* September 2001.

of inflation,[35] focusing on capital investment and constraint of growth in technology diffusion seemed to make sense.

By the mid 1970s, most states had passed their own CON laws and were participants in the federal §1122 initiative.[36] While complying with the minimum thresholds set out in federal law, each state employed its own version of CON, with differing thresholds (some more stringent than the federal limit); most states subjected both hospitals and nursing homes to regulatory oversight, but exempted physicians' offices.[37]

The federal statutory authority expired in the mid 1980s, after which a number of states discontinued their own programs. Today, 38 states have CON programs, each reflecting the unique qualities of the states within which they operate. Many apply only to nursing facilities, some extend to physician offices and some only apply to the construction of new hospitals.[38]

Impact

As noted above, the primary intent of Certificate of Need was to constrain cost increases by limiting investment in capital and avoiding the costly duplication of services. A secondary aim was the promotion of hospitals assuming higher levels of indigent care, the theory being to encourage the subsidization of such care with dollars that might otherwise be invested in excess capacity.

One of the earliest studies of the impact of CON was conducted by Salkever and Bice, using data for 1968-1972, examining the influence that state regulation efforts had on facilities. These investigators found that hospitals appear to have continued to invest in technology, while holding bed complement steady, resulting in the regulatory effort having no demonstrable impact on total investment or costs. Similarly, a 1986 study by Hellinger found no significant relationship between CON and decreased hospital investment.[39]

Studies by Sloan and Steinwald using data from a six-year time series (1970-1975) also evaluated the impact of CON on the expansion of facilities and services, on hospital revenue and on utilization of services.[40] [41] These investigators came to a conclusion similar to their colleagues, finding that regulatory programs – including Certificate of Need – did not result in meaningful

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[35] Okunad AA, Murthy VN. Technology as a 'major driver' of health care costs: a cointegration analysis of the Newhouse conjecture. *J Health Econ.* Vol 21(1):147-159. January 2002.
[36] *supra* at 30
[37] *id*
[38] Community Catalyst Website. www.communitycat.org, April 22, 2002.
[39] Hellinger FJ.Effect of Certificate of Need Legislation on Hospital Investment. *Inquiry.* Vol 13:187. 1976.
[40] *supra* at 30
[41] Sloan FA. Regulation and the Rising Cost of Hospital Care. *The Review of Econ and Stat* .Vol LXIII(4):479-487. November 1981.

cost containment during the early part of the 1970s. They also documented a compensatory reaction on the part of hospitals that were anticipating the implementation of CON programs, with marked investment activity in the period immediately preceding program start-up, resulting in a spike in costs.

When the federal legislation expired in the mid-80s, several states chose to either repeal or sunset their CON programs. A study by Conover and Sloan found that the removal of CON regulation did not lead to a marked increase in health care expenditures, reinforcing the notion that this strategy failed to exercise any considerable influence over spending.[42] The literature is silent, however, regarding what the current landscape might look like if CON had never been introduced. It is likely that this type of regulation exercised a chilling effect that discouraged the development of costly new projects.

The view of CON from a provider perspective varies depending upon which providers are consulted, and when. In a 1980 editorial, one physician characterizes CON as achieving nothing but a slow down in equipment acquisition, while serving as a full-employment act for health planners.[43] Others have viewed it as a call to arms for physicians to involve themselves more meaningfully in local health planning efforts.[44]

Sloan and Steinwald point out that capital and facilities regulation tends to protect the providers already in the market, to the detriment of those trying to enter that marketplace. Like licensure, generally, that particular anti-competitive impact was likely to have been embraced by hospitals that struggled to maintain or gain position in a competitive market. In Maine, there was a tremendous struggle between one of the state's largest hospitals and community physicians when, in the early 1990s, a private group practice proposed purchasing an MRI – a plan that was met with displeasure by the hospital administration. This struggle for market position continues to this day. In the most recent legislative session, Maine lawmakers considered competing bills dealing with CON. The first, backed by the allopathic medical association, would have eliminated CON altogether. [45] This bill was strenuously opposed by the hospital association, which characterized the proposal as having "serious negative implications" for access to care and the promise of increased costs.[46] It is probably safe to

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[42] Conover CJ, Sloan FA. Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending? *J Hlth Pol Policy Law.* Vol 23(3):455-481. June 1998.
[43] Valaske MJ. Certificate of Need. *Pathologist.* Vol 34(2):77. February 1980.
[44] *supra* at 25
[45] Personal communication with Andrew MacLean, JD, General Counsel, Maine Medical Association, May 28, 2002.
[46] Maine Hospital Association website. http://www.themha.org/pages/new_pages/new2x.htm. May 28, 2002.

assume that similar scenarios play themselves out in other State Houses as well.[47]

While the success of CON to constrain costs appears to have been less than optimal, it has been suggested that we have, perhaps, given it short shrift by not giving the redistributional effects of the program enough consideration.[48] Limits on capital investment may be viewed as key to the subsidization of indigent patient care, redirecting monies that would have been devoted to increased capacity to care formerly cross-subsidized by other payers. Campbell and Fournier suggest that CON has been used by regulators to implicitly pursue the aim of cross subsidization. They argue that regulators may use their authority to "trade" licenses or restrict competition in the health care market to create inducements for hospitals to provide increased levels of charity care, as restriction of entry into lucrative services is a necessary precondition to forcing higher levels of indigent care. Their study of Florida's CON program between the years 1983 and 1989, found that limiting licensure of capital projects was essential to promoting the internal underwriting of indigent care, essentially serving as an alternative to legislated taxes to support such care.[49]

More recently, there has been growing interest in the concept of regionalization of services and the creation of centers of excellence. A good deal of literature supports the hypothesis that there is a positive correlation between volume and favorable outcomes.[50] While patient education and payer policy can influence the migration of patients to high volume centers, limitations imposed by state governments via Certificate of Need can be quite useful in promoting regionalization of services.[51] This strategy would help avoid duplication of services and promote better patient outcomes.

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[47] A brief review of legislative bills for several other states' most recent sessions supports this contention. Michigan, Missouri and Pennsylvania legislatures all had CON bills introduced and considered.

[48] *supra* at 22

[49] *id*

[50] See, for example, Birkmeyer JD, Siewers AE, Finlayson EVA, Stukel TA, Lucas FL, Batista I, Welch HG, Wennberg DE. Hospital Volume and Surgical Mortality in the United States. *NEJM.* Vol 346(15):1128-1137. April 11, 2002 and Begg CB, Riedel ER, Bach PB, Kattan MW, Schrag D, Warren JL, Scardino PT. Variations in Morbidity After Radical Prostatectomy. *NEJM.* Vol 346(15). April 11, 2002.

[51] Epstein AM. Volume and Outcome – It Is Time to Move Ahead. *NEJM.* Vol 346(15):1161-1163. April 11, 2002.

Lessons Learned

There are a number of lessons for policymakers in the efforts undertaken by government in its attempts to curb investment in facilities and services:

- There is little data to support the notion that CON helps curb costs. While it does have a demonstrated impact on the number of patient beds, intensity of services appears to counteract any cost savings realized;
- There is a demonstrated correlation between CON and the availability of indigent care, redirecting funds from investments in capital to subsidization of care; and
- CON may be useful in promoting regionalization of services, with a concomitant improvement in patient outcomes for selected, high risk services.

The characteristics of CON programs vary from state to state, with no single program standing out as a model for others to adopt. It appears that the measure of influence particular interests have on the legislative and regulatory processes in each state are demonstrated in the reach and tenacity of the regulatory system.

CON was one of the earliest attempts at cost control and characterized an era when governmental intervention was viewed as a necessary element of any cost containment effort. It served as a precursor to rate regulation and, later, to the development of managed care systems, each strategy having similar goals. While some states allowed their CON programs to lapse (either by sunset or repeal) when the federal enabling legislation expired, many chose to continue the program as one device in a range of cost saving strategies, adopting rate regulation and encouraging the growth of HMOs at the same time.

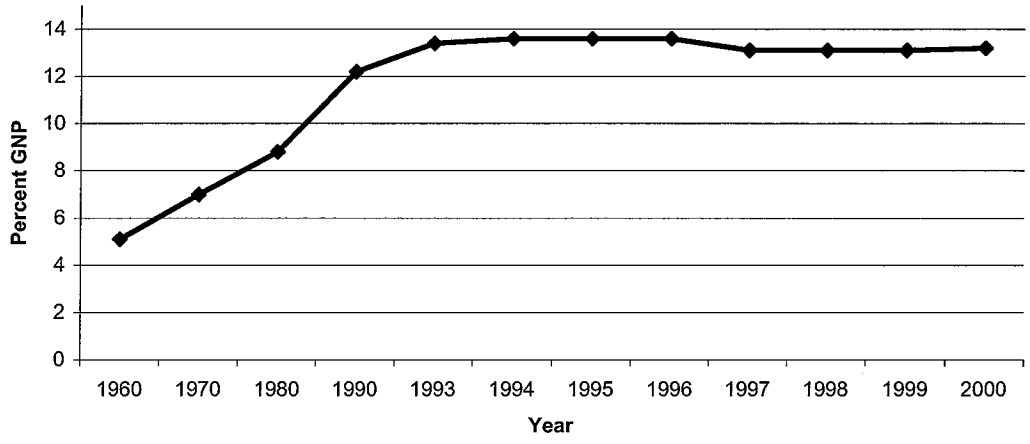
Hospital Rate Setting

Background

In the 1940s, the US witnessed the "birth of the blues" with the formation of the earliest private health insurance coverage – the forerunner of today's Blue Cross and Blue Shield plans. This movement launched a trend in coverage structured on a fee for service model of reimbursement, providing risk protection both to enrollees and providers. Twenty years later, the New Societies era ushered in the Medicare and Medicaid programs, extending the benefits of health care coverage to some of our nation's most vulnerable citizens and creating a new sensitivity to the cost of care for both the federal and state governments.

The introduction of Medicare and Medicaid was also marked by the initiation of several decades of rapid growth in health care expenditures, by government as well as private plans and individuals, which was, at least in part, fueled by the fee for service reimbursement orientation of the health insurance market.[52]

National Health Expenditures as Percent of Gross National Product



Note: Data for chart taken from citation nos. 68 and 69

It has been argued that, because providers exercise considerable influence over the use of health services, fee for service systems tend to be inflationary as there is economic incentive to encourage utilization to maximize providers' income.[53]

[52] *supra* at 28
[53] *see,* for example, RG Evans. *Strained Mercy: The Economics of Canadian Health Care.* Butterworths. 1984. Toronto.

Expenditures for health care rose from 5.1 percent of gross national product in 1960[54] to 13.2 percent in 2000.[55] (See chart above) While the majority of spending in 2000 was attributable to Medicare and Medicaid, private spending on health care grew at the same rate.[56] After a period of relatively stagnant spending increases observed since 1992, the rate of increase now appears to be gaining steam once again, raising the concerns of both the private and public sectors.

Inflation in the health care expenditures of the state and federal governments in their role as public payers stimulated a search for new ways to constrain costs and provide predictability in expense budgets, while safeguarding access to care. This was especially critical in the post-Vietnam era when the country faced substantial budget deficits attributable to the war effort. Nixon's Economic Stabilization Program (ESP), implemented in 1971, froze wages and prices throughout the economy, including the hospital industry (which accounted for the lion's share of health care expenditures); these restrictions would last until ESP's expiration in the spring of 1974.

ESP had the desired effect on hospital expenditures, reducing growth to somewhere between zero and three percent.[57] Once ESP was rolled back, though, Medicare expenditures for hospital care skyrocketed, increasing even faster than they had prior to the introduction of ESP. While this regulatory program was clearly unable to exert a sustainable influence on hospital costs, it does serve as an early rate setting model leading the way for many states in their own efforts to control health care expenditures.

In 1972, Congress amended the Social Security Act, allowing and encouraging states to experiment with new methods of cost containment. These amendments made provision for waivers for states pursuing cost controls via hospital rate setting. In 1983, further amendments encouraging cost containment innovation were enacted. These waivers allowed for the participation of federal programs in rate setting schemes, as long as increases in expenditures for hospital care did not exceed what would have been experienced without the regulatory system. This federal encouragement spurred a number of states to develop and institute rate setting as an answer to their rising costs[58] leading to, at one point just prior to 1980, regulatory efforts in almost thirty states.[59] However, interest and

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[54] KR Levit, HC Lazenby, BR Braden, National Health Accounts Team. National Health Spending Trends in 1996. *Hlth Aff.* Vol 17(1):35-51. January/February 1998.
[55] K Levit, C Smith, C Cowan, H Lazenby, A Martin. Inflation Spurs Health Spending in 2000. *Hlth Aff.* Vol 21(1):172-181. January/February 2002.
[56] HCFA website: www.hcfa.gov/stats/NHE-OAct/hilites.htm. April 2002.
[57] *supra* at 28
[58] The first iteration of New Jersey's rate setting effort was actually implemented in 1969, well before the SSA amendments. That version of the program was not an all payer system and served as the model for the Medicare PPS.
[59] McDonough JE. Tracking the Demise of State Hospital Rate Setting. *Health Affairs.* Vol 16(1):142-149. 1997.

commitment to rate setting soon waned. Today, only Maryland's system remains intact. That system, though, has recently undergone substantial revision (discussed later).

There is variability in the form assumed by the enabling legislation in each regulatory state. Some states chose to lay out the parameters of the rate setting system in excruciating statutory detail, resulting in long, formulaic and complex laws and tightly constraining the flexibility and determinative action that regulatory staff took. Other legislatures chose to enact statutes that, instead, laid down the objectives and broad parameters for the regulatory system, leaving the development of the details of the system to agency staff and allowing them maximum flexibility. This latter model is credited as being a factor in the success of the long-standing Maryland system.[60]

It is not entirely clear from the research what factors were instrumental in determining a state's decision to pursue rate setting. While worries about rising Medicaid budgets were certainly important determinants, other factors, such as high physician/population ratios, large Blue Cross and Medicaid market shares, high cost/admission and cost/capita, relatively high personal income levels and population density also appear to be related to regulatory adoption. The political environment in each state and state budget deficits also appear to have been influential.[61]

In the early 1970s, Congress actively encouraged states to employ rate setting as a cost containment device. At the same time, it acted to encourage the development of health maintenance organizations as another cost containment strategy. Because both of these strategies are related to the manner in which the market for health care services operates, it may seem counterintuitive that they would ever co-exist. However, the degree to which managed care was present in a given market does not seem to be related to the decision to adopt rate setting mechanisms. In fact, McDonough found the presence of independent practice associations and pre-paid group practices to be positively correlated with the operation of rate setting systems.[62] He points out that this phenomenon does not imply that rate setting stimulates the development of managed care, only that the same environmental factors are conducive to both. High hospital costs, for example, are known to have motivated the desire to implement both rate setting policies as well as having stimulated the formation of managed care plans.

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[60] *id*

[61] McDonough JE. *The Decline of State-Based Hospital Rate Setting.* National Academy for State Health Policy. May 1995.

[62] *id*

Characteristics

A wide range of variations of rate setting programs has been used over the years. There are four basic axes of each program, which can be used to describe its character:

- mandatory v. voluntary participation of providers;
- the regulatory or advisory nature of the rate setting body;
- the payers included under the regulatory scheme; and
- the unit that is regulated.

In 1980, most of the rate setting programs were voluntary in nature. Four state statutes mandated public disclosure of hospital budgets and charges, but carried no regulatory clout. Only eight programs were both mandatory and regulatory, that is, the law mandated compliance with rules and regulations established by a public rate setting body. Two other states implemented mandatory regulatory systems in the early 1980s, just as other states began to deregulate their markets.

The mandatory regulatory systems have proven to be of the greatest interest to policy makers, as it is these programs that have demonstrated the most significant influence on hospital costs. Four of these states – Maryland, New York, New Jersey and Massachusetts – obtained Medicare waivers, creating true "all payer" systems, where each payer in the market was required to participate in the regulatory program. Research has shown that the inclusion of all payers under the rate setting system enhances the program's ability to control costs and is more conducive to the equitable funding of uncompensated care than less comprehensive regulatory efforts, [63] [64] [65] as cost-shifting is minimized and payers bear their "fair share" of charity care and bad debt, as specified in the regulatory scheme.

Different rate setting programs regulate rates at different "levels" with some focused on per diem rates, per service rates or per case rates, others on global revenue caps and still others using a combination of these units. Prospective rate setting systems focus on output or the services produced, rather than inputs such as the cost of labor or other raw materials, as a strategy for encouraging cost conservation and the efficient use of resources. The selection of the unit regulated has consequences for the behaviors incented by the choice of approach.

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[63] Rosko MD. A Comparison of Hospital Performance Under the Partial-Payer Medicare PPS and State All-Payer Rate Setting Systems. *Inquiry.* Vol 26:48-61. Spring 1989.
[64] *supra* at 61
[65] Hsaio WC, Sapolsky HM, Dunn DL, Weiner SL. Lessons of the New Jersey DRG Payment System. *Hlth Aff.* Vol 5(2):32-45. Summer 1996.

Many of the earliest programs started out regulating per diem rates or per service rates; these states saw drops in daily rates and ancillary charges. However, hospitals tended to respond to this type of constraint by generating an *increase* in the average length of stay along with a decline in ancillary service use (under the per diem strategy) or an increase in service intensity (in the case of per service regulation).[66] Some states, such as New York, attempted to control overall costs by imposing a budget cap over the per diem rates.[67]

Between 1980 and 1987, hospitals in the area of Rochester, New York participated in the Hospital Experimental Program or HEP. This program established a broad range of financing and regulatory provisions, including what was essentially a global budget for the region and was intended to limit total hospital revenues.[68] An analysis of the project, conducted by Friedman and Wong, found that the initiative did indeed result in a restraint in the case mix adjusted cost per case. Capital investment and utilization of costly technologies were similarly constrained, without an impact on quality of care. The impact of the demonstration on hospital operating margins varied from one institution to the next.[69]

Other states modified the unit regulated in an attempt to encourage more desirable behaviors. Per case regulation – first tested by New Jersey in the late 60s – predominated the second wave of regulatory efforts. Like Medicare's PPS, this strategy centers on the development of prospective rates of reimbursement for case mix adjusted admissions. The payment allowance is set on a per admission basis and recognizes the costs associated with caring for more severely ill patients by setting higher payment rates for more complicated admissions. This type of payment allows for changes in case mix intensity or patient severity, but only recognizes the variable costs associated with changes in volume. Limits on charges are calculated using rates from a predetermined base year, and are made up of only those costs that are allowable under the particular regulatory scheme.

Medicare's Prospective Payment System was spurred by the passage of the federal Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The program was to move Medicare to being a prudent purchaser of hospital services by shifting the program away from its historical cost-based reimbursement methodology to prospectively determined rates of payment based on diagnosis related groups. During the first year of PPS, hospitals realized substantial operating margins as a result of the system's implementation. That windfall was quickly reversed, though, as the cost per discharge outstripped change in

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[66] *supra* at 28
[67] *id*
[68] Friedman B, Wong HS. Impacts of Hospital Budget Limits in Rochester, New York. *Hlth Care Fin Rev.* Vol 16(4):201-219. Summer 1995.
[69] *id*

payment rates in PPS Years 2 and 3[70] generating a downward trend in the PPS margin that has continued.[71] The rate of growth in federal Medicare spending has also remained on a downward trend, falling from an annual rate of 14.6% in 1998 to 5.6% in 2000.[72]

The New Jersey DRG (diagnosis related groups)-based prospective payment system created an incentive for hospitals to curtail the length of inpatient stays, since payment was triggered by the admission and did not ordinarily vary by the length of a patient's stay. While average length of stay in New Jersey did fall following the implementation of the DRG payment system, hospitals offset that decline through increases in admission rates.[73] A similar phenomenon was observed in the earliest years of Maryland's rate setting program, as it was designed as a prospective "payment per case" system.[74]

Trending allowable costs using a base year rate (as opposed to simply determining allowable costs anew each year) is intended to encourage cost conservation. However, there is risk in refusal to consider rebasing (i.e. updating the base rate) as an option at some point during the life of the system; such an inflexible stance may jeopardize the long term support for the regulatory system as the base year becomes more and more part of the distant past. The health system is changing rapidly; the goods and services that comprise a base rate from five years ago may simply not be representative of the goods and services used to produce health care today. Similarly, the willingness or latitude allowed by the system to grant exceptions to rate setting rules or make extraordinary adjustments is important.

The context within which hospitals operate has and continues to change at a stunning pace. It seems new technological advances become available on a daily basis. Hospitals are becoming increasingly complex organizationally, entangled in mergers, vertical integration and risk arrangements. The severity of illness observed in hospital inpatients has grown substantially as the population ages and as our ability to care for less severely ill patients in ambulatory settings increases. The ability to be flexible – as McDonough points out – is critical to regulators' capacity to ensure the system remains responsive and relevant to the changing environment.

Administrative procedures and the need for accountability can make it difficult for any regulatory system that relies on public rulemaking procedures to guide its actions to remain responsive to such a rapidly changing environment. That was

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[70] Sheinnold SH. The First Three Years of PPS: Impact on Medicare Costs. *Hlth Aff.* Fall 1989:191-204.
[71] Guterman S, Altman SH, Young DA. Hospitals' Financial Performance in the First Five Years of PPS. *Hlth Aff.* Spring 1990:125-134.
[72] Heffler S, Smith S, Won G, Clemens MK, Keehan S, Zezza M. Health Spending Projections For 2001-2011: The Latest Outlook. *Hlth Aff.* Vol 21(2):207-218. March/April 2002.
[73] *supra* at 65
[74] *supra* at 63

certainly the case in Maine, where regulators strenuously resisted requests for exceptions and special adjustments as well as calls for rebasing from the industry, which contributed to a situation where the agency was constantly battling rate appeals and litigation, leading to the system's eventual political demise after a decade of cost containment.[75] Maryland also eventually found its system challenged by the profound changes in the market for hospital services in that state. As a result, the system has recently been substantially "renovated" and will include more frequent hospital rate reviews.[76]

Outcomes/Impacts

The predominance of research on rate setting has focused on the several all payer systems originally enacted around 1980. There has also been considerable research regarding the utility and effectiveness of reimbursement mechanisms incorporating DRGs, although that question is beyond the scope of this paper. There is an entire body of literature devoted to the topic of diagnosis related groups, their design, intended consequences and actual impacts. This paper is focused on the use of DRGs as a unit of payment in hospital rate setting; discussion of the intricacies of the classification mechanism itself is left for others to address.

In fact, there is relatively little in the contemporary literature related to the evaluation of rate setting, reflecting the decline in interest in this cost containment strategy since the 80s. However, the published literature reflects broad-based agreement that rate setting was able to exercise considerable control over the cost/admission and over per capita hospital costs.[77] [78] [79] [80] For example, the New Jersey DRG rate setting system and the system in Maryland cut the average rate of increase in cost per case by almost 5%.[81]

In contrast, most investigators have found that rate setting has *not* constrained the rate of growth in health care costs per capita.[82] [83] [84] This is attributable to the fact that these programs have largely failed to control rates of admission. Both

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[75] Wihry DF, Fralich JT, Schneiter EJ. The political economy of rate regulation in Maine. *ME Pol Rev.* Vol 2(2):18-34. September 1993.
[76] *Achievement, Access and Accountability: A Guide to Hospital Rate Regulation in Maryland.* Maryland Hospital Association. January 2002.
[77] Schramm CJ, Renn SC, Biles B. Controlling Hospital Cost Inflation: New Perspectives on State Rate Setting. *Hlth Aff.* Vol 5(3):22-33. Fall 1986.
[78] *supra* at 59
[79] Biles B, Schramm CJ, Atkinson JG. Hospital Cost Inflation Under State Rate-Setting Programs. *NEJM.* Vol 303(12):664-668. September 18,1980.
[80] *supra* at 63
[81] *id*
[82] Antel JJ, Ohsfeldt RL, Becker ER. State Regulation and Hospital Costs. *Rev Econ & Stats.* 1995.
[83] Finkler MD. State Rate Setting Revisited. *Hlth Aff.* Vol 6(4):82-89. Winter 1987.
[84] *supra* at 63

the Maryland and New Jersey systems were found to be associated with almost 4% annual rates of increase in the volume of admissions, offsetting savings generated on a cost/case level.

The degree to which substitution of unregulated outpatient services for regulated inpatient services has occurred as a direct market response to cost containment is debatable. Still, as noted earlier, we have witnessed a marked shift in delivery site off campus for many procedures previously offered only within the hospital walls. Costs (and expenditures) have followed these services into the community, resulting in lower inpatient expenses with no significant savings in total expenditures.

Some research has shown the early success of rate setting (in non-waiver states) began to erode as Medicare Prospective Payment System (PPS) went into full implementation.[85] This program stimulated increases in rates of admission, helping to offset gains made by the rate setting programs. It may be, however, that the introduction of PPS simply coincided with a period of rapid growth in managed care, which also exerted pressure on rate setting system; this phenomenon is discussed later.

Many critics of rate setting argued that this form of regulation would result in a marked degradation in the quality of care; this question, though, has yet to be answered. Hadley and Swartz concluded that savings from rate setting were primarily associated with increased efficiencies in production and/or degradation in the quality of care provided.[86] Hsaio and colleagues agree, finding that New Jersey hospitals responded to rate setting through belt tightening – letting plants age and going without full staff complements – rather than by influencing physicians to use resources more wisely. Similarly, Finkler argues that innovators will be loath to enter a market where prices are fixed.[87] Such reactions are argued to jeopardize the quality of care. In contrast, Smith *et al,* in a more recent study, failed to find any adverse relationship between rate regulation and patient or population mortality.[88]

One of the most important policy features of rate setting systems – particularly all payer systems – is their potential to control cost shifting and "institutionalize" subsidization for indigent care.[89] [90] [91] [92] [93] While many states cited cost control as

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[85] *supra* at 77
[86] Hadley J, Swartz K. The Impacts on Hospital Costs between a980 and 1984 of HOsp;ital Rate Regulation, Competition, and Changes in Health Insurance Coverage. *Inquiry.* Vol26:35-47. Spring 1989.
[87] *supra* at 83
[88] Smith DW, McFall SL, Pine MB. State Rate Regulation and Inpatient Mortality Rates. *Inquiry.* Vol 30: 23-33. Spring 1993.
[89] *supra* at 59 and 61
[90] *supra* at 65
[91] *supra* at 76
[92] Sloan FA, Blumstein JF, Perrin JM, *ed. Uncompensated Hospital Care: Rights and Responsibilities.* Johns Hopkins University Press. Baltimore/London. 1986.

their primary goal for their rate setting programs, access to care for the medically indigent was often mentioned as a motivating factor for passage of such a program. When rate regulation involves the actual approval of a gross revenue limit, limits per diem or limits per unit of service, the regulatory agency is able to build in an allowance for expected charity care and bad debt. In states where negotiated discounting is prohibited, this allowance may be more equitably allocated over all payers covered under the rate setting system. Rather than pushing the responsibility for shortfalls attributable to indigent care to payers with less capacity to negotiate a substantial discount, a comprehensive rate setting system is able to redistribute this burden, assuring payers share this cost-shift proportionately.

The evidence regarding the impact rate setting has on hospital profitability and financial condition is mixed. Arguably, a payment system should allow efficient providers to remain viable. However, if rates are set too high, the system will fail to realize its cost containment goals. If they are set too low, hospital financial positions may be compromised.

In a study by Hsaio and colleagues, data is presented documenting that between 1997 and 1985, hospitals in Maryland and New Jersey tended to have operating margins that were somewhat below the national median, suggesting that the rate setting systems in those states reduced the hospitals' "bottom line."[94] The same study points out that little evidence can be found to differentiate the financial impact of all payer systems versus partial payer systems.[95] In his 1982 paper, Mitchell finds that rate setting exercised harmful effects on the profitability of the hospital sector,[96] an observation echoed by the Maryland Hospital Association in its response to the Mitchell article.[97]

The Maryland Rate Setting Commission documents the degradation in the financial condition of hospitals under the payment system in a January 2002 report. At the end of the system's second decade, serious concerns began to be raised regarding hospital financial positions, spurring an in-depth study and the development and implementation of corrective action. These changes resulted in operating margins at Maryland hospitals roughly equaling those seen nationally. Moreover, the average age of plant, which had been increasing over years (presumably due to the rate setting system's less than desirable treatment of capital allowances), declined markedly toward the national norm.[98] This trend has not lasted, however, and it appears that Maryland hospitals are again experiencing problems related to narrow operating margins, low liquidity, and high debt ratios. A redesign of the Maryland system which will address these

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[93] *supra* at 28
[94] *supra* at 65
[95] *id*
[96] Mitchell SA. Issues, Evidence, and the Policymaker's Dilemma. *Hlth Aff.* Vol.1:84-98. Summer 1982.
[97] Davidson RJ. ReViews: A State Hospital Association. *Hlth Aff.* Vol. 1:12-128. Summer 1982.
[98] *supra* at 76

issues was implemented in 2000, and is currently in the midst of a three-year pilot period.[99]

Interestingly, others dismiss the claim that rate setting has a deleterious impact on hospitals' financial conditions. Schramm, *et al*, found the opposite, presenting data to support the observation that the financial position of hospitals in regulated states actually improved over the study period.[100] Similarly, Sloan could find no strong evidence that mandatory rate setting programs eroded hospital operating margins.[101] Differences in findings may be attributable, in part, to the statistical models used by different investigators, differing temporal boundaries of the studies and differing data sets.

Rate setting and managed care

Just as critics used quality as a touchstone for arguing against the use of rate setting, so, too, did they argue that rate regulation and managed care would be incompatible. This simply has not proven to be the case. Most of the early adopter states had, at the time, greater than average HMO penetration.[102] The same factors driving states to contain costs through rate setting (rapidly rising health care and hospital costs) also predisposed markets to the development of managed care. And the same federal legislation that encouraged states to experiment with rate setting also encouraged the development of HMOs.

In all fairness, however, the period when rate setting was in vogue was early in the development of HMOs, which enjoyed relatively small market shares. Because managed care claimed such a small proportion of the market, the two cost containment strategies did not get in each other's way. However, in the 1990s, when managed care experienced such rapid growth, the once benign co-existence came to loggerheads.[103] As the HMOs grew larger and more sophisticated, they became a force to be reckoned with. Believing they would be able to extract better "deals" than what a regulatory agency could provide them, these plans began to demand discounts from charges, when those rate setting systems typically only allowed limited differentials for Blue Cross and Medicaid payers. The political clout wielded by managed care plans was impressive, sweeping along the business community and other key stakeholders who once were supportive of rate regulation into a clamorous call for competition.

Only Maryland was able to weather this storm, a feat attributable, once again, to the substantial flexibility allowed by that system, and to the fact that its Medicare

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[99] *id*
[100] *supra* at 77
[101] *supra* at 41
[102] *supra* at 59
[103] In fact, rate setting may be argued to have assisted in nurturing the growth of small managed care plans, assuring that they were not subject to undue cost shifting of bad debt and uncompensated care at a time when those plans carried little negotiating clout with hospitals.

waiver has been maintained over the years.[104] [105] Regulators there were able to accommodate experimentation with capitation within the framework of rate setting and managed care continued to flourish in Maryland while rate setting was sustained.[106] In other states, a preference for free markets resulted in a roll back of all payer systems to allow for negotiated discounting, the first step toward deregulation.

As McDonough points out in his 1997 paper, it is interesting to note that rate setting (that has moved from per diem to per case payment) and capitation are both forms of prospective payment. Rather than being ideological opposites, they are instead, merely two points on a spectrum of payment mechanisms. The shift from one to the other represents an *evolution* in payment methodology, as opposed to a *revolution.* Rate setting may be viewed as a bridge to the development of capitated systems, constraining costs until managed care could take hold.

Issues

In addition to the advent and growth of managed care, regulatory failure contributed to the decline of rate setting. By its very nature, economic regulation is extremely complex, generating a myriad of rules, regulations and policies that are almost incomprehensible, even to regulatory and hospital staffs;[107] one writer describes the Massachusetts rate setting code as "Sanskrit."[108] This degree of complexity makes it difficult to explain the system to the public (including legislators) and fosters confusion and suspicion, which, in turn, creates vulnerability in the system.

Cooptation is also a danger inherent in these systems, as it is in any regulatory program. Regulatory capture is characterized by a system that works to further the interests of the regulated industry over that of consumers, with the regulatory agency adopting the objectives of the industry as its own. Support for the implementation of state rate setting reflected the self-interest of key stakeholders such as state and national hospital associations, insurers, business and labor, as well as state government.[109] They were all searching for a way to respond to rapidly rising costs. Hospitals were interested in averting the imposition of federal cost controls; insurers were interested in protecting themselves against the growing problem of cost shifting. Payers and purchasers were searching for ways to stem the rising tide of hospital expenditures – Medicaid and otherwise. The

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[104] *supra* at 59
[105] *supra* at 76
[106] It is also noteworthy that Maryland was the only state to have maintained its Medicare waiver, which represented a net influx of revenues to the state's hospitals of $200-$300 million annually.
[107] *supra* at 75
[108] *supra* at 59
[109] *id*

political influence of these parties obviously varied from state to state as did their ability to craft the system to their own advantage.

The statutory language and the resulting regulations shaping the individual rate setting systems reflected the relative power of these interest groups. In some instances, the systems served to protect the relatively inefficient hospital, in others payer differentials were prohibited. As managed care grew and exhibited substantial cost savings in non-regulated states, key stakeholders became enamored of the capitation strategy and began to abandon support for rate setting in favor of this "new" approach.

Most of the rate setting systems were implemented in a political environment that might be characterized as liberal.[110] Most deregulation coincided with a shift in control of State Houses and Governor's mansions to a more conservative orientation[111] and a marked pro-competition attitude. It seems likely that what happened was that stakeholders, anxious to give managed care a run for its money, used the dramatic shifts in governance as an opportunity to push their revised agenda. The new governments – with more conservative stances on state regulation – took up the issue, making deregulation a cause celebre.[112]

Only Maryland departed from this course. According to McDonough, long-term Democratic control of state government sets Maryland apart from states that deregulated.[113] In addition, that state can also quantify and document sustained cost containment successes, holding the rate of increase in hospital cost/admission well below the national average for many, many years.

Lessons Learned

As discussed above, the primary objective of rate setting is cost containment. Success in that arena appears mixed (as cited earlier) and varies with the comprehensiveness of the system. The subsidization of indigent care is also a major goal of rate setting. In this regard, rate setting – particularly all payer systems – seem to have realized relative success.

There are certain factors critical to the success of rate setting systems:

- statutory flexibility appears to be vital to the long term viability of any regulatory system, which must be able to adapt to a rapidly changing environment;

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[110] *supra* at 63
[111] *supra* at 59
[112] *id*
[113] *id*

- rate setting systems must have the authority to limit payer discounts in order to avoid an erosion of the system (and hospital financial viability) created by lopsided negotiating power of a few influential payers;
- there must be solid political support for the system; and
- the inclusion of all payers – including Medicare – under the rate setting scheme provides great strength to the system by minimizing cost shifting and maximizing equity among payers.

The Maryland program is the best example of a successful system, as demonstrated by the fact that it is still functioning after three decades. At the outset of the regulatory program, Maryland had the highest hospital costs in the nation; at the close of the last decade those costs were at the national average.[114]

The success of rate setting must be evaluated in light of its goals. Most systems were implemented to control the rate of increase in hospital care; quite simply, they achieved that goal. It was perhaps the short-sightedness of policymakers that early cost containment efforts were not focused on health care expenditures, generally, but that was not the explicit focus or purpose of enacted rate setting statutes. Moreover, rate setting was intended to accomplish a more equitable distribution of the cost of caring for the medically indigent, relieving individual hospitals from extraordinary bad debt and charity care burdens by spreading subsidization of such costs equally across all other payers. This objective was also realized, and was one of the most important contributions of rate setting, enhancing access to hospital care for those states' most vulnerable citizens.[115] While cost containment might be achieved through the use of other strategies, such as capitation and managed care, payer equity is unique to the rate setting approach.

[114] Maryland Health Services Cost Review Commission. Report to the Governor for Fiscal Year 2001.
[115] *id*

Managed Care

Background

Although we tend to think of managed care as a relatively new phenomenon, prepaid care actually dates back to the late 1920s. The forerunners of the modern HMO were born out of a farmers' cooperative in Oklahoma and in LA, where the Ross-Loos Medical Group provided prepaid care to the employees of LA County's Water and Power, and their dependents.[116] Like today, the initial growth of prepaid care was stimulated by business and community groups searching for ways to increase the availability of affordable health care.

In the early 1930s, a single physician – a surgeon practicing in southern California – began a prepaid health plan for workers building the Los Angeles aqueduct. Dr. Garfield was paid 10 cents/day to provide care to construction workers. This arrangement captured the attention of Henry Kaiser, a California industrialist who was looking for ways to provide health care for workers (and their dependents) involved in the construction of the Grand Coulee Dam. In 1938, Kaiser recruited Garfield to develop a prepaid group practice at a hospital located in close proximity to the construction site. The dam was nearing completion when WWII broke out, bringing an influx of workers to Kaiser's shipyards and presenting Kaiser with the challenge of providing affordable health services to 30,000 employees. Once again, Kaiser persuaded Garfield to take up the challenge and the prepaid group practice came to San Francisco. At the height of the war, the new plan served as many as 200,000 members.

In 1945, the Kaiser health plans were open to community enrollment and, in the early 50s, enrollment reached a quarter million members. In 1955, the corporate entity known as Kaiser Permanente was formed out of the early health plans – plans that exist to this day. Kaiser Permanente now operates managed care plans across the country that, in 1990, boasted 6.5 million members.[117]

Another of the earliest managed care plans, Group Health Cooperative of Puget Sound was launched in 1947. Today, GHCPS is the largest consumer-governed health care organization in this nation and is still operated as a cooperative. Based in Seattle, GHCPS cares for 10% of Washington residents along with residents of northern Idaho, and has a membership of over 600,000.[118]

[116] HAP Website. www.hapcorp.org, April 2002.
[117] Kaiser Permanente Website. www.kaiserpermanente.org. April 2002.
[118] www.ghc.org. April 2002.

As health care costs escalated in the 1960s, calls for cost containment grew. The Nixon administration promoted the growth of prepaid health plans as part of the answer to the growing cost crisis, coining the term "health maintenance organization." In 1973, on the heels of the amendments to the National Health Planning Act allowing rate setting (which occurred in 1972), Congress enacted the Health Maintenance Act. This statute encouraged the development of HMOs by making federal funds available for grants and loans for the establishment of new health plans and by requiring employers who offer health insurance to offer an HMO option, when available. By the end of 1978, there were more than 200 HMOs operating in over 37 states.[119] In 1981, Congress once again demonstrated its interest in managed care with the passage of OBRA, where it authorized states to demonstrate new models of financing and delivering care to Medicaid recipients. This authorization included the establishment of the "freedom of choice" waiver, which permitted states to restrict recipients' access to health care providers for the first time. The bill also relaxed the contracting requirements facing states wishing to enroll beneficiaries in HMOs.[120]

The basic premise of managed care is that effective health care services may be provided with greater efficiency (including cost efficiency) if providers are encouraged to make wise and careful treatment decisions. In managed care systems, the payer attempts to influence the service provider using any variety of strategies, including financial incentives, prior authorization requirements for certain procedures or services, the establishment of "best practices" and treatment protocols.[121] Some of the earliest managed care models completely blended the payment and provider mechanisms, with payers using staff physicians (and sometimes their own hospitals) to deliver care to members. Others put the physician at financial risk for service utilization above actuarially expected levels, creating strong incentives for careful treatment decisions.

Now the line between these varieties of managed care organizations is blurring. Commercial insurers now offer products that look similar to HMO plans, with preferred provider networks and physician financial incentives to constrain costs. HMOs have spun-off point of service products, that relax member restriction to a particular set of physicians. Still, the objective remains the same: lower costs and lower rates of growth in costs – and, therefore, in premiums.[122]

The growth of managed care has been remarkable – it has even been characterized as a "revolution" by the industry.[123] During the 1980s, as employers looked for strategies to help them budget for and contain the cost of health benefits, the number of HMOs more than doubled and enrollment

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[119] *supra* at 116

[120] Previously, states had been only allowed to enroll recipients in federally qualified prepaid health plans with less than 50% Medicaid or Medicare enrollment.

[121] Claxton G. *How Private Health Insurance Works: A Primer.* Kaiser Family Foundation. April 2002.

[122] *id*

[123] Ignani K. Covering a Breaking Revolution. *Hlth Aff.* Vol 17(1):26-34. January/February 1998.

quadrupled.[124] Enrollment continued to expand during the early 90s, reaching an average annual growth rate of almost 7%; approximately 78 million Americans were enrolled in managed care plans by 1998.[125] In 1988, only 18% of employees in mid- to large-sized companies were enrolled in HMOs. Ten years later, that figure had grown to over 50%.[126] In 1995, nearly 70% of all covered lives were in managed care products; that figure is projected to increase to more than 90% by 2007.[127]

The trend toward managed care has also been felt in the public sector, as states searched for answers to the challenge of rising costs. In 1983, 750,000 Medicaid recipients were enrolled in managed care programs.[128] That number grew to 4.8 million by 1993[129] and to 18.8 million by 2000.[130] Managed care has been the dominant delivery system in Medicaid since 1998 serving those with complex needs as well as families.[131] Fifty-five percent of Medicaid beneficiaries were enrolled in one of more managed care programs in 2000.[132] As of the end of 2001, 31 states and the District of Columbia enrolled proscribed categories of Medicaid beneficiaries in limited areas of their jurisdictions into managed care plans under the authority of federal 1915(b) waivers (waiving comparability and statewide application). Nineteen states had active Section 1115 waivers, allowing for the implementation of mandatory, statewide managed care enrollment.[133] The share of the Medicaid population in managed care rose from less than 10% in 1991 to more than 50% by late 1998, reflecting states' desires to control costs and improve continuity of care through managed care.[134]

Growth of managed care continued into the mid-1990s, not flattening out in the commercial sector until 1996; Medicaid enrollments began to stabilize in 1998 although it continued to grow slowly through 2000.[135] The slow-down in Medicaid managed care is interesting in light of the fact that in 1997, Congress enacted the Balanced Budget Act, which allowed states to require enrollment in managed

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[124] *id*
[125] *Health and Health Care 2010: The Forecast, The Challenge.* The Institute for the Future/ IOM. Jossey-Bass. January 2000. San Francisco.
[126] Reschovsky JD, Kemper P. Do HMOs Make a Difference? *Inquiry.* Vol 36: 374-377. Winter 1999/2000.
[127] *id*
[128] Brach C, Scallet L. Trends. A E Casey Website. ww.aecf.org/publications/challeng/trends.htm. May 2002.
[129] *id*
[130] Medicaid and Managed Care. Kaiser Commission on Medicaid and the Uninsured Fact Sheet. December 2001.
[131] Kaye N. *Medicaid Managed Care: A Guide for States, 5th Ed.* National Academy for State Health Policy. 2001. Portland, ME.
[132] *id*
[133] *id*
[134] Long SK, Coughlin TA. Impacts of Medicaid Managed Care on Children. *HSR.* Vol 36(1)Part I:7-23. April 2001.
[135] *supra* at 131

care without special waivers[136] and which lifted a previous federal ban on Medicaid-only managed care plans. The increased flexibility granted to states has not yet stimulated any marked upswing in managed care enrollment. This is likely due, in part, to a trend among managed care companies to exit the Medicaid market; by 1998, there were far more companies leaving that market than entering it.[137] This trend was probably related to the fact that Medicaid reimbursement rates have historically been below commercial reimbursement rates. Federal waivers require state managed care systems to be budget neutral, thereby forcing capitation rates to be lower than those offered by commercial products, making provider participation difficult to sustain.

The American love affair with managed care was fueled by a period of increases in health care costs that, in turn, generated considerable increases in health care premiums. Managed care plans were typically priced lower than traditional indemnity products, and consumers/payers consistently opted for lower premiums over free choice of providers, migrating away from indemnity plans. In Minnesota, researchers documented an 8.6% decline in indemnity market share for every 1% increase in the premium differential between HMO and indemnity products.[138] Fearing they would be left out in the cold, providers joined managed care networks so they could care for enrollees.

As managed care plans gained market share, they used their new-found power to leverage deeper provider discounts, trim provider networks and transfer risk to providers such as hospitals and physicians.[139] Despite the curtailment in access, consumers still flocked to the plans,[140] [141] ever increasing the managed care market position. This triggered rounds of consolidation by both providers and – as a reaction – health plans, to try to reach some form of market stasis. Vertical and horizontal integration became *de rigueur*, and reimbursement mechanisms have grown increasingly complex. Undoubtedly, we have not seen the end of this transformation, yet the precise future of managed care remains unknown.

Characteristics

There are many different configurations of managed care, each utilizing different payment mechanisms. These range from staff model HMOs, to prepaid group practices, independent practice associations and loosely affiliated networks of providers associated with a managed care insurer. There are global capitation

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[136] The exception being the case of children with special needs, dual eligibles and Native Americans.
[137] *supra* at 134
[138] Zwanziger J, Melnick GA. Can Managed Care Plans Control Health Care Costs? *Hlth Aff.* Vol 15(2):186-199. Summer 1996.
[139] *id*
[140] *id*
[141] This refers *consumer* choice of managed care plans over more traditional policies as opposed to a choice by purchasers or employers to offer only managed care plans.

models, where providers are at risk for all health care services, partial capitation models, discounted fee for service arrangements, and primary care case management, with many providers bearing essentially no risk at all. By the end of the 1990s, payment arrangements in managed care plans broke down into four major categories as follows:

- 10% of enrollees were in plans that used global capitation;
- 17% were in plans capitating physician services only;
- 29% of enrollees were in discounted fee for service plans that used withholds and risk pools; and
- 44% were in plans that employed only discounted fee for service arrangements.[142]

Regardless of the particular shape or form of managed care, plans use provider arrangements, financial incentives and administrative tools to reduce the use of unnecessary services and costs while, simultaneously, striving to improve the quality of care. While managed care products generally lower financial barriers for consumers (e.g. by employing modest copayments as opposed to substantial deductibles and, often, through lower premiums), they often use financial incentives – such as capitation – with providers to encourage a more efficient use of services. This particular attribute is often viewed as setting up a disincentive for providers to deliver needed patient care.

Through the use of broad benefit plan designs, managed care plans tend to provide enrollees coverage for primary and preventive services to a greater degree than traditional indemnity products do.[143] These plans maintain relationships with physicians who agree to abide by prescribed participation principles. Enrollee access to care is ordinarily gained through one of these participating providers and specialty care is usually obtained via referral from a patient's primary care physician – the "gatekeeper", which is, in turn, sometimes subjected to prior authorization by the managed care company. Plans try to encourage the use of less expensive care as a substitute for more costly care and to rein in the use of services deemed to have only marginal utility.

Clearly there are trade-offs for consumers involved in choosing between a managed care plan and an indemnity product. On the one hand, the managed care products offer a broader range of benefits at a potentially lower out of pocket cost to the patient. On the other, managed care plans typically restrict access to services. As noted earlier in this paper, consumers' sensitivity to price is high, thus making the lower financial barriers characteristic of HMOs or other managed care plans relatively more attractive than non-HMO products. In fact, privately insured (nonelderly) HMO enrollees generally have lower incomes than that of non-HMO enrollees, increasing their price sensitivity; many more HMO

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[142] *id*

[143] Tu HA, Kemper P, Wong HJ. Do HMOs Make a Difference? Use of Health Services. *Inquiry.* Vol 36:400-410. Winter 1999/2000.

enrollees report a willingness to trade choice for cost savings and prefer policies with lower out of pocket costs.[144] They are also more likely than their non-HMO counterparts to be single, younger and part of a minority group.[145]

Impact

There are several major axes along which we might evaluate the impact of managed care. They are: access to services, service utilization and cost, quality of service provided, and consumer satisfaction.

There is a well-developed literature on the issue of the impact of managed care on enrollees.[146] However, many articles report on studies done with limited data sets and findings are not suitable for generalization. The Community Tracking Study Household Survey, conducted in 1996-1997, avoids that problem by taking a large, nationwide sample.[147] These survey data were used by investigators at the Center for Studying Health System Change to assess the impact of HMO enrollment on access, service utilization and consumer assessment. The investigators adjusted the data for differences in health status, income, enrollee demographic characteristics, enrollee preferences and available insurance options.[148] They also adjusted the data for differences in each of the local health care markets from which survey data were obtained. These adjustments allowed the survey data to be aggregated and used for purposes of making generalized statements regarding HMO versus non-HMO experiences. Prior to this work, observations could be made at the plan level, but could not be generalized.

Access to Care

As pointed out by Reschovsky, despite general fears that HMOs may leave patients – particularly those with chronic health conditions – out in the cold, without access to needed care, there is very little empirical evidence that might justify those fears.[149] The Community Health Tracking studies found the same to be true. HMO enrollees are less likely to face financial barriers to care, such as high out of pocket costs; non-HMO enrollees were more likely to report that they did not receive needed care because of financial barriers.[150] HMO enrollees are significantly more likely to report that they have a usual source of care, but are significantly more likely to report experiencing a delay in receiving what they perceive to be necessary care or having unmet needs due to restrictions in access to providers.[151] HMO enrollees are also more likely to report

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[144] Kemper P, Reschovsky JD, Tu HT. Do HMOs Make a Difference? Summary and Implications. *Inquiry.* Vol 36:419-425. Winter 1999/2000.
[145] *id*
[146] Reschovsky JD. Do HMOs Make a Difference? Access to Health Care. *Inquiry.* Vol 36:390-399. Winter 1999/2000.
[147] Center for Studying Health System Change Website. http://www.hschange.com, April 2002.
[148] These data relate exclusively to privately insured persons
[149] *supra* at 146
[150] *id*
[151] *id*

experiencing unmet or delayed health care needs as a result of convenience or organizational factors such as waiting time for appointments, or office hours. However, in all cases where there are statistically significant differences between HMO and non-HMO enrollees, they are relatively modest differences. Long and Coughlin report similar findings with respect to the experience of children covered by Medicaid who are enrolled in managed care plans.[152]

Utilization of Services

Using the Community Tracking Study data, Tu and colleagues examined the impact exerted by HMOs on the use of services.[153] They found that HMO enrollees exhibit a higher use of ambulatory services, generally, than do non-HMO enrollees; this difference is significant, but modest. HMO enrollees demonstrate a greater likelihood of making any ambulatory visit and those making at least one visit tend to make more visits than their counterparts outside the HMO. This same trend is documented in the use of physician visits, particularly, although those data reflect a preference for – or greater use of – primary care physicians as opposed to specialists. The difference in receipt of mental health services between HMO and non-HMO enrollees is not statistically significant.

HMO enrollees are more likely to receive preventive services such as mammography and flu shots, but there is little evidence to support the hypothesis that HMOs markedly reduce the use of hospital care or surgery. Further, there is no evidence that HMOs substitute outpatient surgery for inpatient surgery.[154] Miller and Luft found that HMOs had lower use of expensive procedures, tests and treatments that could be substituted for by lower cost alternatives;[155] in a more recent literature review, these same investigators failed to turn up any documentation of differences in resource utilization.[156]

Long and Coughlin report finding few differences between Medicaid children enrolled and not enrolled in managed care with respect to utilization.[157] Rowland and colleagues note that the impact on the use of physician services by Medicaid enrollees in managed care programs is mixed, with primary care case management participants being more likely than HMO participants to have increased numbers of office visits.[158] Their study also found a decline in the non-urgent use of emergency department services and a lower use of specialty

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[152] *supra* at 134

[153] Tu HT, Kemper P, Wong HJ. Do HMOs Make a Difference? Use of Health Services. *Inquiry.* Vol 36:400-410. Winter 1999/2000.

[154] *id*

[155] Miller RH, Luft HS. Managed Care Plan Performance Since 1980: A Literature Analysis. *JAMA.* Vol 271(19):1512-1519. May 18, 1994.

[156] Miller RH, Luft HS. Does Managed Care Lead to Better or Worse Quality of Care? *Hlth Aff.* Vol. 16(5):7-25. September/October 1997.

[157] *supra* at 107

[158] Rowland D, Rosenbaum S, Simon L, Chait E. *Medicaid and Managed Care: Lessons from the Literature.* Kaiser Commission on the Future of Medicaid. March 1995. Menlo Park, CA.

referrals, than demonstrated in the fee for service Medicaid population. Finally, Rowland, *et al*, note that managed care does not appear to impact the use of preventive services by Medicaid beneficiaries, with both fee for service and managed care populations being low utilizers of such care.[159]

Quality

Undoubtedly, we have all read and heard horror stories about the quality of care provided to patients in managed care plans. The use of provider financial incentives such as capitation – which puts providers at risk for the total health care costs of a given enrollee – does have the potential for promoting undertreatment in favor of maximizing a provider's revenue. However, the empirical data do not support the popularized notion.

Long and Coughlin found that Medicaid children enrolled in managed care plans did not receive substandard care.[160] Rowland and colleagues found little difference between the quality of care provided under Medicaid managed care to that delivered to the Medicaid fee for service population.[161] In a 1997 meta-analysis, Miller and Luft found the published studies split on this issue, with half of the papers citing improvements in quality and outcomes, while the other half cited degradation in care. They note that the public's fears that managed care will always lead to worse care are unfounded. By the same token, they note that hopes for quality improvement under managed care are unsupported, as well.[162] This contention is supported by the Committee on Quality Health Care in America, which prepared the IOM's report entitled *Crossing the Quality Chasm.* That report notes that the published literature neither supports nor refutes the argument that managed care promotes poor quality care.[163]

The one instance where a difference in quality of care was documented is noted in Miller and Luft's research. The Medical Outcomes Study found that chronically ill elderly enrollees enrolled in HMOs experienced better quality of care for mental health.[164]

Consumer Satisfaction

Community Health Tracking data demonstrate the HMO enrollees report less favorable "reviews" of their health care plan than do non-enrollees, the only exception being the level of trust they have in their physician to provide only necessary services.[165] Although statistically significant, the differences are modest. Importantly, most enrollees – regardless of plan type – give generally high satisfaction ratings to their plans; only a small percentage of HMO enrollees

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[159] *id*
[160] *id*
[161] *supra* at 158
[162] *supra* at 156
[163] Committee on Quality Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Institute of Medicine. 2001.
[164] *supra* at 156
[165] Lake T. Do HMOs Make a Difference? Consumers Assessments of Health Care. *Inquiry.* Vol. 36:411-418. Winter 1999/2000.

give unfavorable reviews. In their 1994 meta-analysis, Miller and Luft found that HMO enrollees were generally less satisfied with the non-financial aspects of their coverage, but were generally more satisfied with the financial aspects of their plan.

Long and Coughlin report little difference in satisfaction between HMO enrollment and non-HMO enrollment for Medicaid children. Fraser and colleagues report a relationship between having a choice of plans and satisfaction with managed care enrollment among Medicaid beneficiaries.[166]

Cost

The question of managed care's impact on cost is answered differently depending upon whom you ask the question and how you ask it. In a 1996 paper, Zwanziger and Melnick describe the evolution of managed care in California and Minnesota, which led the nation in the deployment of this type of health care financing and delivery. These authors argue that the price competition between plans and providers stimulated by the dissemination of managed care into a market motivates both parties to control costs and present data that show that as HMO penetration in an area increases, insurance premiums tend to fall. In the work reviewed by Zwanziger and Melnick, there was a demonstrated reduction in hospital costs in California markets characterized by a high managed care presence; these reductions were of the same magnitude as those achieved by rate regulation in New York and New Jersey. They concede, however, that they are not able to clearly attribute these declines to lower costs. Still, they argue that managed care has succeeded in reducing the rate of growth in health care costs, demonstrating that the market can successfully assume a pseudo-regulatory role.[167]

In their 1994 literature review, Miller and Luft were able to identify relatively scanty evidence regarding the impact of managed care on costs. They found no significant differences in charges per admission or in ambulatory expenditures per enrollee. They uncovered some data indicating that managed care enrollees did experience somewhat lower total expenditures per capita.[168]

Sullivan notes in a recent article that the boast of efficiency attributed to managed care plans has reached folkloric status. He argues that there is evidence that managed care, while perhaps generating lower medical costs, presents higher administrative costs for both the insurer and participating providers. He adds that managed care plans also force cost shifting to fee for service payers by demanding deeper discounts of providers. Both of these factors may actually increase total health care costs, rather than contributing to a decline. He reconciles the apparent conflict between the proliferation of

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[166] Fraser I, Chait E, Brach C. Promoting Choice: Lessons from Medicaid Managed Care. *Hlth Aff.* Vol 17(15):165-174. September/October 1998.
[167] *supra* at 138
[168] *supra* at 155

managed care plans and declines in health care inflation occurring in the mid-1990s by crediting, instead, the convergence of a downturn in the insurance underwriting cycle, the recession of the early 90s, and the political support for managed care as an answer to cost inflation.[169]

Long and Coughlin document a reduction in Medicaid expenditures associated with the enrollment of children in managed care plans. They note that such reductions were achieved primarily through use of lower rates of payment, without adversely impacting access or quality.[170] Rowland found mixed results relative to cost savings, with full risk capitation arrangements generating greater reductions in expenditures than primary care case management programs.[171]

Hurley and Rawlings examine the question of cost containment in a recent (2001) paper entitled "Who Lost Cost Containment: A Roster for Recrimination." They posit that the rise of premium costs in the late 90s is suggestive of a failure on the part of managed care to contain health care costs. They wonder whether health care costs ever really were in hand or were the downward premium trends of the mid-90s simply reflecting underbidding by insurers to attract enrollees. Cautioning that premiums are not entirely representative of cost, they concede that there was, in fact, a slowdown in medical expenditures during the early to mid-1990s, which were most pronounced in the hospital and physician sectors.[172] They note, though, that the blame for managed care's failure to control premium costs over the longer term is one that must be shared by employers, providers, plans and consumers, with each playing a key role in the breakdown of its promise.

Lessons Learned and the Future

Managed care and the health care market are both moving targets, moving so quickly as to make predictions regarding the future rather difficult. Still, it seems fair to say that the status of managed care has come down a notch or two in the past several years as premium costs have begun to skyrocket once again.

The salient lessons that may be gleaned from the managed care experience to date are:

- Managed care plans tend to provide comprehensive benefit packages with less out of pocket cost to the consumer, at a more attractive price;

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[169] Sullivan K. On the "efficiency" of managed care plans. *Int J Hlth Svc.* Vol 31(1):55-65. 2001.
[170] *supra* at 134
[171] *supra* at 12
[172] Hurley R, Rawlings RB. Who Lost Cost Containment? A Roster for Recrimination. *Mgd Care Qrtly.* Vol 9(4):23-32. 2001.

- Consumers, whose price sensitivity relative to insurance costs is high, tend to prefer managed care plans due to the lower financial costs of those plans;
- Consumers are generally satisfied with the financial aspects of managed care plans, but are less satisfied with the administrative features of the plan designed to control access to services;
- Managed care plans do impact utilization of certain services, but it is not clear that these plans adversely impact the quality of care;
- Evidence of managed care's ability to constrain health care costs is mixed; it is not clear whether today's rising health care costs reflect a failure of managed care or simply the correction of a competitive insurance market flooded by underbidding.

Rising premiums have encouraged purchasers to shift more and more risk to enrollees, in the form of cost sharing for coverage, reductions in the scope of coverage and increases in copayments for services.[173] If the economy remains in a slump and the job market loosens, these shifts will probably continue. Because managed care consumers are attracted to and satisfied with their plans' financial characteristics and relatively dissatisfied with the organizational aspects of those plans, increased enrollee cost sharing will likely fuel growing frustration with managed care. Moreover, Americans are voracious in their appetite for top-notch health care that is easily accessed, whenever and wherever they want or need it, but are loathe to pay high prices for it.[174] It is that basic dilemma which continues to plague policymakers as they move ahead into the 21st century.

It is important to bear in mind that the market has not really allowed managed care to operate in accordance with the conceptual framework originally designed for health maintenance organizations. These organizations were designed to make use of best practices, treatment protocols, and risk sharing arrangements to incent appropriate provider behaviors. Instead, they have evolved into variants that rely on negotiating positions and prior authorization to control costs. Perhaps the most important lesson to be learned here is that it is unreasonable to expect managed care to live up to its promises if it is not allowed to be implemented as intended.

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[173] *supra* at 12
[174] *id*

Regulation of Health Insurance

Background

Issues surrounding the cost of health insurance are virtually inseparable from the cost of care and cost containment generally. While some have attributed rising premium costs to failures of managed care systems, others have suggested that, perhaps, health care costs have never really been under control, with the low premiums of the first half of the 1990s reflective of insurer underbidding in a competitive marketplace.[175] However, the reasons for the rise and fall in premium costs include factors both related to the underlying cost of care and to factors unrelated to those costs such as the underwriting cycle and a need to maintain profit margins.

Health insurance is often blamed as being a major contributor to the crisis in health care costs because it tends to cushion health services consumers from the true costs of care, contributing to market failure.[176] As the cost of coverage spirals upward (again, for reasons both related and unrelated to the underlying costs of care), there will likely be a trend toward increasing numbers of uninsured, particularly if the economy remains in a slump.[177] Increases in the numbers of uninsured individuals will place additional stress on providers' ability to deliver uncompensated care.[178] Providers – particularly hospitals – subsidize care for medically indigent persons through several mechanisms: public financing from tax revenues, uncompensated care pools where they exist, Medicare/Medicaid and disproportionate share payments as well as private financing via philanthropy and cost shifting to other payers.[179] The reality of limited resources threatens the viability of providers already operating at thin margins.

There is ample evidence that uninsured persons – and those persons faced with substantial cost sharing (as may be imposed in an effort to dampen premium increases and curb demand-side inflation) – have poorer access to care and lower use of health services.[180] [181] The uninsured are more likely to experience

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[175] *supra* at 172
[176] *supra* at 21
[177] Miller JE. A Perfect Storm: The Confluence of Forces Affecting Health Care Coverage. National Coalition on Health Care. November 2001.
[178] Smith BM. Trends in Health Care Coverage and Financing and Their Implications for Policy. *NEJM.* Vol 337(14):1000-1003. October 2, 1997.
[179] Cunningham PJ, Tu HT. A Changing Picture of Uncompensated Care. *Hlth Aff.* Vol 16(4):167-175. July/August 1997.
[180] Holohan J, Spillman B. Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance. Urban Institute New Federalism Program Briefing. Series B, No. B-42. January 2002.

potentially avoidable hospitalizations for conditions that could be more efficiently treated on an outpatient basis,[182] if access to such care was reasonably available. When they do seek hospital care it is often at a point when their medical condition reaches a crisis point – making their care more costly.

The effectiveness of cost sharing mechanisms may be mitigated by the simple reality that a minority of patients generates the vast majority of health care expenditures.[183] Because these people are ill, they would likely receive services, regardless of the cost sharing design employed; the imposition of cost sharing in this situation is unlikely to influence the level of utilization. Use of cost sharing devices are probably only marginally effective in impacting levels and patterns of utilization.[184]

Controlling the cost of insurance is, like other regulatory strategies, a lever policymakers may employ as part of a comprehensive cost containment program. While this approach may not exercise a direct impact on the cost of care, it carries with it the possibility of a substantial indirect effect on the cost and viability of the current system.

The concept of insurance – any type of insurance – is protection from individual, potentially catastrophic losses by spreading risk over a larger population. Health insurance is predicated on the same notion, with a bit of a twist. While there are many ways in which society strives to protect the health of citizens – for example, through efforts to maintain clean air and water – exposure to the risk of major expenses related to illness can be devastating. We seek to protect our assets should we become ill and we seek the ability to access expensive medical care which likely exceed our individual resources, should we need it. Health insurance is a form of income transfer, allowing those who are sick to obtain more medical care than they likely would if they were uninsured.[185]

CPS data indicate that more than 200 million Americans were covered by private health insurance in 2000.[186] More than 80% of these people are non-elderly who receive benefits through an employer-sponsored plan.[187] While a substantial number of people are covered by self-funded plans, many participate in

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[181] *The Uninsured and Their Access to Health Care.* Kaiser Commission on Medicaid and the Uninsured. January 2001.
[182] *id*
[183] *AHRQ Has New Data About Cost of Health Care.* Press Release, July 10, 2000. Agency for Healthcare Research and Quality, Rockville, MD. http://ahrq.gov/news/press/pr2000/meps96pr.htm. June 14, 2002.
[184] Personal communication with Scott Leitz, director of the Health Economics Program, Minnesota Department of Health, June 13, 2002.
[185] Nyman JA. The Theory of the Demand for Health Insurance. *Division of Health Services Research and Policy Research Brief.* University of Minnesota School of Public Health. Vol 9(3). April 2002.
[186] CPS Website. http://www.ferret.bls.census.gov/macro/032001/health/h01_001.htm. May 20, 2002.
[187] *supra* at 121

commercial health plans, health maintenance organizations and not-for-profit Blue Cross Blue Shield plans. The federal Employee Retirement Income Security Act of 1974 (commonly known as ERISA) governs the conduct of all self-funded plans, but oversight of the business of health insurance products falls primarily to the states. This has been the case since 1945, when Congress enacted the McCarran-Ferguson Act, clarifying the states' leading role in the regulation of the insurance business,[188] a delegation of responsibility that is reaffirmed by ERISA.

Health insurance is important not only to those who are covered by it, but to the provider community as well. Providers rely on health insurance as a "guaranteed" revenue stream. Medicare, Medicaid or other state-funded benefits programs often do not pay 100% of provider charges and providers are restricted with regard to their ability to balance bill for the difference. The uninsured generally have the least ability to pay, leaving the privately insured to absorb much of the otherwise unreimbursed expense of providing services to the broader public. While the market power of payers often leads to the negotiation of contractual allowances (discounts from charges), this class of patients – the privately insured – represents one of the few realistic targets for provider cost-shifting. To the extent that providers are unable to recover the legitimate costs of producing care, their fiscal viability may be threatened, as may access to care.

Over the past several years, we have witnessed dramatic increases in insurance premium prices. Although the underlying causes for this inflation are debatable, it is clear that such increases will eventually have an impact on the numbers of people who are covered by private insurance, especially if the economy remains sluggish. Employers are already beginning to shift more of the costs – along with risks for costs - of health care to their employees.[189] If it continues, this trend may result in growth in the numbers of persons who are uninsured, despite their employment status, generating a potential growth in the numbers of people who rely on public benefits. This contingency holds obvious implications for state governments, many of which are facing difficulty in maintaining the health benefits programs they now provide due to shrinking budgets and health care cost inflation. These concerns help motivate public strategies to assure that private health care coverage remains affordable and available, forming the impetus for the regulation of the insurance industry.

Types of Regulation

States typically focus their regulatory efforts relative to health insurance in the following areas: licensure, business practices, financial standards, access to coverage, access to services and premium pricing/rating.

The most basic type of regulation applied to health insurers (commercial and otherwise) is the requirement of state licensure. While at its most fundamental

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[188] *id*

[189] Swartz K. "Enron-ing" Health Insurance. *Inquiry*. Vol. 38(4):344-346. Winter 2001/2002.

level, licensure constrains entry into a market, it is also used as a mechanism to assure that insurers and others offering health benefits coverage (HMOs) meet certain financial standards.

Importantly, licensure involves a review of a company's financial status, including capitalization, investments and capacity to maintain reserves adequate to cover anticipated claims. These reviews are aimed at evaluating the current and likely future financial solvency of the plan, the primary goal of regulators.[190] The process of licensure also includes an assessment of whether the company is actually able to provide the coverage promised in the markets (group, small group, individual) they are entering.

Business practices such as marketing, advertising, claims processing systems and so on, are overseen by state regulators. Policy forms, language and disclosures are also subject to oversight, with consumer protections in mind. Standard terminology is often required, making it easier for consumers to understand and compare plan offerings and contracts. The provision of information to consumers is also the subject of regulation; many states specify the items of information insurers are required to disclose. This may include details as specific as the methods used by the company to share risk with providers (in the case of HMOs, for instance). Other states, like California, publish "report cards" that facilitate comparisons of cost and quality across plans.[191]

There are a variety of regulatory approaches employed to control access to coverage, particularly in the small group and individual markets. Insurance reforms enacted in HIPAA have their roots in state strategies. These strategies include guaranteed issue, guaranteed renewability, rating factors and community rating. Entry into an attractive and potentially lucrative market is sometimes predicated on an insurer's agreement to participate in somewhat less attractive markets, as well. Some states, Massachusetts, for example, require insurers covering more than 5,000 enrollees in the small group market to provide guaranteed issue policies in the individual market, as well.[192] Similarly, a 1992 law required group carriers doing business in New Jersey to either offer individual coverage or pay an assessment to subsidize the losses of carriers operating in that market.[193] By the end of 1999, 50 states had implemented statutes requiring guaranteed issue and renewal of all products in the small group market; 7 states required guaranteed issue of all products and 9 required

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[190] Structuring Health Insurance Markets: Protecting Consumers and Protecting Competition. Agency for Health Care Policy and Research. Summary of May 1998 ULP Conference. Website: http://www.ahcpr.gov/news/ulp/ulpmarkt.htm. May 22, 2002.

[191] *see* for example: http://www.hmohelp.ca.gov/pa. June 6, 2002.

[192] Massachusetts Division of Insurance. Bulletin 97-07:Implementation of the Massachusetts Nongroup Health Insurance Law. June 9, 1997.

[193] New Jersey Department of Banking and Insurance/New Jersey Individual Health Coverage Board/New Jersey Small Employer Health Benefits Program Board. Individual and Small Group Health Insurance Markets: Progress Report; August 1993-April 1996.

guaranteed issue of *some* products in the individual market. By that time, however, all 50 states required guaranteed renewal of individual policies.[194]

State regulations also specify the conditions under which policyholders may add or drop dependents, including mandating coverage of adopted children equivalent to natural children and of handicapped children. Pre-existing condition clauses are in place in 50 states, limiting the waiting periods that can be imposed as part of benefits coverage for specific medical/physical conditions and limiting the maximum number of months an insurer can "look back" at an individual's experience to impose a pre-existing condition restriction.[195] Again, restrictions imposed on the small group market by regulators are more stringent than those applied to companies doing business in the individual market.

Guaranteed renewability requirements define the extent to which consumers have the right to renew a policy at its anniversary date, without being subject to risk reevaluation. Such provisions assure that policyholders who become ill during the period of time a policy is in force aren't subject to "churning" by the insurer. That is, the insurer's ability to drop a high risk enrollee (or force disenrollment through marked rate increases) is limited and cannot be carried out for reasons designed to avoid risk or future claims. Similarly, some states limit insurers' ability to preclude coverage for individuals with pre-existing medical conditions, prescribing the circumstances under which any such limitations may be imposed.

While states differ in their approach to access to coverage in the small group and individual markets, all states have laws that require state licensed health benefits companies to offer or include coverage for certain services referred to as mandated benefits.[196] The range of such services varies substantially from state to state, but can include but is not limited to access to alternative or complementary medical services such as chiropractic, naturopathy and acupuncture, maternity care for both married and unmarried women, newborn services, and mammography. Mandated benefits do generate increases in premium costs, but these increases are relatively modest.[197] Parity for mental health benefits, access to breast reconstruction services for mastectomy patients, and minimum inpatient stays for maternity care are now specified in federal law (*see* the 1996 Mental Health Parity Act, the 1998 Omnibus Consolidated and Emergency Supplemental Appropriations Act, and the 1996 Newborns' and Mothers' Health Protection Act, respectively). Costs associated with mental health parity have been documented as being negligible, when

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[194] Chollet DJ, Kirk AM, Simon KH. *The Impact of Access Regulation on Health Insurance Market Structure.* DHSS. October 20, 2000.
[195] *id*
[196] *supra* at 178
[197] *Mandated Health Insurance Benefits and Health Care Costs.* Minnesota Department of Health, Health Economics Program Issue Brief 2001-02. July 2001.

benefits are offered within a managed care context or substantial, when benefits are not subject to managed care.[198]

In addition, some states – Maine, for example – impose requirements on organizations that restrict enrollees to a network of participating providers. These requirements may include proof of sufficient provider participation to ensure adequate enrollee access to primary and specialty clinicians within reasonable distances or travel times from their home or workplace.[199]

Many states regulate premium pricing for products outside the group market. This category of regulation includes the limitation of rating factors. The extent to which the premium is regulated depends on the state and the type of insurer – be it a commercial insurer, an HMO/PPO or a non-profit health and medical services plan such as certain Blue Cross/Blue Shield programs. Actuarial fairness is the objective of this regulatory approach, discouraging the strong incentive for health plans to segment the market and decrease their exposure to risk.

Some states, including New York and Minnesota, regulate minimum loss ratios for certain lines of health insurance business,[200] [201] above and beyond the minimum loss ratios established by the federal OBRA legislation for Medicare supplemental policies. These provisions effectively limit the proportion of the premium dollar that may be used to fund administrative costs and/or profit, thus guaranteeing the consumer a minimum direct health services value for his/her policy purchase.

Insurers – even not-for-profit insurers – are faced with incentives to segment risk to bolster earnings. In every population, there are some people who tend to incur higher medical expenses and those healthier individuals who generate very few, low cost claims. Insurers would prefer to provide coverage to people who are healthy and who are less likely to need expensive services.[202] Even when faced with constraints on segmentation, forces within insurance markets tend to incent resegmentation.[203] For example, insurers, wishing to avoid underwriting losses and desirous of holding down rates of increase in premium prices, turn to industry rating (charging differing rates to groups depending upon the type of business – high risk or low risk – the group is engaged in) when health status rating is limited. Others may raise premiums substantially at the end of the

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[198] Varmus HE. *Parity in Financing Mental Health Services:Managed Care Effects on Cost, Quality and Access.* National Advisory Mental Health Council, NIH. May 1998.
[199] *see* 24-A MRSA c56A, subchap 1,§4303.
[200] New York State Insurance Department Website. Selected Health Regulations. http://www.ins.state.ny.us/hregindx.htm. May 23, 2002.
[201] Minnesota Statutes 2001, Chapter 62A.021, Subdivision 1. Loss Ratio Standards.
[202] This is interesting phenomenon turns the social theory of insurance on its head. Insurance is intended to spread risks over a broad population, to minimize harm to individuals within the group. Market segmentation works counter to that notion.
[203] Risk-Spreading or Risk Adjustment Mechanisms. Georgetown University. Website: http://www.georgetown.edu/research/ihcrp/chep/Risksd-adjkp_wa.htm. May 22, 2002.

allowed underwriting period for pre-existing conditions, to reflect the perceived increase in their risk. Premium regulation – along with other strategies such as guaranteed issue and renewal requirements – are designed to address this issue.

Experience rating is the practice of pricing an insurance policy based on the historical claims experience for that individual or group being written. In this case, a small group with one very sick member can drive up the rates for the entire group, yielding coverage unaffordable and resulting in protection from future risk for the insurer. Community rating is the opposite of experience rating, where the premium for any person enrolling in the benefits plan is arrived at by considering the health care costs of all persons in the community or area in which the plan is offered. Neither characteristics (such as health status) nor experience of particular individuals is considered in the rate calculation, rendering this approach the closest approximation of social insurance we have through our private market mechanism. In 1999, 13 states prohibited insurers from factoring health status into their rate setting and 21 states limited the extent to which rates could be adjusted for health status.[204]

There are variants of community rating that incorporate geographic factors (allowing rates to differ based on the experience of the community in a defined geographic locale as a segment of a larger community or market) or demographic factors (allowing rate adjustments for deviations between the rated group's average age and gender distribution and that of the community's average age and gender distribution). Often, insurers' ability to modify rates for demographic or geographic factors is limited to prescribed bands; that is, rates may vary but only within a defined range say, plus or minus 20% of the average community rate.[205] In 1999, one state (New York) prohibited the application of age bands in small group markets; only two states (New York and New Jersey) prohibited that practice in the individual market.[206]

The regulation of insurers also varies by type of insurer. The rules applied to commercial indemnity products will differ from those applied to health maintenance organizations and non-profit Blue Cross Blue Shield plans.

As alluded to earlier, there is federal law that seeks to influence the business of private health insurance. ERISA, HIPAA, the ADA, the Social Security Act, the Civil Rights Act and the tax code each impact health insurance.[207] ERISA and HIPAA are two of the most important pieces of federal legislation relative to health benefits coverage. ERISA generally serves to exempt self-funded plans from much state regulation; this creates an attractive haven for larger firms that are able to afford self-funding, allowing a business to offer benefit plans that are

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[204] *supra* at 192
[205] *supra* at 178
[206] *supra* at 192
[207] *id*

exempt from state rules and mandates. Among other things, HIPAA establishes portability of private coverage for subscribers, establishes certain renewability guarantees, prohibits discrimination against less healthy individuals within groups who are seeking coverage and requires certain minimum benefit mandates. These mandates include minimum hospital stays for maternity and newborn services, breast reconstruction following mastectomy and the strengthening of mental health parity standards for large groups.

Impact of Insurance Regulation

The impact of insurance regulation differs in the group and individual markets and is not altogether clear. Although some had argued that the guaranteed issue requirements implemented by states and imposed by HIPAA on the group market would encourage insurers to flee the market, Chollet and colleagues found no evidence of that result in group markets.[208] In fact, they found just the opposite to be true. The imposition of guaranteed issue rules for all products appears to have resulted in there being more insurers operating in any given market and, arguably, more competition. In those states where guaranteed issue rules for groups are less comprehensive, the result is similar, though more modest.[209]

The number of insurers operating in individual markets was less impacted by guaranteed issue rules. However, these rules appear to have affected the relative share of the individual market enjoyed by different types of insurers. Mandating guaranteed issue of only some products has been found to favor commercial insurers; mandating guaranteed issue of *all* individual products favors BCBS and HMO plans over commercials.[210]

Guaranteed renewal rules seem to vaguely favor insurers attaining greater economies of scale (generally larger insurers); this phenomenon may, in turn, favor consumers, because the lower average costs generated by such economies may lead to more affordable premiums. Chollet *et al* also found that limits on insurers' ability to impose pre-existing condition exclusions resulted in a greater concentration of insurers within a market, favoring larger plans over smaller ones. Investigators found no impact of mandatory renewal on the individual market.[211]

Limiting exclusions of pre-existing conditions has had little or no impact on individual markets and have not resulted in any substantial adverse selection. Group markets with these limits tend to be more concentrated; that is, they have

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[208] *supra* at 192
[209] *id*
[210] *id*
[211] *id*

fewer numbers of insurers, each with larger market shares, favoring larger firms over smaller ones. [212]

The issue of mandated benefits is one that often serves as the topic of lively debate. While they assure access to certain services and/or providers, insurers sometimes argue that they can be cost drivers. However, the literature presents mixed evidence on this point. As mentioned earlier, some analysts have found that while there is indeed some cost impact of mandates, it is relatively modest.[213] Hall, *et al*, argue that elimination of mandated benefits requirements is not likely to reduce the cost of insurance in any substantial way, citing the historically poor sales performance demonstrated by "bare bones" policies.[214] These investigators hypothesize that eliminating these rules may, in fact, destabilize the markets, removing the level playing field facing all competitors and forcing traditional plans out.[215]

The published literature includes a number of investigations of the impact of mental health parity laws on the structure of the insurance market. The articles reviewed for this paper - which included literature reviews of extant publications – failed to find any substantial negative impact of this regulatory strategy. Utilization of mental health and substance abuse services was found to have increased, particularly for children, in managed care programs, *without* increases in costs. This net effect appears to be attributable to a decline in hospital days (but not in the number of admissions). At the same time though, groups not subject to the mandate tended to exhibit similar increases in treatment prevalence,[216] implying that there was a general trend towards increased use of mental health services in the market studied.

The report published by the National Advisory Mental Health Council found that mental health parity requirements have little impact on costs, perhaps less than a 1.5% impact on premiums, with a simultaneous decline in total health care costs. [217] While the Council was unable to determine any impact of the mandates on the quality of care, they found that the combination of parity and managed care results in increases in the proportion of mental health services obtained on an outpatient basis. Children especially have experienced increased access to specialty mental health services.[218]

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[212] *id*
[213] *supra* at 195
[214] Hall MA, Wicks EK, Lawlor JS. HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed. *Hlth Aff.* Vol 20(1):142-153. January/February 2001.
[215] *id*
[216] Zuvekas SH, Regier DA, Rae DS, Rupp A, Warren WE. The Impacts of Mental Health Parity and Managed Care in One Large Employer Group. *Hlth Aff.* Vol 21(3):148-159. May/June 2002.
[217] National Institute of Mental Health. *Insurance Parity for Mental Health: Cost, Access, and Quality: Final Report to Congress by the National Advisory Mental Health Council.* NIH Publication No. 00-4787. 2001.
[218] *id*

The impact of rate regulation and the impact of broad "packages" of market reforms, generally, are ambivalent. Marquis and Long[219] examined the impact of reforms implemented in eleven states and the District of Columbia during the mid-1990s. These reforms included guaranteed issue and the elimination of health status as an allowed rating factor. They failed to find any impact of these reforms on small group markets. At the same time, they were unable to conclusively find that the reforms were of any help, relative to reducing variability in premium rates or stimulating any substantial expansion of employer-based coverage.

Chollet, *et al,*[220] found that states that limit overall rate variation have markedly more insurers operating in the group market than states that do not. Similarly, they found that the requirement of pure community rating had only a slight (negative) impact on the number of insurers operating in a group market. These same constraints appeared to exercise no significant effect on the number of insurers operating in individual markets. However, they did tend to concentrate market share in the hands of Blue Cross plans, as opposed to commercial products. Regulation of minimum loss ratio failed to result in any notable impact on the number of insurers writing coverage in either market.

Using CPS data for 1990-1996, Zuckerman and Rojan[221] examined the impact of market reforms on access to coverage. Their study also failed to find any significant impact of comprehensive small group reforms on the rates of uninsured. However, they point out that these reforms have not generated any adverse impacts, either, and may have actually served to stem the erosion of private coverage. These findings are similar to those made by Sloan and Conover,[222] using data from 1989-1994.

Lessons Learned and Prospects

The efficiency of market regulation remains an open question. The evidence suggests that this type of regulation does *not* harm markets; at the same time, the efficacy of such efforts is unclear. Despite all of these efforts, increases in premium rates for all sectors of the market have caught everyone's attention over the past several years. Premiums for employer-sponsored insurance increased an average of 11% between 2000-2001, the greatest rate of increase since 1993 and the fifth consecutive year of growth in the rate of increase.[223] It appears that much of the fluctuation in premium rates is attributable to the underwriting cycle,

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[219] Marquis MS, Long SH. Effects of "Second Generation" Small Group Health Insurance Market Reforms. *Inquiry.* Vol 38(4):365-380. Winter 2001/2002.
[220] *supra* at 192
[221] Zuckerman S, Rojan S. An Alternative Approach to Measuring the Effects of Insurance Market Reforms. *Inquiry.* Vol. 36(1):44-56. Spring 1999.
[222] Sloan F, Conover C. Effects of State Reforms on Health Insurance Coverage of Adults. *Inquiry.* Vol 35(3):281-293.
[223] *supra* at 12

which generally moves over a three-year period, with premium prices lagging slightly behind general changes in health care costs. Hurley and Rawlings characterize criticism of the underwriting cycle akin to "bemoaning gravity."[224] Perhaps that cycle and its influence on premium fluctuations will, like gravity, always be with us.

Still, it seems important to bear in mind the possibility that market reforms have prevented or slowed erosion of coverage. While not proven, the importance of this potential cannot be ignored by those struggling to maintain the stability of the market.

What does the future hold for insurance regulation? While the market may be able to control cost and, to some extent, quality, it cannot work to achieve an efficient or equitable distribution of health care resources across the entire community.[225] To the extent that is the policymaker's goal, some form of regulatory intervention will always be required. While we may see the evolution of more elegant risk adjustment techniques, it is therefore unlikely that we will witness any substantial retreat from the market reforms already in place.

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[224] *supra* at 172

[225] Enthoven AC, Singer SJ. Markets and Collective Action in Regulating Managed Care. *Hlth Aff.* Vol. 96(6):26-32. November/December 1997.

Conclusion

Where Have We Been?

For the better part of thirty years, health care cost containment has been one of the most difficult challenges facing policymakers. Efforts to constrain costs can be categorized using a simple taxonomy: strategies targeted at impacting supply, strategies targeted at controlling price, and strategies targeted to influencing demand. As discussed in this paper, variations of each of these strategies have been used in any number of states across this country. Certificate of Need has been in place – at one time or another – in a majority of the states. Hospital rate setting was a somewhat less popular alternative, but with notable results. Managed care is pervasive, as is regulation of the insurance industry.

Although policymakers have often embraced cost containment with hope and enthusiasm, these strategies have not always restrained cost growth as anticipated or they have been unsustainable. Several, however, did succeed in reallocating resources and increasing funds available for indigent care.

We are again facing rising health care costs and the potential of devoting an ever-increasing share of our gross domestic – and state – products to this commodity. This prospect is especially daunting when the economy is faltering and states are faced with severe budget deficits.

Historically, though, it is in times just as these when policymakers – private and public – have made their boldest moves toward cost containment. Nixon's ESP was instituted at a time when the cost of the war in Vietnam was demanding austerity at home. Employers sought innovations in insurance coverage when a stagnant economy and increasing competition forced them to look for ways to save benefits expenses. States designed and instituted cost containment programs in response to sluggish economies, shrinking federal revenues, and demands from constituents. As important, many of the strategies used over the past thirty years did not, in fact, reduce spending growth but did reallocate expenditures. Resources "saved" by cost containment efforts were often redirected to the uninsured through the subsidization of indigent care.

Noticeably absent, though, were coherent, systematic approaches to cost containment. Instead, these attempts were made reactively and in a fragmented, uncoordinated manner. The extent to which individual efforts actually worked together toward a unified objective is small. Not surprisingly, then, the overall effectiveness of past cost containment efforts is fairly disappointing. Standing at the brink of another health care cost crisis, both public and private health policymakers are facing what may be their next best opportunity to design and implement meaningful and effective cost containment initiatives.

Where Are We Headed?

We are already beginning to see the outlines of a new iteration of cost containment efforts. The new wave of efforts look like a variation on a historical theme – more of the same disparate attempts at controlling supply, price, and demand.

Most visible are the attempts to reign in one of the leading factors in rising health care expenditures: the price of prescription drugs. States are exploring the expanded use of drug formularies, using their Medicaid market leverage to gain deeper discounts from pharmaceutical manufacturers in return for placement of drugs on the preferred formulary listing, and initiating joint purchasing among state agencies and between the public and private sectors.

Insurers are building benefits designed to limit consumer demand for costly drugs through multi-tiered prescription drug pricing. Usually three-tiered, consumers face different co-pay requirements depending upon the class of drug they are prescribed. Generic drugs are usually subject to the lowest level of co-payments, encouraging patients to opt for them as often as possible. Brand name drugs on a preferred formulary are subject to the next lowest level of co-payment. In this instance, an insurer identifies brand name drugs it believes to be cost effective. Consumers who do not opt for a generic drug are encouraged to purchase a second-tier drug by its relatively low co-payment. Finally, third tier drugs are brand name pharmaceuticals that fall outside the preferred formulary. Consumers purchasing these drugs are often subject to steep cost sharing requirements, intended to persuade them to opt for a less expensive alternative.

The redesign of health insurance coverage is also becoming popular as a means to restrict consumer demand. Whereas increased premium sharing and nominal deductibles and co-payments were common premium cost containment strategies over the past decade, the transfer of risk from insurer to consumer is now gaining ground. This trend is reflected in the growing number of high deductible insurance plans now sold in the small group and individual markets. It is not uncommon for these plans to incorporate $2,500, $5,000, or $10,000 deductibles, protecting the subscriber from only the most catastrophic of losses. While this type of coverage is suitable for individuals financially capable of self-insuring for most health care expenses, it does not provide comprehensive coverage for many people.

Finally, disease management is growing as policymakers come to appreciate that health care cost growth is driven in part by the demands of an aging population and more chronic illness. Disease management (DM) ranges in form from the development and implementation of physician guidelines or patient education mailings to sophisticated initiatives involving nurse case managers at the plan or health system level. There are programs that focus on populations of chronically ill patients – such as persons with diabetes – and some target individual patients

with high cost conditions (for example, a patient with traumatic brain injury). A third form of DM involves the monitoring of an entire population, working to improve provider compliance with, evidence-based, best practices and to improve patient outcomes.[226] The overall aim of these efforts is the management of demand for services and the limitation of the supply of services, assuring that consumers get only those services most likely to address their needs.

Cost sharing is also on the rise as a strategy to limit cost and demand. There is a marked trend by employers to shift a greater proportion of premium costs to the employee, especially relative to the cost of dependent coverage. This accomplishes two objectives. First, it simply reduces the benefit cost for the employer, helping to hold the line on the benefits budget. Second, it may reinforce the notion that the benefit is not free, imparting a greater cost sensitivity to the employee.[227]

These structural changes in health coverage do not bode well for efforts to constrain growth in the number of uninsured. The extent to which consumers are financially compromised by the cost of coverage will be reflected in an increased uninsured population. This phenomenon, in turn, will contribute to growth in the level of uncompensated care, increased stress on marginal providers (especially safety net providers) and increased cost shifting, creating a situation that is simply untenable in the long run.

We have important social objectives for the provision of health care in this country. That is, we have a fundamental desire to see that necessary medical care is provided to those persons who need it. While the individual strategies that have been tested or are now being implemented may have potential, the synergy of the market place appears to challenge their collective ability to contain costs.

Where to Now?

The key lesson we can take from the past is that a haphazard approach to cost containment will not achieve or sustain its objectives. Policymakers need methods to integrate supply, price, and demand, building a comprehensive, tripartite strategy that is sensitive to the complexities and idiosyncrasies of the health care marketplace. Such a comprehensive approach to health care cost containment may well require a re-thinking of the entire health care delivery system to assure that clear goals are set and that incentives are properly aligned to reach them. NASHP is committed to working with states and others to design such strategies to build systems of care that balance cost, quality, and access.

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[226] Mechanic RE. Disease Management: A Promising Approach for Health Care Purchasers. *Executive Brief.* National Health Care Purchasing Institute. May 2002.

[227] Swartz K. The View From Here: Where is Efficiency Leading Our System of Health Insurance? *Inquiry.* Fall 1997.

MEDICAID AND STATE BUDGETS IN FY 2004: WHY MEDICAID IS SO HARD TO CUT

James W. Fossett and Courtney E. Burke
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The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

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Major Findings

This report assesses how Medicaid was treated in fiscal year 2004 in the budgets of ten states. Drawing on detailed analyses of state budgets, it examines state budget-balancing strategies, with particular attention to changes in Medicaid spending and eligibility compared to other government functions.[1] Major findings follow:

1. **The states in the sample were in weak financial condition in FY 2004. The gaps between revenues and expenditures states had to address were large by historical standards. In seven of the ten states these gaps exceeded 10 percent.**

2. **The major cause of state financial problems was revenue declines produced primarily by slowed economic growth and the decline in the stock market, rather than large increases in state spending. Political discussion of state financial problems did not focus on Medicaid as a major cause of the state's financial difficulties.**

3. **Most states relied on a mix of revenue increases and expenditure cuts to bring their FY 2004 budgets into balance, with more reliance on expenditure cuts in FY 2004 than in FY 2003.**

4. **Cutting Medicaid was not a major element of most states budget balancing strategies. While almost every state enacted some form of Medicaid expenditure reduction, most were modest compared to the size of the budget gap and total Medicaid expenditures. In three states, Medicaid spending cuts amounted to more than 10 percent of the state budget-balancing package.**

5. **The availability of additional Medicaid funding enacted by Congress in 2003 had little effect on state decisions about Medicaid expenditure cuts. In two states, the availability of these funds appeared to restore or limit cuts in Medicaid. Most states used these funds to support the state budget generally rather than prevent reductions in Medicaid.**

6. **Other state government functions were cut more than Medicaid, particularly public higher education, where official tuition rates were increased in many states.**

7. **The attitudes and actions of elected officials, particularly governors, were the most important influence on the nature and extent of Medicaid spending cuts. In four states, governors made more or less explicit decisions to protect Medicaid from significant spending cuts and were largely successful. In one state, legislators opposed cuts proposed by the Governor.**

8. **There are several reasons why Medicaid has proven so hard for states to cut. State governments derive considerable financial benefit from Medicaid by us-**

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1 An earlier paper in this series examined similar issues in state budgets for FY 2003. James W. Fossett and Courtney Burke, "Is Medicaid Retrenching? State Budgets and Medicaid Spending, FY 2003," *Managing Medicaid Take-Up*. Albany, NY: Rockefeller Institute, February 2003.

ing it to pay for social service programs previously supported by state funds and through various "creative financing" techniques that allow states to receive substantial Medicaid funding without increasing their own spending. In addition, providers such as hospitals and nursing homes that receive Medicaid payments are major employers and purchasers in legislative districts, adding to the constituencies opposed to reducing Medicaid spending.

Research Method

Adopted state budgets for fiscal year 2004 were examined in the ten states listed. Although this is not a random sample, the states selected represent a range of fiscal conditions, Medicaid program size and liberality, political circumstances, and other factors that might be expected to influence Medicaid spending. The sample states have experienced similar budget problems of declining revenue and increased Medicaid and education spending as the country as a whole.

Sample States

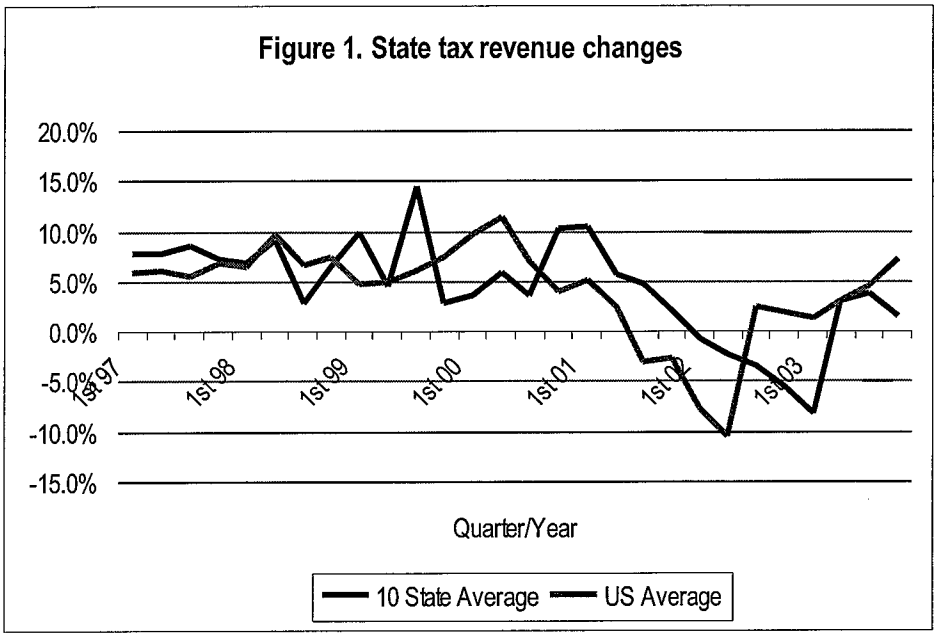
Arizona	Michigan	Oregon
Colorado	New Jersey	Texas
Kansas	Ohio	West Virginia
		Wisconsin

The analysis of individual state budgets was performed by a network of local academics familiar with state finances and in many cases extensively in studying Medicaid and other programs in their states. They were asked to assess the state's financial situation and report on the mix of revenue and expenditure measures their state used to balance the FY 2004 budget, with particular attention to changes affecting Medicaid and Children's Health Insurance Program (CHIP). The names and affiliations of the field researchers are listed in an appendix.

State Financial Conditions — FY 2004

The ten states in the sample experienced budget problems similar to those of other states in FY 2004. Figure 1 compares average quarterly revenue growth in these states in the period 1997-2003 with the average for the country in this same period. Revenue conditions in these states were less severe than those in the country as a whole in 2001 and early 2002; however, their revenue continued to decline in late 2002 and reached their lowest level in early 2003 after other states were starting to experience revenue growth. As a whole, in the period covered in this report, the sample states were in slightly worse shape than the national average.

The rates of growth in Medicaid spending from 2000-2003 in the sample states as compared with the national average are displayed in Table 1. While these states demonstrate a wide range over this period, Medicaid spending in these states grew at a slightly faster rate than the U.S. average.



Source: Rockefeller Institute of Government, Fiscal Studies Program

Table 1. Percent Change in Medicaid Expenditures 2000-2003

State	*Total Change*	*Fed Change*	*State Change*
Arizona	86.60%	92.41%	74.16%
Colorado	31.43%	35.08%	27.71%
Kansas	24.35%	27.86%	19.10%
Michigan	13.95%	18.18%	8.75%
New Jersey	33.73%	37.24%	30.18%
Ohio	37.81%	42.16%	31.66%
Oregon	26.56%	29.87%	21.56%
Texas	44.01%	44.67%	42.97%
West Virginia	35.13%	38.89%	24.46%
Wisconsin	43.49%	47.09%	38.37%
10 State Average	37.70%	41.35%	31.89%
U.S. Average	34.51%	38.45%	29.33%

Source: Centers for Medicare and Medicaid Services

Budget Gaps in FY 2004

The combination of declining revenues and increased Medicaid spending, along with other budget pressures, produced budget problems for the sample states in FY 2004. Table 2 reports on the size of the general fund budget gaps for FY 2004 in these states. The budget gaps are the holes states had to fill — what some places call a baseline budget that compares baseline revenues and expenditures — not what they wound up with. Gaps are measured in different ways in different states; generally they represent the difference between an extrapolation of expenditures for current services (as well as planned additional expenditures) and expected tax and other revenue. Different agencies and organizations involved in the budget process may begin with different estimates of this gap; the estimates reported here are those embodied in the final enacted state budget. Every state expected a general fund budget gap in FY 2004; in New Jersey and Arizona, this gap was over 20 percent. These are large estimated deficits by historical standards, and warrant the "fiscal crisis" label.

Table 2. General Fund Budget Gaps, FY 2004
(B= billions; M= millions)

State	*Anticipated General Fund Expenditures*	*Estimated Gap Between Revenue and Expenditures*	*Gap as Percent of General Fund Expenditures*
AZ	7.000B	1.47B	21.0%
CO*	5.584B	253M	4.5%
KS	4.490B	760M	17.0%
MI	8.793B	1.34B	15.0%
NJ	23.700B	4.9b	21.0%
OH*	24.100B	694M	2.9%
OR	10.740B	1.2B	11.0%
TX	63.500B	8.8B	14.0%
WV	3.040B	250M	8.0%
WI	12.400B	1.5B	12.0%

** Estimated based on negotiations between Governors and legislatures. Texas budget is biennial.*

The fiscal crisis of the states, both in political perception and in fact, is primarily, although not exclusively, the result of sharp declines in state revenue rather than unusually large increases in state spending in general or Medicaid in particular. Declines in state revenue were the result of the mild recession and sharper declines in the stock market values that depressed state income tax revenue from capital gains, the exercise of stock options, and bonuses for the financial services industry. Nicholas Jenny explains the effects of these developments on state finances as follows:

> ...initially the market downturn affected relatively few wage earners, (but) it turned gains into losses for investors, thus sharply contracting a hitherto rich source of revenue almost overnight. Meanwhile, stock options became both less common and less lucrative. The recession only lasted eight months but it had significant after effects as the loss of investment capital manifested itself in weak employment numbers, which in turn depressed (tax revenue from) withholding.[2]

Medicaid spending growth over this period was higher than historical averages and the low growth rates of the late 1990s, but was well below the 20 percent plus annual growth rates of the early 1990s. Alan Weil has observed that Medicaid spending growth is high even in normal times:

> ...Medicaid operates from a high base of growth that is easily susceptible to shocks. Medicaid pays for health care services, which exhibit long-term growth rates in excess of general inflation and in excess of prevailing economic growth. The most expensive populations Medicaid serves — elders and people with disabilities — are growing steadily. These two characteristics assure that, on average, Medicaid will experience cost trends that outpace overall economic growth... In the longer view, it is the late 1990's, not the 2000's, that stand out as different.[3]

Budget discussions in most of the sample states followed a similar pattern. State financial problems were typically seen and publicly discussed as the result of declining revenues, rather than excessive spending growth. While Medicaid spending growth was discussed publicly and reported in the media, there were few attempts to cast Medicaid as the primary cause of state financial problems. In Ohio, for example,

> Although there is general acknowledgment that Medicaid's growth has added to the difficulty of balancing Ohio's state budget, the Governor and the state legislature have continued to allow the largest portion of new spending to go to the Medicaid program. This is not to imply that certain aspects of the program have been immune to cuts and freezes, but budgets have allowed for increases in medical and prescription costs and caseloads. (The state's major newspapers) — the Cleveland Plain Dealer, the Toledo Blade, Canton Repository, Dayton Daily News, and Cincinnati Inquirer — have all covered the budget with specific mention of the Medicaid increases. The tone of the coverage has been less critical than matter of fact.[4]

Similarly, in West Virginia:

> ...Medicaid is not seen as the budget busting issue that it was in the early 1990's. Indeed, no one issue was seen as the budget buster in West Virginia during the development of the FY 2004 budget.... Explanations for the state's budget conditions are linked more to cyclical factors associated with a poor economy.... Some point to Medicaid as a source of continuing funding strains, but most attention is now focused on the costs of the Workers Compen-

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2 Nicholas Jenny, "State Tax Revenue Grows Slightly," *State Revenue Report No. 54.* Available online at http://stateandlocalgateway.rockinst.org/fiscal_pub/state_rev/sr_reports/rr_54.pdf. Accessed March 11, 2004.

3 Alan Weil, "There's Something About Medicaid," *Health Affairs* 22 (January/February 2003): 19-20.

4 Miriam Wilson, Ohio Field Report.

sation program, the Public Employees Insurance Program, and the long term debt obligations found in the state teachers pension program.[5]

Our findings indicate little support for major cuts in Medicaid in most of the sample states. While growth in the cost of Medicaid was seen as a problem in almost every state, there was no substantial political sentiment that it was a or the major cause of state financial problems. Public discussion focused on revenue declines as a major cause of budget stress, and cuts to Medicaid were put forward as one, but far from the only, possible means of addressing this problem.

State Budget Balancing Strategies

Table 3 shows the budget balancing strategies used by these states, divided between revenue enhancements and expenditure cuts. Revenue enhancements include borrowing, shifting general fund expenditures to other revenue streams, raising tuition, securitizing tobacco settlement funds, and drawing down rainy day funds or other surpluses, in addition to raising taxes and fees. Expenditure cuts, particularly in Medicaid and similar programs, are typically reductions from an estimate of projected spending rather than reductions in the absolute amount of money to be spent. If state Medicaid spending, for example, was $1.5 billion in FY 2003 and is estimated to grow to $2 billion in FY 2004, then policy changes estimated to save $250 million are counted as a "cut" because they reduced the expected rate of spending growth, even though Medicaid still costs more in FY 2004 than in FY 2003.

Table 3. Methods for Filling GF Budget Gaps, FY 2004

State	*Percent of Gap to be Filled With Revenue Enhancements*	*Percent of Gap to be Filled With Expenditure Cuts*
AZ	92%	8%
CO	10%	90%
KS	67%	33%
MI	30%	70%
NJ	25%	75%
OH	30%	70%
OR	0%	100%
TX*	30%	70%
WV	90%	10%
WI	77%	23%

* The Texas budget is biennial.

5 Chris Plein, West Virginia Field Report.

Compared with the actions taken by many of the sample states in FY 2003, Table 3 shows a shift towards expenditure cutting, rather than revenue enhancement, as a budget balancing strategy in FY 2004.[6] States may have used available options for covering spending from other than general fund sources in FY 2003 and thus had fewer such alternatives available for the 2004 budget.

This research indicates that the choice of whether to reduce expenditures or raise revenue was not related to the magnitude of a state's budget problem. There is little relationship between Medicaid expenditure growth, the size of budget gaps, and decisions to cut programs or raise revenue. Arizona and New Jersey, which had the largest budget gaps of the sample states, enacted opposing strategies. Arizona, which had by far the largest Medicaid growth rate among the sample states in the early 2000s, filled most of its budget gap by raising revenue. New Jersey enacted a 2004 budget with greater emphasis on expenditure cuts.

How the sample states balanced their budgets had less to do with the severity of their budget problems and more to do with the positioning of governors and others in the budget process. In Arizona, Kansas, and West Virginia, governors made more or less explicit decisions to protect Medicaid and other human service programs from cuts and were able to sustain this position in the legislature, thus focusing their state's budget balancing actions around revenue enhancement. By contrast, there was little sentiment for raising taxes or other revenue among elected officials in Texas and New Jersey (the governor in New Jersey had run his campaign promising to balance the state's budget without raising taxes) thus increasing the amount of expenditure reduction that had to be done to bring their budgets into balance.

Other states were constrained externally. Colorado operates under a voter-mandated limit on expenditure growth, making it difficult for the state to cover large budget gaps by raising revenue. Oregon's outcome was shaped by requirements that tax increases be approved by voters; the legislature passed a budget relatively evenly balanced between expenditure cuts and revenue increases. However, the revenue measures that were enacted did not receive voter approval. The failure of the revenue measures at the polls triggered a pre-established set of expenditure cuts which were called "disappropriations."

Revenue Enhancements

Similar to FY 2003, states used a variety of revenue enhancements to balance their budgets in FY 2004, with one-shots the most widely used method. Colorado and New Jersey securitized tobacco money. Ohio transferred proceeds from the Tobacco Use Prevention and Control Foundation to the general fund; Michigan transferred $10 million from an employee contingent fund. Some states used rainy day funds both in FY 2003 and in FY 2004. Most states used a variety of revenue enhancing strategies. For example, Arizona used $75 million in lawsuit settlement funds and $150 million in transfers from other dedicated funds, among other sources, to help balance its budget. Other methods that states used to increase revenues included deferring payments, transferring money from special funds to the general fund, tax amnesty programs, drawing on Temporary Assistance for Needy Families (TANF) funds, and increasing tuition at state universities. Table 4 provides an overview of state revenue enhancement strategies in FY 2004.

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6 Compare these figures with those in Fossett and Burke, "Is Medicaid Retrenching?," Table 1.

Table 4. Summary of Revenue Enhancement Strategies, FY 2004									
State	*Raise Tax*	*Fees, Sur-charge*	*Tap Earmark*	*One Shot*	*Draw Surplus*	*Rainy Day Fund*	*Special Finance*	*Tuition Increase*	*Other*
AZ	*	*		*		*	*		*
CO				*					*
KS	*		*	*		*		*	*
MI		*	*	*					*
NJ	*	*		*	*				
OH	*	*	*	*	*				*
OR*	*								
TX		*				*			*
WV	*		*	*		*	*	*	*
WI		*		*			*	*	*
* Oregon proposed tax increase did not receive the required voter approval.									

One difference between the budget balancing strategies in 2003 and 2004 was that more states resorted to increasing taxes, although these increases were often limited in scope and impact. For instance, rather than implementing a new tax, Kansas eliminated the expiration of a 2002 state sales tax increase. Sin taxes on such items as tobacco, alcohol, and other luxuries were preferred over broad-based income and sales tax increases. Fees were increased on automobile registration, realty, nursing home beds, and utilities.

The Impact of One-Time Federal Medicaid Revenue

In FY 2004, a major Medicaid-related federal revenue enhancement came from one-time payments under the Jobs Growth Tax Relief Reconciliation Act (JGTRRA) that provided $20 billion to the states. Ten billion was for Medicaid and $10 billion for general fiscal relief. The Medicaid money was provided in the form of a temporary increase in the federal Medicaid assistance payments (FMAP).

At the time this law was passed, this temporary increase in the Medicaid FMAP was seen as a way to avoid cuts to Medicaid.[7] *However, our study revealed that a small number of states actually used the federal money to restore enacted Medicaid cuts.* Texas was the only state in our sample that clearly used the federal money to restore Medicaid cuts. Texas received a total of $1.3 billion, of which $372.3 million was used for Medicaid to partially restore provider cuts, cuts in community care programs for the

7 Leighton Ku, "State Fiscal Relief Provides an Opportunity to Safeguard Medicaid Budgets," Center on Budget and Policy Priorities, June 4, 2003.

aged and disabled, and for the partial restoration of mental health benefits under the CHIP program. The remainder was used to support general fund expenditures. Even in this case, the first inclination was to put these funds toward general fiscal relief. However, public pressure from advocates eventually allowed this money to be used for partial restoration of Medicaid cuts. In Ohio, the legislature passed a budget without some of the Medicaid cuts that the governor had proposed. Observers of the budget process believed that the added federal fiscal relief avoided the need for a more intense debate between the Ohio governor and legislature about the proposed cuts.

The other states in the sample used the federal money for general fiscal relief rather than for restoration of Medicaid cuts. In Arizona, other programs were seen as receiving more relief from the extra federal money than Medicaid. Wisconsin used the money as a replacement for Upper Payment Limit (UPL)[8] revenues that were projected to be lower than the state had previously anticipated. West Virginia viewed the federal fiscal relief as a one-time measure and was debating whether the money should be used to *expand* Medicaid eligibility. Kansas was already far enough into the budget decision process that the enhanced FMAP had little impact on spending decisions in FY 2004.

At the time this report went to print, a handful of states in the sample had yet to resolve how the added federal money would be used. This was true in Colorado where federal funds were placed in a special account while the Governor and Assembly debate over who had the authority for allocating these funds. The governor suggested that some of the funds be used to restore some of the cuts that were made to Child Health Plan Plus (CHP+).[9]

In sum, this research indicated that the initial round of extra federal money in FY 2004 arrived too late, was irrelevant to many of the state budget debates of 2003, and except in Texas, did little to help restore cuts to Medicaid.

Expenditure Cuts

Compared to our examination of state budgets in 2003[10] states had to rely slightly more on expenditure cuts in FY 2004. This is probably because the use of one-time revenue enhancements in 2003 left fewer resources for states to use in this way in FY 2004. Two states in the sample relied almost exclusively on expenditure cuts — Colorado and Oregon. But these states differ because each was subject to voter-approved measures that limit spending. In the case of Colorado, a voter-approved measure limits the growth of state revenue and state spending.[11] In the case of Oregon, as mentioned before, cuts were the result of voters disapproving a tax increase after the budget had been agreed to by elected officials. The defeat of this tax increase subsequently resulted in what

8 "Upper Payment Limit" revenue comes from a provision that allows states to nominally pay certain types of nursing homes more than would otherwise be possible and keep the excess revenue. Regulations were recently enacted to curb this practice limiting the amount of money states could draw from this funding source. For more information see, *States Use of Maximization Strategies to Tap Federal Revenue* by Teresa Coughlin and Stephen Zuckerman. Urban Institute, June 1, 2002.

9 As this paper went to press, it was not clear if a final determination had been made as to the use of these funds.

10 James W. Fossett and Courtney Burke, "Is Medicaid Retrenching? State Budgets and Medicaid Spending, FY 2003," *Managing Medicaid Take-Up*. Albany, NY: Rockefeller Institute, February 2003.

11 Colorado is subject to limits on local property tax collection, causing the amount of revenue share from property taxes to shrink substantially over the past decade.

was called a "disappropriation" assigned to Oregon state agencies. The original budget, by partially relying on revenue enhancements, would have avoided these cuts.

In the remaining states in the sample, a variety of measures were used to cut expenditures such as across the board cuts, staff cuts, hiring freezes, and discretionary program cuts. Most states directed agencies to look for ways to control spending, so the size of the cuts varied by program area. For instance, in New Jersey, health and senior services was cut by 12.8 percent and Treasury was cut by 6.1 percent. Other examples of cuts included eliminating the Medicaid outreach program in Michigan and positions in the Corrections Department in Colorado; cuts to information technology projects in schools in Wisconsin; and to the civil rights commission, adult corrections program, library and historical programs in Ohio.

State workforces were noticeably impacted by staff cuts, merit award reductions, performance pay delays, and the elimination of salary increases. The cumulative impact of cuts to state agency staff, early retirements, and hiring freezes in FY 2003 and FY 2004 resulted in noticeable attrition and staffing shortages in many states. This was particularly true in Ohio where the workforce was reduced by 3,000 positions in FY 2003 and in Michigan where an early retirement incentive caused the state workforce to shrink dramatically.

Medicaid Spending Cuts

Even in this environment of severe budget difficulties and significant spending cuts, Medicaid was not a major budget target in most of the sample states. Table 5 shows estimated general fund spending cuts to Medicaid in the final enacted budgets in the sample states, together with the associated federal match. Cuts are largest in dollar terms in Texas and Oregon. In Kansas and West Virginia Medicaid spending cuts were not enacted.

Table 5. FY 2004 Medicaid Cut (in thousands)

State	*Medicaid General Fund Cut*	*Total Fed Cut*	*Fed & State Medicaid Cut*
AZ	26,700	54,735	81,435
CO	36,000	36,000	72,000
KS	0	0	0
MI	64,000	79,360	143,360
NJ	4,900	4,900	9,800
OH	155,000	221,650	376,650
OR	167,000	252,170	419,170
TX	777,000	1,165,500	1,942,500
WV	0	0	0
WI	52,500	74,025	147,251

Note: Based on FY 2003 match rate and does not include enhanced FMAP from JGTRRA

Table 6 summarizes the types of Medicaid spending cuts enacted in the sample states. The most common action was prescription drug cost controls, with nearly every state implementing some sort of mechanism to control drug costs.[12] Other cost control measures included freezing or cutting provider rates, cutting optional services, or slowing enrollment. In the sample states, cuts were made to a variety of services, including: durable medical equipment, chiropractic benefits, prescription drugs, transportation services, mental health, and substance abuse (among others).

Table 6. Summary of Select Medicaid Cost Controls

State	*Cut Eligibility*	*Eliminated/Slowed Expansion/Enrollment*	*Cut Services/ Limited Utilization*	*Cut or Froze Provider Rates*
AZ		*	*	
CO		*	*	*
KS	*			"minimal"
NJ		*	*	
OH			*	*
TX	*	*	*	*
WV		*	*	
WI			*	*

* Data for Oregon and Michigan unavailable

Most states in the sample were reluctant to make major cuts to eligibility. The fact that states resisted outright eligibility cuts is indicative of the perceived political ramifications of eliminating populations from Medicaid. To get around outright eligibility cuts, a number of the sample states used other methods, such as capping enrollment, or limiting or eliminating planned program expansions.

Eligibility Changes

States that did cut or limit eligibility tended to target adults. For instance, Arizona planned to repeal eligibility for parents under KidsCare beginning June 30, 2004. Kansas planned to cut adults receiving general assistance benefits from Medicaid if they had received services for a total of 24 months — impacting approximately 400 adults. Texas reduced eligibility for pregnant women from 185 percent of the federal poverty level to 158 percent and eliminated the Medically Needy Spend Down, a temporary coverage program that averages 10,000 adults with dependent

12 For information on state prescription drug cost controls see Dawn Gencarelli, *"Medicaid Prescription Coverage: State Efforts to Control Costs,"* George Washington University, National Health Policy Forum, May 10, 2003.

children per month.[13] Ohio eliminated a planned expansion of the CHIP program to parents. [14]Parents/adults may have been targeted for two reasons: First, it may be seen as politically easier to cut adults than children from government programs; second, most states had well-established programs for children and had only recently begun to consider eligibility expansions for adults; therefore, the most recent expansions generally tended to be the first programs to be rolled back.

Enrollment Outreach

Our findings indicate that although legislative and budget actions in FY 2003 and FY 2004 impacted Medicaid enrollment and services, *administrative actions to increase enrollment remained largely unchanged.* For instance, in Arizona, aside from the legislatively enacted tightening of the redetermination time frame, there were no efforts to limit enrollment and the state was still using a simplified application form. Colorado was still pursuing enrollment efforts even with the implementation of a cap on enrollment of children. State officials in Kansas continued support for sustaining enrollment as did those in New Jersey Michigan, Ohio, Wisconsin, and West Virginia.

Simplified Enrollment Processes

The research indicated that efforts by front-line workers to streamline eligibility processes continued during the fiscal downturn. However, in some Texas counties, staff cuts made it difficult for front-line workers to provide the same level of enrollment assistance. This resulted in higher transaction costs for applicants to pursue Medicaid enrollment and in a lower enrollment. In general, most states expected Medicaid enrollment to continue to increase in 2004 and 2005, although not necessarily as fast as in prior years.

Access to Care

The effects of spending cuts on access to care for current and former Medicaid recipients are hard to assess. Eligibility reductions have a clear negative effect on access, as do such measures as the shortening of the enrollment period adopted in Arizona. The effects of other types of policy changes are less clear. For example, efforts to address the high cost of prescription drugs by adopting a preferred drug list, may have little adverse effect on Medicaid clients, depending on the details of co-pays and the availability of off-list drugs. In similar fashion, freezing or making decremental cuts in the rates paid to providers may not have a large short-term effect on the availability of care; physicians may be unwilling to eliminate connections with established patients, although they may limit the number of new Medicaid patients they accept. Hospitals, particularly so-called "safety net" facilities, typically have less choice about the patients they accept, especially for emergency care, so cuts and freezes in these rates may have a limited effect on access to care.

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13 Spend down is defined s the process in which an individual spends assets to pay for health care until the assets have been depleted to the required level for eligibility under the Medicaid program.

14 A summary of cost controls for all 50 states can be found in Vernon Smith, Rekha Ramesh, Kathleen Gifford and Eileen Ellis, "States Respond to Fiscal Pressure: A 50 State Update of State Medicaid Spending Growth and Cost-Containment," Kaiser Commission on Medicaid and the Uninsured, January 2004.

Summary of Findings

While the 2004 reductions to Medicaid were larger than in prior years, our findings indicate that most states did not rely heavily on Medicaid cuts as a budget balancing strategy. The first two columns of Table 7 compare enacted Medicaid general fund expenditure cuts with the size of the state's budget gap and total enacted general fund expenditure cuts. On average, Medicaid cuts accounted for less than 7 percent of the "gap filling" strategies these states adapted to balance their budgets and only about 12 percent of the expenditure cuts. In only three states — Colorado, Ohio, and Oregon — did cuts to Medicaid account for more than 10 percent of the state's total budget balancing package. Medicaid cuts were a larger percentage of enacted general fund expenditure cuts, but it should be remembered that expenditure cuts were not very large in several states.

More significantly, the total reductions in Medicaid spending resulting from these expenditure cuts did not constitute a large share of Medicaid spending in most states. The third column of Table 7 compares the total estimated reduction in Medicaid spending (including both state and federal funds) with total Medicaid spending in FY 2003. Most Medicaid reductions were relatively small — in only two states did enacted cuts exceed 10 percent of Medicaid spending. In one of these states (Texas), most of these cuts were "backloaded" into the second year of a biennial budget, so that most of these cuts had not happened at the time of the preparation of this report and indeed may not actually happen, as the legislature can still meet in special session to rescind the cuts before implementation.

Table 7. Medicaid Cuts in Context, FY 2004

	General Fund Medicaid cut as Percentage of 2004 GF Gap	*Medicaid General Fund Cut as Percentage of Total General Fund Expenditure Cuts*	*Total 2004 Medicaid Cut (State and Federal) as a Percentage of Total 2003 Medicaid Spending (State and Federal)*
AZ	1.82%	25.67%	1.95%
CO	14.20%	15.78%	2.83%
KS	0.00%	0.00%	0.00%
MI	4.78%	6.83%	1.85%
NJ	0.10%	0.13%	0.13%
OH	22.33%	31.89%	3.37%
OR	13.92%	13.92%	13.39%
TX	8.83%	12.61%	14.44%
WV	0.00%	0.00%	0.00%
WI	3.50%	13.22%	3.28%

* Medicaid; ** General Fund.

This analysis indicates that the impact of enacted Medicaid spending cuts on total Medicaid spending will be relatively small in most of the sample states. In two states — Oregon and Texas — spending cuts amounted to more than 10 percent of Medicaid spending in FY 2003, suggesting a slowdown in the rate of growth in Medicaid spending in FY 2004. In the other eight sample states, Medicaid spending cuts amounted to less than 4 percent of FY 2003 Medicaid spending.

How Did Other Programs Fare Compared to Medicaid?

If Medicaid was not substantially cut, did other programs fare better or worse? Elementary and secondary education was also relatively unaffected. The only state in our sample that substantially reduce K-12 education funding was Oregon because of the "disappropriation" of funds that resulted from the voters not approving a tax increase. Strong constituencies against cuts, lawsuits, and legislative requirements were factors that caused states to avoid cuts in K-12 education.

Cuts in human service programs were also modest relative to cuts in other program areas. Cuts occurred in Colorado (1.6%), and Michigan (1.2%).In New Jersey, although cuts to the Department of Health and Senior Services were by far the largest, Medicaid, which is in this Department, experienced only a $4.9 million cut — less than 1 percent of the overall cut experienced by the department.

The program area that was most affected by state budget difficulties in 2004 was public higher education. It was cut in eight of the ten sample states, and by a much higher percentage than cuts in other program areas. If FY 2003 is taken into account, all ten of the sample states cut state spending on higher education, mostly by raising tuition, in some cases substantially. The cumulative impact of these cuts in Colorado, for example, was estimated to be 20.9 percent over two budget cycles, more than any other program area cuts. These cuts are reflected in Table 8, which lists changes in FY 2003 and FY 2004 in state appropriations for higher education operations and undergraduate tuition and fee increases for FY 2004 and over the last four years.[15] On average, the sample states projected spending 4.5 percent less on higher education in FY 2004 than in FY 2003, and raised tuition and fees by almost 14 percent on average.

Other state departments and agencies also suffered relatively large cuts. Transportation agencies were cut significantly in Ohio, Kansas and Texas. Corrections spending was reduced in Oregon, Arizona, Ohio, and Texas. Michigan, Texas, and New Jersey relied on cuts to a variety of other programs, particularly environmental programs.

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15 Data are from the State Higher Education Executive Officers (SHEEO), "Appropriations of state funds for higher education," and differ only slightly from our research.

Table 8. Changes in State Higher Education Appropriations, and Changes in Tuition				
State	*Changes in State Appropriations*	*Tuition and Fee Change, Undergraduate, Flagship Universities*		
	FY 2002 to 2003	*Projected FY 2004*	*2003-2004 % Change*	*Year % Change*
AZ	-2.80	0.09	39.1	59.1
CO	-11.00	-13.70	12.7	28.9
KS	-4.60	0.85	17.7	62.9
MI	0.30	Na	6.5	25.9
NJ	2.30	-1.30	8.5	2.1
OH	-1.00	0.80	17.6	56.0
OR	-11.10	-5.00	2.7	33.3
TX	1.50	-6.70	7.4	67.6
WV	-2.90	-5.90	9.5	29.1
WI	2.20	-10.48	16.1	37.5
10 State Average	-2.71	-4.59	13.8	43.2
U.S. Average	-0.80	-1.54	11.6	38.2

Sources: 2003-04 Tuition Fee Rates: A National Comparison" Washington Higher Education Coordinating Board, December 2003, and SHEEO data www.sheeo.com, *"Appropriations of state funds for higher education."*

These findings suggest that although Medicaid was cut in most states, and substantially in a few, it was not the primary target of spending cuts. Other programs took bigger hits. This pattern appears to be largely the result of politics. In West Virginia, Kansas, Michigan, and Arizona, governors made more or less explicit decisions to protect Medicaid from budget cuts and were largely able to sustain this position even under challenge. In Arizona, for example, proposals from some legislators to cut Medicaid more substantially were blocked by the program's legislative allies and others were vetoed by the governor. In West Virginia and Kansas, there appeared to be little political sentiment for cutting Medicaid, and the governor's position against doing so went largely unchallenged. While there was a greater challenge to the governor's position in Michigan, she was willing to accept only limited cuts in Medicaid. In Ohio, by contrast, the state legislature turned down a number of Medicaid cuts proposed by the governor. In the other sample states it was largely agreed that Medicaid should not be a primary budgetary target.

Why Is Medicaid So Hard to Cut?

These findings suggest that Medicaid — popularly thought to be a program which provides health care to poor people through medically and politically marginal safety net institutions — in fact has considerable political resilience. Despite expectations and predictions to the contrary, Medicaid has been able to survive these two bad budget years without major retrenchments in most states. While cuts have been significant in some of the sample states (Oregon and Texas) in most they have been modest, particularly in comparison to those experienced by other programs. Elected officials have found it in their political interest either to protect the program budgetarily or to resist cuts urged by others. Medicaid has not been expanded, and in some states, its growth has been appreciably slowed, but there has been no large-scale retrenchment.

Several factors appear to account for this resilience. One is the financial incentive problems' that Medicaid presents to budget cutters. Since state spending for Medicaid carries a federal match. Cutting a state dollar from Medicaid causes total Medicaid spending to decline by at least two dollars and as many as four dollars. This makes cutting Medicaid less attractive than cutting programs funded solely by state funds where cutting a state dollar causes spending to decline by a dollar. In addition, cutting the Medicaid rolls rarely reduces the cost of treating former Medicaid clients, but rather transfers the financial burden for serving them to hospitals, county health programs, or other institutions.

State governments benefit from Medicaid in two major ways. One is achieved by having Medicaid support programs that traditionally had been supported with state general funds. While precise numbers are difficult to come by, many states have realized considerable general fund savings by "*Medicaiding*" programs in mental health, mental retardation, education, and other human service programs. Cutting Medicaid would jeopardize these savings and would require large cuts in state programs because of the loss of federal matching funds. States have also benefitted considerably from "creative financing" schemes under which states have been able to claim considerable federal reimbursement without spending their own money in more than an accounting sense.[16] While the Clinton and Bush administrations have taken steps to limit excessive state claims under such schemes, many states can still claim significant amounts of federal funds this way. Cutting Medicaid services or enrollment appreciably could limit the ability of states to make claims under these schemes. Public-sector unions, too, have a big stake in Medicaid-funded jobs both in public and nonprofit health care institutions.

A second factor that limits the appeal of large-scale Medicaid cutting is the program's substantial political constituencies.[17] As shown in Table 9, Medicaid accounts for an average of one dollar in every eight spent on health care in these ten states, a figure which is below the national average. Its financial importance for health care industries is very large. Nationally, for example, Medicaid

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16 For detailed descriptions and discussions of these mechanisms, see Teresa Coughlin, Brian Bruen, and Jennifer King, "States Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23 (March/April 2004) and U.S. General Accounting Office, "Medicaid: Improved Federal Oversight of State Financing Schemes is Needed" (GAO 04-228), February 2004.

17 Lawrence D. Brown and Michael Sparer, "Poor Program's Progress: The Unanticipated Politics of Medicaid Policy," *Health Affairs* 22 (January/February 2003): 31-44.

accounts for almost half of all nursing home spending, approximately, 15 percent of spending on hospitals, and also large (though difficult to quantify) fractions of spending in such program areas as mental health and services for the mentally retarded and developmentally disabled.[18] Medicaid is the largest maternal and child health program in the country, covering approximately 25 percent of children and as many as half the births in some states. This extensive coverage has created a large, geographically dispersed network of providers (including hospitals, nursing homes and other long-term-care facilities and programs, residential and treatment facilities for the mentally ill and mentally retarded, pediatricians and obstetricians/gynecologists) who receive considerable income from Medicaid and might be expected to object to loss of this income. The geographic dispersion of these providers means that large numbers of state legislators have influential constituents with an economic interest in Medicaid to answer to.

Table 9. Medicaid Spending as a Share of a State's Personal Health Care Spending in 1998

State	*Medicaid Share of Personal Health Care Spending*
AZ	12.6
CO	11.9
KS	10.8
MI	14.9
NJ	14.0
OH	15.6
OR	15.3
TX	12.5
WV	17.3
WI	13.4
10 State Average	13.8
U.S. Average	15.7

Source: Anne Martin, Lekha Whittle, Katharine Levit, Greg Won, and Lindy Minman, "Health Care Spending During 1991-1998: A Fifty-State Review" Exhibit 4, *Health Affairs*, July/August 2002.

18 Don Boyd, "Medicaid Spending — New York Versus Other States" Presentation to the New York State Health Care Task Force, Albany, New York, September 5, 2003.

Medicaid provides economic development benefits that are broadly dispersed geographically. Nursing homes and hospitals are major employers and purchasers in many states, particularly in rural areas, and Medicaid's support of these facilities supports jobs and business activities. Table 11 presents estimates by Families USA, a Medicaid advocacy group, of the total employment and business activity supported by Medicaid in the ten sample states. While it is difficult to judge the accuracy of these estimates, they suggest that Medicaid supports, directly or indirectly, tens of thousands of jobs and billions of dollars of business activity. Advocates in some states have begun to argue against cutting Medicaid not only on public health but also on economic development grounds. Elected officials who might otherwise be indifferent to Medicaid as a health care program are likely to be sensitive to these economic benefits and hence to be hesitant to reduce support for these employers in their districts.

Table 10. Medicaid's Role in the Economy, FY 2005*

State	*State Medicaid Spending (millions of dollars)*	*Total New Jobs Created*	*New Business Activity (millions of dollars)*
AZ	1,888	78,527	8,033
CO	1,335	28,356	2,989
KS	759	25,112	2,393
MI	3,906	98,773	10,171
NJ	3,901	65,965	8,805
OH	5,022	160,618	15,962
OR	1,158	34,775	3,614
TX	6,476	214,597	23,585
WV	527	27,009	2,605
WI	1,992	59,747	5,557

* Source: Families USA, "Medicaid: Good Medicine for State Economies," May 2004 update, select information from Table 1 & 2. Figures are based on an enhanced FMAP rate that is set to expire in June 2004.

The Future of Medicaid

Although the constituency behind Medicaid enhances the program's robustness, there are three factors that in the future could damp down Medicaid spending pressures: (1) enrollment growth rates; (2) implementation of cost controls; and (3) revenue collections. Each could impact budget decisions for Medicaid. Enrollment in the near term is not likely to be as big a cost pressure as in recent years. Enrollment growth projections for 2005 are one-third slower than for prior

year.[19] Some states have been successful at controlling Medicaid costs — especially compared to the private market. This is particularly true of prescription drug costs, where states have implemented many cost-containment actions.[20] If states continue to be successful in doing this and Medicaid costs grow more slowly than the private market, there will be less reason to target Medicaid for cuts. Finally, there are signs that state revenue collection are recovering,[21] although the full impact of the revenue recovery is slow and may not be fully felt by all states.

Still, predicting the future of Medicaid enrollment and services is difficult. Given the flexibility of the Medicaid program, the degree to which states will cut the program will likely depend on the following factors — the speed a state recovers from revenue losses, how much a state used one-time revenue enhancements during the past two years, how strongly budget makers view Medicaid as a revenue generating/economic development program, the diversity and strength of the constituency of institutions and individuals opposing cuts to other programs, how much other state-funded programs have already been cut, and other possible mitigating factors such as federal fiscal relief.

All of this suggests a need for close and continuing attention to Medicaid spending. Medicaid is one of the largest programs in state budgets, with total spending amounting to $260 billion in FY 2003, roughly one dollar in every six spent on health care nationally. The program enrolls over 45 million people, ranging from low-income women and children to the elderly and disabled, and covers an enormous range of health care and other services. Medicaid covers one-third of all the births in the country and provides health insurance for one in every five children. It accounts for almost one-half of total spending on long-term care and significant portions of state spending on programs for the mentally ill, mentally retarded and developmentally disabled. Medicaid is a big deal in state budgets and health care systems. It is the most volatile program in state budgets, and Medicaid spending has proven extremely difficult to forecast even in the short run. Changes in prices, enrollment, and utilization of health care are especially hard to predict.

In spite of its size, importance and volatility, there is little on-going systematic analysis of state Medicaid spending and its consequences. Compared to other social programs, reporting systems for Medicaid are relatively underdeveloped and data are released only after lengthy lags. More systematic attention to Medicaid spending is needed on a continuing basis. A new Rockefeller Institute information initiative, now being established, will provide regular reports on Medicaid finances and enrollment.

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19 Vernon Smith, Rekha Ramesh, Kathleen Gifford and Eileen Ellis, "States Respond to Fiscal Pressure: A 50 State Update of State Medicaid Spending Growth and Cost-Containment," Kaiser Commission on Medicaid and the Uninsured, January 2004.

20 Ibid.

21 Nicholas Jenny, "The State Personal Income Tax Recovers," *State Fiscal News* Vol. 4, No. 4. Albany, NY: Rockefeller Institute of Government, May 2004.

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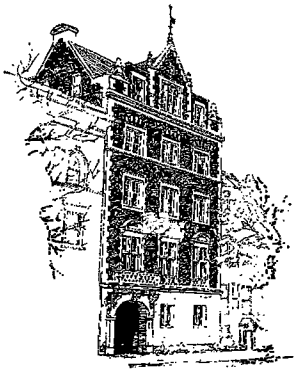

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MANAGING MEDICAID COSTS
A LEGISLATOR'S TOOL KIT

FORUM *for* STATE HEALTH POLICY LEADERSHIP
NATIONAL CONFERENCE *of* STATE LEGISLATURES

DECEMBER 2001

Managing Medicaid Costs
A Legislator's Tool Kit

by

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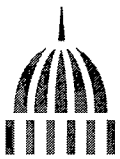

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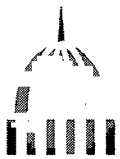

NATIONAL CONFERENCE
of STATE LEGISLATURES

The Forum for America's Ideas

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§ To foster interstate communication and cooperation, and
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FOREWORD

Few challenges legislators face are as difficult and complex as the urgent need to wisely manage health care spending, particularly in the Medicaid program. Curtailing spending in an arbitrary way creates the risk of real harm to needy senior citizens, people with disabilities, and adults and children who have few or no other options to have their medical costs covered. Yet, failure to rein in program costs can wreak havoc on all other legal and programmatic state responsibilities such as education, environment, criminal justice, economic development, and non-health related human services.

The cost control challenge can be especially difficult when—as now—rising costs occur in the midst of an economic downturn. Legislators face daunting choices at a time when the need is greatest, and those who may be adversely affected face few viable alternatives. Rising unemployment, increasing public assistance rolls, closing businesses, and businesses canceling health insurance coverage—these all set the context and frame the urgency for legislators to act wisely, carefully, and yet decisively.

Adding to this dilemma is the reality of the past 30 years in U.S. health policy. Between the 1960s and the late 1980s, federal and state governments for the most part pursued a regulatory strategy to control rising costs—both public and private—through devices such as certificate of need, rate setting, and coordinated health planning. In the late 1980s and early 1990s, that strategy came to be seen as a failure and was abandoned or significantly de-emphasized. In the 1990s, policymakers pursued a market-based strategy, relying on managed care and competitive purchasing to restrain costs. At the beginning of the 21st century, that strategy is also now seen as ineffective as health care inflation once again surges.

Thus, we enter this period of renewed inflation with less clarity than ever regarding an overarching approach to cost control. Widespread implementation of managed care, thought by many in the early 1990s to be a silver bullet, has been carried out and has run its course as costs rise and public antipathy solidifies. There is an important lesson in this for all legislators—new and veteran— to be skeptical of the "next big thing," to be cautious in the presence of those who wrap their proposals with grand predictions of huge, painless savings.

Legislators also must keep their objectives in perspective. The growth dynamic in state medical costs is intimately tied to the growth in private sector spending. Small business premiums and Medicaid costs, large business premiums and state employee health insurance costs, all tend to rise in tandem—because all are driven by the same forces. States cannot on their own reverse the overall growth in health sector spending. At the same time, effective, well designed interventions can effectively reduce the rate of growth—reductions that can translate into vitally important savings in millions of dollars. In other words, although it may not be able to drive your rate of cost growth from 15 percent to zero, there can be real benefits in decreasing the rate to 12 percent or 13 percent.

In baseball terms, legislators facing health cost growth realistically should expect to hit more singles and an occasional double than home runs or grand slams. It is in this sense that this report, prepared by the Health Policy Staff at the National Conference of State Legislatures, is particularly timely, important and helpful. The policy directions outlined in this report are realistic, practical and informed by hard experience and history. Legislators who were first elected after 1991 will particularly benefit from the wisdom and experience contained in these pages. Legislators in states

with term limits also will find real value because they serve with few colleagues who have any memory of the prior fiscal crises and health cost explosions.

In the spirit of realism, many legislators will discover that their hard work to find responsible ways to constrain cost growth will win them few fans or friends. But no task in the current environment is more important and needed. Veteran legislators understand that times of fiscal stress are also periods when important reforms can be achieved that are not possible in calmer times. The experiences obtained by those who face these challenges head on may be the supreme challenge one faces in an entire legislative career. The wisdom gained will serve any legislator well in the years ahead when the past fiscal distress becomes a faint memory to others.

The National Conference of State Legislatures has experienced and time-tested staff who are able to assist legislators as they address these challenges. Readers should feel welcome and encouraged to interact with NCSL staff to learn more about specific policy choices and to discover opportunities to engage with other legislators who face similar problems.

Every fiscal crisis in the past 50 years has been followed by fiscal recovery. Every health spending crisis is followed by some degree of spending moderation. Those who aid their publics in this time of stress fulfill the highest obligation to their citizens and to their oath of office.

JOHN MCDONOUGH
Co-Director, Health Chairs Project

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This report is truly a team product. The Forum director, Richard Merritt, conceived and guided the project. In addition to writing individual sections, the various authors helped plan and review other parts of the report. In particular, Donna Folkemer, the Forum's Medicaid expert, served as the in-house consultant to all the authors, providing substantive guidance, review and editing for the individual strategies and was the lead on the strategy section. Phyllis Kaye edited the parts into a whole and, with NCSL's production and editorial staff, including Gregory Martín, Allison Hansen and Leann Stelzer, met constantly shifting deadlines with grace and skill. A number of friends of NCSL and the Forum provided advice, reviewed drafts, and suggested examples of state activities. These include Kurt DeWeese, John Kasprak, Jeanne Lambrew, Cindy Mann, John McDonough, Vic Miller, Chuck Milligan, MaryJo O'Brien, Lee Partridge, Vernon Smith and Alan Weil. We are particularly grateful to our project officers, Julie Hudman at the Kaiser Family Foundation and Pamela Dickson at the Robert Wood Johnson Foundation, for their continuous involvement, support, guidance and inspiration.

1. *INTRODUCTION*

As rising health care costs meet flattening revenue projections, state health budget-makers will face tough decisions, especially when it comes to Medicaid spending. Although most states are in good financial health overall, state revenue collections are showing signs of slowing and, in many states, the health spending budget is often the first to face a crisis. Spending on direct, personal health care accounts for more than a quarter of total state spending. Almost three-fourths of these dollars—$186 billion in fiscal year (FY) 2000—go to Medicaid, a joint-federal state program.[1] In 23 states, these Medicaid expenditures were emerging as problematic as early as February 2001.[2] By June 2001, two-thirds of the states projected shortfalls in their Medicaid budgets for the current fiscal year.[3]

> For an introduction to Medicaid, see the NCSL Medicaid FAQ at http://www.ncsl.org/programs/health/forum/faqmedicaid.htm

What can a legislator do? How can legislatures help ensure that funds for health care are used wisely? Legislators called back into special session to deal with Medicaid shortfalls, or faced with Medicaid budgets that threaten to crowd out discretionary spending, will want quick solutions. But the underlying causes of cost increases are complex and deeply rooted. Cost control will require a mix of short-term and long-term strategies. Although there is no one solution, many opportunities exist for incremental savings.

This report will help state lawmakers ask the right questions when considering whether a given approach is appropriate for their state. It ends with snapshots of 10 strategies that states typically consider when faced with Medicaid budget crunches.

Chapter 2. (Spending and Costs) **This chapter follows the money by taking a close look at what drives Medicaid, the largest piece of health spending in most state budgets.** It describes what influences state Medicaid spending and costs, provides a little economic and financial theory, contains national data on where Medicaid money comes from and where it goes, and points readers to sources of information about state-specific costs and spending. Summary tables show which strategies address each of the different factors that are helping to increase spending and costs.

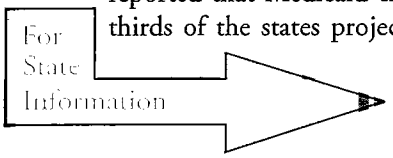
Chapter 3. (Thinking Strategically) **This chapter focuses on legislative action.** It offers advice on how to obtain and analyze state-specific information that helps legislators and others determine what approaches are suitable for a given state. Health budget strategies tend to have complicated interactions with one another, and an apparently simple decision about state spending can reverberate in the private sector or conflict with another state health policy.

Chapter 4. (Ten Cost-cutting Strategies) **This chapter contains brief profiles of 10 strategies that states have used to contain costs.** Each profile includes enough information to help you decide whether to explore the strategy in more depth and offers tips on how to tell whether an approach might be right —or very wrong—for your state. The profiles also suggest resources for more information.

2. *Medicaid Spending and Costs*

Influences on State Medicaid Spending

Medicaid spending is on the rise as states forecast flat revenues. After some six years of record low growth, Medicaid spending began to accelerate in 1999. In 2001, the national economy slowed, bringing down government revenues as well. In response to a February 2001 survey, 23 states reported that Medicaid expenditures were emerging as problematic.[4] By June 2001, roughly two-thirds of the states projected Medicaid budget shortfalls in the current fiscal year.[5]



See http://www.nasbo.org/Publications/PDFs/FSJUN2001.pdf

Low Medicaid spending growth in the 1990s was an anomaly. There are a number of different explanations for the relatively low rates of increase in Medicaid spending during the mid-1990s.

- **There was lower underlying health inflation.** Medical inflation, which was in the double digits from 1990 to 1992, slowed through the second half of the decade, falling as low as 3.2 percent.[6] This decrease was at least in part the result of competition-driven changes in financing and organizing care—both public and private—that often are lumped together as "managed care."

Medicaid Inflation

- According to Ku and Guyer, Medicaid grew at 11.2 percent per annum 1998 to 2000.
- CBO predicts average annual growth from 2000 to 2011 of 8.7 percent for Medicaid
- Twenty-three states in NCSL (February 2001) survey report that Medicaid expenditures are emerging as problematic.
- Two-thirds of the states recently projected Medicaid shortfalls in their current fiscal year according to a 2001 survey by NGA and NASBO.
- In 2000 and 2001, for the first time since 1992, states outspent their Medicaid budget expectations, forcing HCFA to request additional funds to get through the year.

- **Medicaid managed care controlled prices and utilization.** By 2000, 55 percent of beneficiaries were enrolled in managed care—17.8 million, with 13.8 million in risk-based plans and 4.5 million in primary care case management (PCCM) programs. This is up from 10 percent in 1991.[7]

- **Federal laws limited states' expansions of payment mechanisms that resulted in increasing federal payments to the states.** For example, the federal government put a cap on the amount of additional payments available to the states to support disproportionate share hospitals (DSH), i.e., those serving large numbers of Medicaid beneficiaries and uninsured patients.

- **A number of states improved cost control in long-term care, which is one of the most significant components of Medicaid expenditures.** This was accomplished through limits on nursing home beds, tightened payment rates to the facilities, and expanded coverage of home and community-based services.[8]

- **Family enrollment fell as people left the ranks due to a strong economy and welfare reform.** Continued lower Medicaid enrollment, even after state outreach efforts were put in place, coupled with slightly higher rates of employer-based coverage, suggest that some people leaving welfare were finding employer-based coverage. At the same time, a number of people who were eligible for Medicaid appeared to have been improperly dropped from Medicaid rolls.[9]

Why Medicaid Spending Is Rising Now

A number of factors are pushing up state Medicaid spending. The explanations include: general economic theory and normal business cycles; some "usual suspects" such as demographics, technology, and labor costs; managed care backlash; and new concerns such as the cost and use of pharmaceuticals and changes in federal regulations.

> "Medicaid costs are influenced by a variety of factors including the size and health care needs of the eligible population, the scope of medical benefits provided, service utilization levels, and the amount of payment for services provided. The double digit Medicaid increases in the first half of the 1990s were primarily attributable to: (1) increases in eligibility; (2) inflation in the costs of medical services paid for through the programs; and (3) special financing measures to maximize federal funds...Other influences include broad social and economic conditions such as increases in the poverty level, unemployment rates, the number of uninsured, the aging of the population, the explosion of new medical technologies, and inflationary trends in the health care system which also place spending pressures on the Medicaid program. Many of these pressures will continue well into the future."
>
> Source: Bill Fairgrieve, Michigan House Fiscal Agency, *Medicaid Costs in Michigan* (Lansing: HFA, 1998). See http://www.house.state.mi.us/hfa/medcost.htm.

Economic Theory and Normal Cycles

- **Baumol's law.**[10] This theory argues that costs for services (such as medical care) rise faster than the economy as a whole because "high touch" goods like care cannot replace labor with technology as easily as manufacturing can. This almost guarantees that health cost inflation (including Medicaid) generally outpaces general inflation.

- **Normal price fluctuations.** Many analysts argue that an overdue upturn in the normal, cyclical fluctuation of prices for both public and private insurance (sometimes known as the insurance or underwriting cycle) is taking place. They believe insurance prices were artificially suppressed in the late 1990s as a result of market share competition described in the previous section.

The Usual Suspects

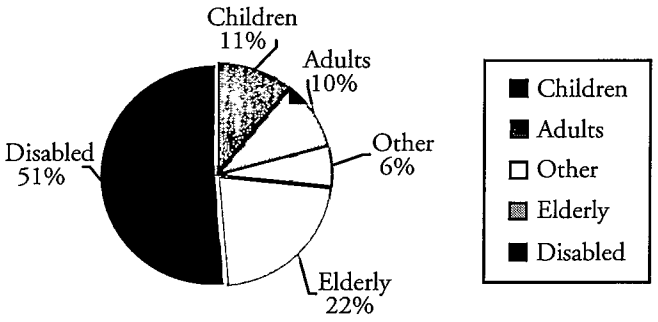
Demographic trends. The mix of people in the program ("case mix") is changing. By 2030, the over-65 population will double, and the over-85 population will triple. Because of this growth,

overall levels of disability in the population as a whole are expected to continue to rise. This change in demographics is expected to increase the average per capita cost of Medicaid overall.

Three-fourths of projected increases in federal Medicaid spending, according to Congressional Budget Office projections, will be due to care for the elderly and disabled. One-fifth of this growth is a result of rising enrollment in these categories. However, more than half is due to expected higher expenditures per enrollee in these categories. Growing proportions of people on Medicaid are higher cost disabled enrollees—average expense: $9,558 in 1998, compared to $1,892 for an adult and $1,225 for a child. [11]

The CBO projects another 900,000 children and 200,000 adults will be enrolled in FY 2001 as a result of outreach and program changes, but this will increase federal expenditure on Medicaid only by 0.8 percent. After that, "enrollment is expected to remain flat for children, with only modest increases for adults" due to demographic changes.[12]

Figure 1.
Components of Projected Federal Medicaid Spending Growth, By Beneficiary Category, 2001-2006



Source: Ku and Guyer, *Medicaid Spending: Rising Again, but Not to Crisis Levels* (Washington, D.C.: Center on Budget and Policy Priorities, 2001).

- **New technology.** New therapies are coming on line, partly because of new technology and new medical procedures. This puts pressure on Medicaid to cover additional services, many of which come with a relatively high price tag. Furthermore, new medical technologies often increase labor costs rather than lowering them.

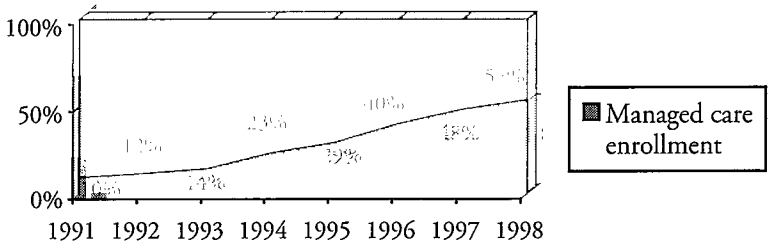
- **Labor costs.** Provider—particularly nurse—shortages drive up labor costs. The average age of the nurse workforce is over 40. Hourly wages in health services establishments increased in 2000 at the highest rate since 1992.[13]

Managed Care Backlash

- **Managed care savings peaked.** The transition to managed care is nearly complete. Markets are highly consolidated, frequently as a result of plan mergers. Some areas have only two or three managed care organizations, so there is little competitive leverage. Savings from managed care already have been achieved or are not occurring as expected.

- **Higher rates.** Providers, managed care plans and carriers are making up for the conservative budgeting of their recent past. Health plans are withdrawing from the Medicaid and Medicare markets, citing excessively low prices. Those that remain are successfully demanding and negotiating higher compensation and rates.

Figure 2.
Growth of Medicaid Managed Care
1991-1998



Source: Center for Medicaid and Medicare Services, Office of Managed Care Medicaid National Summary Statistics: (HCFA-2082 Report) National summary of Medicaid managed care programs and enrollment as of June 30 of each year (Washington, D.C.: CMS, 2001). See http://www.hcfa.gov/medicaid/msis/2082-11.htm (Accessed November 2001).

- **Loosening restrictions.** Managed care plans are loosening the restrictions they traditionally have used to control excess utilization. For example, plans are making it easier for consumers to obtain services without obtaining prior authorization. They also are removing restrictions designed to reduce the use of emergency rooms. Some analysts believe these actions are contributing to the rise in Medicaid spending.

Table 1.

PROGRAMS AND ENROLLMENT AS OF JUNE 30 OF EACH YEAR (POINT-IN-TIME DATA)			
YEAR	ELIGIBLES (MILLIONS)	ENROLLEES (MILLIONS)	[illegible]
1998	30.9	16.6	[illegible]
1997	32.1	15.5	[illegible]
1996	33.2	13.3	[illegible]
1995	33.4	9.8	[illegible]
1994	33.6	7.8	[illegible]
1993	33.4	4.8	[illegible]
1992	30.9	3.6	[illegible]
1991	28.3	2.7	[illegible]

Source: Center for Medicaid and Medicare Services, Office of Managed Care Medicaid National Summary Statistics: (HCFA-2082 Report) National summary of Medicaid managed care programs and enrollment as of June 30 of each year (Washington, D.C.: CMS, 2001). See http://www.hcfa.gov/medicaid/msis/2082-11.htm (Accessed November 2001).

New Developments

- **Pharmaceuticals.** Spending on pharmaceuticals is projected to grow at least 15 percent to18 percent annually through 2004. The Center for Medicare and Medicaid Services (CMS)—formerly HCFA—projects that Medicaid's prescription drug expenditures will grow 70 percent faster than overall Medicaid growth between 2001 and 2006,[14] especially for the elderly and disabled. These estimates do not take into account possible offsetting savings in other areas.

- **Creative financing.** The most important factors in the 2001 increases were states' use of so-called "creative financing"—techniques for drawing down additional federal funds through

accounting methods used to value health care provided through public entities or for uncompensated care (see Strategy 3—Intergovernmental Transfers and Other Alternative Funding Mechanisms). Because these methods, which include intergovernmental transfers, increased the federal matching rates without raising state spending, their main effect was on federal, not state Medicaid spending.

Influences on State Medicaid Costs

Medicaid costs depend on who receives care, what care they receive, who provides it, what the provider is paid, and the basis for the payment. Federal law allows states some flexibility in each of these areas, while requiring that certain categories of low-income people (children, pregnant women; and aged, blind and disabled people) and certain services (long-term care, hospital, physician) be covered. Other populations and services may be covered or excluded at each state's option.[15]

Average Medicaid Spending by Category, 1998

Child	$1,225
Adult	$1,892
Blind and disabled	$9,585
Elderly	$11,235

Source: Kaiser Commission on Medicaid and the Uninsured. Bruen and Holahan, *Slow Growth.*

Total Medicaid Spending by Category, 1998 ($billion)

Child	$24.5
Adult	$16.0
Blind and disabled	$67.7
Elderly	$46.1

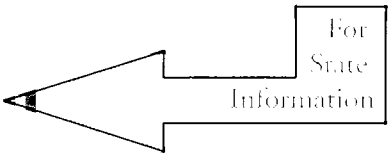
Source: Kaiser Commission on Medicaid and the Uninsured. Bruen and Holahan, *Slow Growth.*

Costs may grow because the size of a group grows, or because services change. A rapidly growing group is not necessarily one whose costs are high. Because different groups use services at different rates, when a group that uses higher levels of services grows faster than other groups, average Medicaid costs also rise faster.

Who Receives Care: Enrollee Mix

Who is covered has more of an effect on Medicaid costs than how many people are covered. On average, Medicaid spends more than nine times as much for an elderly recipient as for a child, and spending for elderly, blind and disabled people accounts for more than 70 percent of health services spending. About half of all poor people are covered under Medicaid; almost 40 percent of births are paid for by Medicaid; about 20 percent of children age 18 and under are covered by Medicaid; and some 6 million people who are poor or disabled rely on Medicaid to supplement Medicare and pay for such things as pharmaceuticals and long-term care. Costs are affected by the number of people enrolled and the services they use.

(For information about state-by-state enrollment see www.statehealthfacts.kff.org)



Most Unpredictable Growth: Children and their Families

- **Changes in Medicaid costs for children and families are largely driven by changes in enrollment, which is a function of state and national eligibility policy, the condition of the economy, outreach, and public perception of the program.** This population is most like the general population covered under employer-based insurance. Although this is the largest group of enrollees, even in aggregate less is spent on these families than for the numerically smaller eligible groups, the elderly and disabled. Nationally, children represent half of all enrollees but only 15 percent of the spending for Medicaid.

> *Myth: Costs are going up because so many children enrolled in Medicaid as a result of SCHIP outreach.*
>
> *Fact:* Children are the cheapest group to cover, and prevention in this age group pays off. Children and their parents make up 73 percent of the Medicaid covered population but only 25 percent of the health care spending.
> According to Ku and Guyer, very little of the growth in Medicaid spending is due to more children, because per capita costs are quite low. In FY 2000, $200 million in increased federal Medicaid spending was due to adding children and adults vs. $1.8 billion due to state fiscal strategies. In FY 2001, greater enrollment success and higher growth are expected. CBO projections are flat for this population after this year (due to demographic changes).
> Source: Ku and Guyer. *Medicaid Spending.*

- **In the late 1990s, states experienced level or declining enrollment for this group. About 200,000 fewer people were on Medicaid in 1998 than in 1997.** This drop was attributed to a strong economy, welfare reform and confusion over continued eligibility for the working poor that led to declines in Medicaid coverage. These falls were offset in some states by higher enrollment due to outreach efforts for the State Children's Health Insurance Program (SCHIP) that also reached people who were eligible, but who were not enrolled in Medicaid.

- **Not all eligible people enroll; it is estimated that three-fourths of uninsured children are eligible for Medicaid or SCHIP but fail to enroll.** There are many reasons why people do not enroll, ranging from the complexity of the enrollment process to their perception of the program. Within this group, however, people who are sickest are likely to enroll first because they are in contact with the health system. For this reason, outreach can lower per capita spending (while raising the overall program spending) because it tends to bring in people who use the same or fewer services, on average, than those currently in the program.

The Most Costly Growth: Poor Elderly People and People with Disabilities

- **The poor elderly and people with disabilities consume a much higher share of the Medicaid budget.** Compared to children and families, these groups are likely to be in poorer health or to need extensive support such as long-term care. Many states make it easier for these groups to enroll by either allowing certain groups to "spend down" to become eligible or using the "medically needy" optional eligibility category available for people with particularly high medical

expenditures—typically people in need of nursing home care; 56 percent of elderly enrollees are in the optional category.[16] Although in theory a state could choose not to offer this coverage, it makes financial, social and political sense to use the Medicaid program to fund this essential care. Medicaid is a way of mobilizing federal resources for health care for groups that otherwise would rely heavily on public services and institutions

- **Spending changes for these groups are largely due to changes in the service mix.** For example, changes in policies related to home and community-based care have led to rapid growth in spending for non-institutional long-term care services. Recently, spending for pharmaceuticals has registered sharp increases. These increases are due in part to changes in prices and prescribing practices, but also to the availability of new therapies that substitute for other treatments.

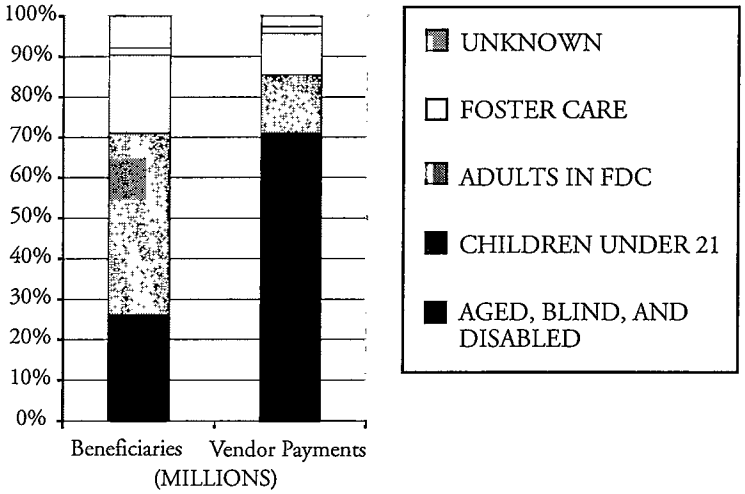
Myth: Aging America will bust the health budget

Fact: Americans are living longer, but they are living longer in better health. A recent study (Manton) found that average lifetime numbers of days with disability had remained constant, even as people's life expectancy rose.

Hard truth: Caring for disabled people is a major area of increased Medicaid spending. Some of this is due to more people with disabilities—due to better medical care that spares people who might have died in the past. Part of this may be an artifact of state financing changes that capture more federal dollars to cover people whose care was previously primarily paid for by states and local governments. Some is due to aging.

Source: K.G. Manton, "Future Trends in Chronic Disability and Institutionalization: Implications for Long-term Care Needs," Health Care Management 3, no. 1 (June 1997) 177-91.

Figure 3.
Medicaid Beneficiaries and Vendor Payments, 1998



Source: Center for Medicare and Mediaide Services, *Medicaid National Summary Statistics* Table 3.
See http://www.hcfa.gov/medicaid/msis/2082-3.htm.

"Medicaid spending for aged, blind, and disabled people dominates the program. While just over one-quarter of Medicaid enrollees in 1997 were aged, blind, or disabled, they accounted for 72 percent ($104.9 out of $145.2 billion) of Medicaid spending on medical services. Long-term care, particularly in institutional settings, is a significant contributor to these expenditures. States spent $57.9 billion on long-term care for the aged, blind, and disabled in 1997, including $42.6 billion for nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs). Other significant contributors to the high cost of coverage for these enrollees are inpatient hospital care ($13.6 billion, mostly for the blind and disabled) and prescription drugs ($8.5 billion)"

Source: Brian K Bruen, Joshua M. Wiener, Johnny Kim, and Ossai Miazad, *State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People.* (Washington, D.C.: The Urban Institute, 1999), 99-109.

Medicaid's relatively generous service mix—better coverage for mental health services, pharmaceuticals, personal care attendants and various rehabilitative therapies—affects enrollment. Medicaid typically provides better coverage than Medicare or private insurance for services that people with disabilities use. As private coverage and Medicare become more restrictive, the sickest people with dual eligibility become likelier to enroll in Medicaid. To the extent that private insurance coverage is restrictive, expensive and even unavailable for persons with disabilities, Medicaid becomes an insurer of last resort for low-income workers with chronic conditions.

Different Enrollees, Different Care: Prevention

For children and their families, prevention is particularly important as an investment against future health costs. For older and disabled populations, prevention emphasizes managing existing conditions to avoid worse outcomes as well as protecting against communicable diseases such as influenza.

- **Once enrolled in Medicaid, a person who is elderly or permanently disabled is likely to remain in the program.** Changes in enrollment are more likely to reflect changes in demographics and program requirements (such as changes in income eligibility levels) than changes in the economy.

- **Costs for the low-income elderly and disabled are difficult to manage because these are particularly vulnerable enrollees and many are dually eligible for Medicaid and Medicare.**[17] Among the more expensive groups covered under Medicaid are individuals with developmental disabilities, chronic and severe mental illnesses, conditions such as HIV/AIDS, and the frail elderly. These groups depend on states to act as their advocates and also to fund their care. This can place state agencies in conflicting roles, with one agency having protective responsibility for the vulnerable patients while another must manage budgetary demands. Legislators face both responsibilities.

What Care Is Provided: Service Mix

Different groups have very different costs because they use different services. For example, people with disabilities accounted for 17 percent of enrollment and 43 percent of medical service expenditures in the program nationwide in 1998.[18] The services and needs of this group differs from those of pregnant women and children, for example. This means that strategies for managing costs will differ among groups.

Services vary across states. Although the federal government requires that states provide medical, hospital and long-term care to all eligible groups, there are other services—such as chiropractic services, hospice care, eyeglasses and rehabilitative services—that states have the option of covering. If a state chooses to offer an optional service, it must be offered to all eligible groups. Some optional services, such as prescription drugs, are universally offered because the cost of providing them is deemed to be less than the cost of treating the more severe illnesses that may result from not covering the cost of the drug.

For information on state expenditures by service, see www.hcfa.gov/pubforms/Martin.pdf

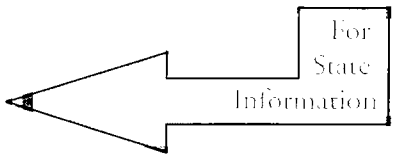
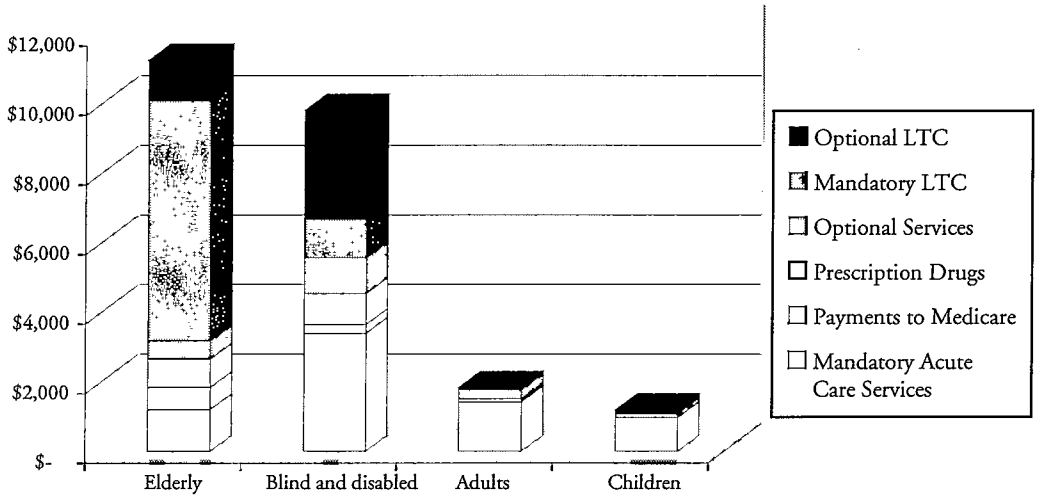


Figure 4.
Medicaid Expenditures by Beneficiary Group and Type of Services



Source: John Holahan, *Restructuring Medicaid Financing: Implications of the NGA Proposal* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2001). See http://www.kff.org/content/2001/2257/2257.pdf

States can, and have, set "reasonable" limits on both mandatory and optional services, such as the number of prescriptions or the number of visits to a particular type of provider. In practice, with the exception of required services for children,[19] states have exercised wide discretion in the amount, duration and scope of services they cover. Research suggests that such limits can be problematic in a small number of cases where there are particularly complex medical needs.[20]

Whether it is done by the Medicaid agency or a health plan, a first step in managing costs and care is to look at categories of spending and changes in spending, by eligibility group, to see where costs are higher than expected. Restrictions and opportunities that apply to specific vendors will affect various groups—elderly or disabled persons versus indigent families—in different ways. Even apparently similar services are used differently. For example, dental care for children has very different requirements, typical services and average costs than dental care for people with disabilities. Strategies that entail changes in what services are offered can be expected to mobilize providers as

well as recipients and their families. Because their needs are complex and family members are advocating for them, children with disabilities have become a touchstone for whether or not care management is coordinating services and thus improving quality, or whether it is chiefly throwing up barriers to access.

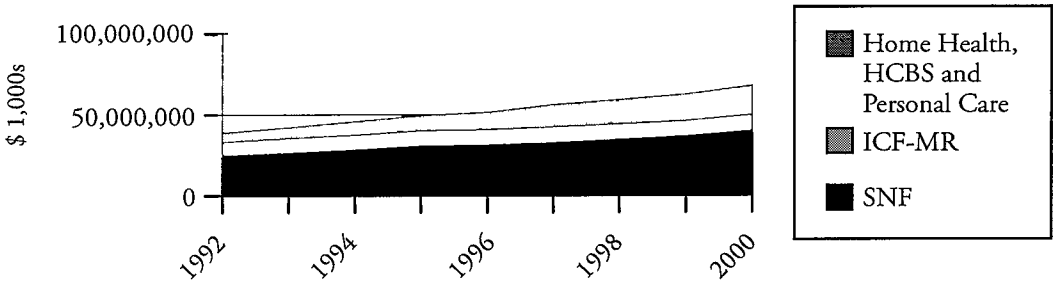
How Trade-offs Are Managed

Rapid growth in one category of spending is not necessarily bad because increasing the use of some services may decrease the use of more expensive services and lower costs over time.

- Outpatient and physician's office visits increased a decade ago due to a shift from inpatient to less expensive outpatient care.

- Pharmaceutical spending has swelled alarmingly in recent years; however, it is not clear that this is undesirable. For at least some conditions, such as chronic mental illness, pharmaceuticals are an alternative to more expensive care or procedures and may slow the costly progression of disease and disability.

Figure 5.
Medicaid Long Term Care Vendor Payments, By Category 1992-2000



Source: Medstat, Home and Community Based Services Resource Network, *Financial Management Medicaid Long Term Care Expenditures in FY 2000* (Washington, D.C.: CMS, 2001).

- Home and community-based care have been growing at double-digit rates, encouraged by the view that it often is less expensive than institutional alternatives. New community-based services create budget problems if they are not offset by decreased use of nursing facilities. More than half of Medicaid long-term care spending goes to nursing homes, although the proportion varies from state to state (see chapter four).

For State Information

Waiver services by state:
See http://medicaid.aphsa.org/waivers/HBCWaiver.htm

To understand the effect of spending for specific services on Medicaid budgets, the entire profile of spending, including offsetting savings and improved outcomes, needs to be considered. Remember, however, that it may be difficult to evaluate savings that result from substituting one service for another.

How Care Is Financed

Another traditional lever for controlling costs has been to limit reimbursement rates. Over the years, rate-setting methodologies have become more complex, with more attention focused on how different payment systems affect providers' choices. Medicaid rarely pays as much as other third parties and is legally the last payer when more than one party is responsible for medical costs. Medicaid rates have tended to be closer to marginal rates—the cost of an additional unit of care—than to a proportionate share of total costs.

> "Why Change to Managed Care?
> The cost of providing health care continues to increase. There is a point at which either fewer persons can be covered or fewer services can be provided, unless there are some measures instituted to control the cost of providing health care. Of all the options available to the state, implementing managed care seemed the best."
> Source: Texas Mental Health Consumers, tmhc.org/managedhc.html, accessed November 2001.

Today, rather than setting prices and limiting services one at a time, most states use managed care to achieve wholesale control of prices and utilization. Mirroring the growth of managed care in the private sector, all states expect Wyoming and Alaska have experimented with financial arrangements designed to manage costs and utilization for at least some of the Medicaid population. The Federal 1997 Balanced Budget Act gave states new flexibility to manage spending by allowing them greater freedom in setting payment rates for institutional care[21] and allowing them to require recipients to enroll in managed care without a waiver. Reimbursement often is based on average per person costs (capitation) paid to an intermediary—a health plan—that then makes various service and payment arrangements with a range of providers. In addition to contracting with health plans, states are experimenting with directly managing care or contracting out components of care management for some populations. The rapid growth of managed care has changed how care is coordinated and how access to services is managed, even outside of managed care plans. Although a majority of enrollees are in managed care, it actually comprises a small portion of the Medicaid budget.[22]

Some analysts have announced the death of managed care. Nonetheless, a creative variety of approaches to bundling and coordinating care continues to grow, as described in the strategy profiles in chapter three. Costs are increasingly controlled by changing the mix of services and the number and type of services that individuals receive based on their medical needs.

Costs for the "dually eligible"—low-income disabled or elderly people who are covered by both Medicaid and Medicare—may be difficult to manage because control is divided. This is because Medicare chiefly covers hospitalization and physician services, while Medicaid is the primary funder for pharmaceuticals and long-term care. Rehabilitation and supportive services, (generally used by the elderly and people with disabilities) may raise state Medicaid spending, even when they lower total health costs by lowering hospital use. It is also difficult to enroll dually eligible people in managed care, since the benefits must be coordinated across the two programs.[23]

Challenges to Controlling Medicaid Budgets

Medicaid was called "the Pacman of state budgets" in the late 1980s because of its propensity to gobble up budget surpluses. The program looms large over state budgets. Because Medicaid is an entitlement,

once rules for eligibility and reimbursement are set, the program cannot be terminated when funds run out without legislative action. Furthermore, providers and plans may effectively resist changes in their payments and contracts. For all these reasons, accurate budgeting is important. This is complicated because it requires accurate forecasting; dealing with uncertainties built into the Medicaid program; understanding how Medicaid interacts with other state spending and leverages federal support; and predicting how Medicaid policies may spill over into the private sector.

Forecasting Issues

Medicaid budgets are difficult to forecast for a number of reasons.

- Medical costs are fungible. Like a water balloon, when pressure is applied to prices in one part of the health system, another part of the system is affected. Providers typically charge purchasers of health services different rates. Before private sector employers began to use managed care to extract low prices, Medicaid sometimes was blamed for shifting costs to the private sector. Today, the pressure may work in either direction. Medicare and private insurance rate changes will affect whether states can negotiate lower Medicaid rates.

- Enrollment increases if the economy slows.

- Complicated connections exist between the number of people covered and the cost of care. Because Medicaid shares the cost of uncompensated care with other payers, Medicaid costs change if there are changes in the number of people receiving unpaid care. States may have to rescue public providers.

- Policy changes—including programmatic and judicial decisions—affect Medicaid enrollment, services and spending in unpredictable ways. Some recent examples are shown here.

Myth: It's all because of unfunded mandates.
Fact: Mandates have been relaxed. The Boren amendment—which required states to pay certain providers market rates—has been repealed. States have more managed care flexibility and more waivers than ever before. No major mandated eligibility increases have occurred since 1990, except fully funded Medicare-related groups. There were minor changes in federally qualified health center (FQHC) payments in 2000. However, states have used administrative devices to drive up their own budgets, making creative use of programs such as disproportionate share hospital payments (DSH) and intergovernmental transfers (IGT) to define a greater part of public health spending as Medicaid and capture a larger federal match.
Source: Ku and Guyer, *Medicaid Spending.*

- A recent Supreme Court decision (*Olmstead*) dictates that states provide the least restrictive possible care for people with disabilities. This has forced many states to restructure their services for people with disabilities and it may lead to increased spending if institutional costs are not contained at the same time.[24]

- Outreach for SCHIP brought new populations into Medicaid. At the same time, TANF eligibility changes resulted in many families being wrongly dropped from Medicaid. States still are re-enrolling these eligibles.

- The same law that repealed the Boren amendment[25] and thus gave states flexibility to lower provider payments also cut Medicare payment rates. Although provider groups succeeded in rolling back some of the cuts, one upshot has been pressure to increase Medicaid rates.

- Medical costs in general are notoriously hard to predict. State-level data needed for projections may be nonexistent (e.g., health inflation), unreliable (e.g., counts of uninsured persons) or not timely (e.g., expenditure data.)

Programmatic Complexity

The Medicaid program itself makes Medicaid budgets difficult to explain and difficult to project. Much of this stems from programmatic complexity built into Medicaid rules. Although these rules (added incrementally over the years) often were meant to give state programs more flexibility, they also can confusion.

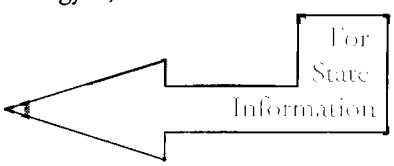
- **Different program partners use different calendars.** Different entities—states, the federal government and health plans with managed care contracts—use different fiscal years. The Medicaid budget is a mix of state and federal (and sometimes local) spending. It is important to know which figure and which time period are being discussed.

- **A state dollar spent on Medicaid can reduce overall state spending growth.** One of the ways states manage the growth of Medicaid spending is to increase federal financial participation through a variety of techniques. This cost shifting can make the Medicaid budget seem to grow faster, even as it relieves total state spending growth. The rules for these programs are complex and have changed when the federal government determines they are being misused by states. Federal policies that unexpectedly change the availability of these options can challenge state budgets. (See chapter three, strategies 1 and 3.)

- **Federal payments vary.** The extent to which the federal government matches state Medicaid payments varies (see strategy 2 – Low Match to High Match). At least half of Medicaid payments for medical services are paid by the federal government (50 percent in 11 states, up to 76 percent in Mississippi); other costs may be covered at higher rates. As a result, $1 of state general fund money is worth at least $2 on the Medicaid budget and frequently more, depending on the federal matching rate (FMAP) for the state.[26] Designating other state health spending as Medicaid (e.g., expenditures for school-based health services to eligible children) allows the state to draw down matching federal funds to offset other state spending on health (see strategy 1).

Although Medicaid spending in 2000 grew at double-digit rates in nine states, much of that spending growth reflects changes in how states account for health care costs. Only three states with high Medicaid spending growth Idaho, Kansas and Nebraska experienced higher than average general fund spending growth as well. In at least one of these states, Kansas, the increase may reflect changes in federal rules that limit the extent to which states can take advantage of another aspect of the Medicaid program known as "disproportionate share hospital" (DSH) payments to offset state spending in mental hospitals

Source: Gloria Timmer, Greg Von Behren, Stacey Mazer, and Jill Schamberger, *1998-1999 State Health Care Expenditure Report*, (New York: Milbank Memorial Fund, National Association of State Budge Officers, and the Reforming States Group, March 2001). 51-53. See http://www.milbank.org/1998sheer/index.html.



See
FMAP's at http://aspe.os.dhhs.gov/health/fmap.htm

- **Federal matching rates change.** The rate at which the federal government will match state payments is set annually. Depending on the period for which the budget is being forecast, or if the average per capita income in the state has changed sharply, there may be some uncertainty over the federal reimbursement rate, and hence the amount of the grant to the state. Even a fraction of a percentage point will have an enormous effect on a state's spending.[27]

- **Determination of actual costs takes time (the problem of estimation and reconciliation).** The federal government quarterly advances state Medicaid programs its estimated share of spending. Actual vendor payments (net of recoveries from such things as third party payers, and fraud and abuse enforcement) then are reconciled, a process that can take an extended period of time if there are disputes over methodologies between the state and providers or between the state and the federal government. When there are rapid fluctuations in Medicaid spending, this can become complicated. The vendor payment data often are produced by MMIS contractors,[28] who receive claims, determine whether they will be approved, and generate the reports needed for federal reimbursement. This either can add another layer of complexity when the systems are not working well or can facilitate the process when they work right. At the end of this process, a state may owe or be owed money, so it is difficult to know the extent of state Medicaid shortfalls or windfalls at any point in time.

- **Federal policy changes are being considered.** Some policy changes that have been discussed in Washington could substantially change states' Medicaid obligations or how they program Medicaid spending either by increasing flexibility or by creating new federal programs that affect some populations that are at least partially covered under Medicaid. These include recent changes in 1115 waiver policies and methodologies and proposals related to easier or expanded SCHIP family coverage, pharmaceutical benefits under Medicare, and changes in the treatment of dually eligible individuals.

Federal Cost Containment Mandates

Although these are not a major focus of policy, the federal government dictates that state Medicaid programs carry out certain activities that are designed to contain costs. The justification for each of these is cost control. State and federal governments both save when they work, but some states have found the pay-off to be low in relationship to their administrative costs. Legislators may want to know how their state is pursuing these activities.

- **Third-Party Liability and Recovery**

  Medicaid is the payer of last resort. State programs are required to recover from other carriers, including noncustodial parents and private insurers. A recent study of pharmaceutical cost recovery by the HHS inspector general's office found that, "States are at risk of losing over 80 percent ($367 million) of the payments they tried to recover ($440 million) in 1999 through the 'pay and chase' approach. However, the cost-avoidance approach prevented $185 million from being at risk"[29] (see strategy 4).

- **Estate Recovery**

  Since 1993, states have been required to recover certain expenditures for hospitalization or long-term care from the estates of deceased Medicaid beneficiaries, typically through a lien on

a home after the death of a surviving spouse.[30] This program often referred to as "grave-robbing" by opponents has spawned an entire legal industry.

- Administrative Simplification-HIPAA

  States are among the payers being called upon to conform to uniform, electronic standards in billing that are designed to lower administrative costs while still protecting privacy. Federal—and, thus, state—rules have been slow to emerge because of seemingly intractable privacy concerns. Changes will require substantial up-front investment in Medicaid information systems.[31] Most states are using vendors to meet these requirements. This investment will be largely reimbursable. Some states have seen this as an opportunity to upgrade and coordinate a variety of health data collection, as well as and reporting activities, including public health and hospital data collection as well as Medicaid systems (see strategy 2).

- Reduce Fraud and Abuse

  Each state has a Medicaid Fraud Control Unit that is funded at 75 percent by the federal government. Estimates of the amount of fraud and abuse vary, but states that have focused on payment irregularities often have been able to find problems and either recover misspent funds or prevent continued problems, according to a recent GAO report.[32] The new MMIS may be a tool for reducing fraud and abuse, since many vendors have developed sophisticated programs to flag patterns of unusual billing activity for scrutiny.

The Medicaid Budget: Consequences

Medicaid budgets are particularly difficult to manage because they interact with other health spending in complicated ways. Even aside from the federal matching share, what a state Medicaid program spends is not the same thing as the cost of coverage to a state.

Cutting Medicaid spending affects other state spending and providers. The cost of Medicaid coverage for the state is the difference between the state's share of Medicaid coverage and what would be spent by the state (through programs such as general assistance, hospital uncompensated care programs, and local health departments and clinics) for the person's health care if he or she is not covered under Medicaid.

- Medicaid spending replaces spending on uncompensated care, which states often pay either directly (through grants and reimbursements to providers of uncompensated care) or indirectly (through intergovernmental transfers to counties and in higher payments for public employees' coverage—state-only spending).

- If a person is not covered by Medicaid or other public funds, care still will be needed. Cost shifting to private insurers and payers may result in higher insurance rates, harming access to insurance and even increasing Medicaid enrollment if low-income workers and their employers drop coverage.

- Not being able to obtain care may cost more than care itself. For example, consider the relative costs of hospitalization for pneumonia vs. a flu shot or amputation of a limb vs. insulin management.

Medicaid budget decisions can affect insurance premiums and reimbursement rates for the entire state. State and federal health spending now makes up approximately half of all health spending (more, according to Employee Benefits Research Institute; less according to Center for Medicaid and Medicare Services), so state decisions on how to buy health care reverberate heavily in the private sector. Because they are so dominant in the market, state and federal decisions about payment rates, contractual terms and reimbursable services may influence what the private sector does or may force other buyers to pay more to compensate for underpayments. As if the push and pull of state, federal and private spending were not complicated enough, economists point out that health spending can be difficult to control because most is through insurance or insurance-like public programs (Medicaid, SCHIP and Medicare) that shield users from the true costs of care. ▯ *KL*

3. *THINKING ABOUT SOLUTIONS*

It has been said that there are 56 different Medicaid programs, with every state and territory's program having a unique set of rules. That means that no single strategy will work for every state. This chapter lays out some core strategic issues, proposes some features to consider when putting together a package, and suggests policy questions to ask when deciding what approach to try. It also offers suggestions about where to go for answers tailored to a specific state.

Some Medicaid Budget Strategies

What keeps health budgets down? In the starkest terms, states can do less, pay less, do for fewer people, or do better. Most so-called cost containment consists of one of these four options.

The obvious solutions—cut people from the program, provide fewer services, pay less—may be examples of Mencken's easy solutions: "Explanations exist; they have existed for all times, for there is always an easy solution to every human problem—neat, plausible, and wrong."[1] Because these are fundamental policy shifts that require political, not technical analysis, this report does not profile reducing eligibility or eliminating service options[2]. Instead, it suggests some strategies that prudent administrators, with the encouragement of watchful legislators, may want to consider as they respond to expected growth in demand and costs.

The Problem with Simply Cutting

- **Individuals who are not covered by Medicaid can turn up elsewhere in the system eventually, paid for by state or local governments without the generous federal cost sharing.** Moreover, cuts in eligibility or services represent a shift in policy, since most federal and state health policy changes in the 1990s were to make coverage available for more people. States have wooed employers, insurers and providers to be partners in new financing arrangements such as managed care and buy-ins. If states are seen as unreliable partners, their abdication could crush carefully cultivated ties.

- **Doing less or for fewer people can depend on someone else paying for services.** Deferred or denied services can result in higher treatment costs in the future. If the state pays for those costs as well (through uncompensated care and indigent care or lower workforce productivity), it needs to consider which is the better way to pay. In the case of Medicaid, getting someone else—the federal government, employers or individuals-to pay part of the bill also is an important option.

- **Paying less[3] can have unexpected effects on the rest of the system, as the excess costs are absorbed by other payers.** Underpaid providers may shift costs to private insurance or refuse to treat Medicaid patients altogether. If providers and plans find lower payments unacceptable, paying less can reduce access as well.

Doing It Better

- **Ideally, costs are saved by giving care more efficiently, eliminating unnecessary and wasteful systems, and keeping people well by preventing rather than treating illnesses.** Unfortunately for states that are facing budget crunches, the best of these are long-run strategies that may require investment: for example, public health, information systems, and quality improvement systems all promise long-term savings and better quality, but require up-front expenditures that may not be possible in a year of budgetary constraints.

No Simple Solutions

- **Just as the growth in Medicaid spending has many faces and complex causes, state responses will have to be nuanced and multi-faceted.** Usually, lawmakers will want to tackle costs on more than one front, rather than trying to achieve budget goals through a single strategy. In that case, lawmakers need to consider how the approaches complement one another—for example, balancing long- and short-term strategies, or mixing ones that have the greatest effect on providers and ones that change rules for managed care plans. Where strategies depend upon one another—for example, increasing home and community-based services while constraining the availability of beds—lawmakers may even consider adding nonseverability provisions to avoid problems that could arise if only one strategy is implemented.

- **Health budget strategies tend to have complicated interactions with one another.** An apparently simple decision about state spending can reverberate in the private sector or conflict with another state health policy. Medicaid provides literally vital—life-giving—services to the most vulnerable populations. Managing its budget without doing harm is one of the most-difficult challenges a lawmaker faces. Strategies include increasing the flow of money into the Medicaid program from non-state sources—especially the federal government—as well as slowing increases in spending.

Ways to Cut the Pie

States will want to consider a number of factors in developing the strategies that best fit their needs. Strategies vary in their effect, in who is affected, in the kind of environment they require to work, and in the mechanisms they use. States are likely to want to use a mixture of strategies. These categories may be helpful to policymakers as they think through the best mix for their states.

- **Long-term or short-term strategies.** How long does it take to implement and how soon is there a pay-off? Many strategies that are likely to accomplish long-term savings require investments in the short-term: prevention, changes in the long-term care delivery system, or disease management. Strategies that maximize federal and private funding—such as Medicaid maximization—may have a quick budgetary pay-off, but do nothing about underlying cost inflation. A strategic mix of short- and long-term approaches may give a state the leverage to begin fundamental cost-saving changes, such as a shift to community-based care, by providing a financial bridge to carry the state through start-up costs.

- **Macro or micro strategies.** Does the strategy work by changing systems at a health plan or statewide level—for example through health planning—or does it affect individual decisions at the patient or treatment decision level—for example through financial incentives and managed care?

- **How extensive or intensive is the strategy?** Does it make a small difference across a large number of people or cases (for example, substituting generic pharmaceuticals for all), or are the effects very concentrated (for example, managed care for people with disabilities)? Are activities coordinated or selectively targeted? The answer will have implications for the politics of change. For example, a narrowly targeted change may mobilize a group if it feels unfairly targeted.

- **Is the strategy collective or individual?** This is related to the previous two concerns. Does the strategy have widely shared or individualized costs? One collective, widely shared strategy is to spread the costs of health care more widely across the entire population—for example, using general revenues to cover Medicaid expansions or requiring health insurance companies to community-rate. Making eligibility standards more stringent individualizes costs for people who lose eligibility.

- **Regulate or compete?** Does the strategy depend on state administrative action or on market competition for its effect? This is a key decision in designing managed care strategies, and will be affected by which approach is most familiar to providers, health plans, and the state Medicaid agency.

- **Who has to act, and who is affected?** Although states initiate cost saving, they almost always need cooperation from others to carry out their plans. Who else is key? Providers? If so, which ones—doctors, hospitals, long-term care providers? Patients? Health plans? Strategies that change where care is provided—such as reimbursement changes that move people from hospitals to the community, or experiments that divert people from nursing facilities to community-based care—generate winners and losers. When multiple strategies are adopted, their effects and costs need to be balanced so they all do not fall on one group.

- **Levels of risk and certainty.** Every new strategy involves some risk. Insurance is about risk; one of the biggest unknowns is how much health costs will change in the future. States have tried to minimize uncertainty through "public-private partnerships," such as managed care contracts in which health plans assume some of the risk. The federal government has encouraged states to develop information systems to gather data and improve their understanding of their own spending in order to find opportunities to lower costs. For example, many have tried to reduce uncertainty about clinical practices by identifying medical practices that vary significantly in different parts of the state.

- **What state and federal laws apply?** The federal environment is the same for every state, but Medicaid law permits considerable state flexibility. Some strategies—such as home and community-based care—may require a federal waiver. Other areas—such as pharmaceutical coverage or eligibility for unemployed workers—are being debated at the federal level. State Medicaid policies exist in law and also in state Medicaid plans that are approved by the federal government.

Questions to Ask

Each of the 10 strategy profiles that follow includes a set of key questions to consider in deciding whether to adopt that strategy and in designing its details. Several of these questions seemed especially important to ask when approaching any of these Medicaid budget strategies. Another set of questions should be asked in order to assess a specific state's starting point and capability:

- **What is the reason for trying to use a given strategy? What is its goal?** To generate funds to maintain current access and reduce state funding? To increase access and maintain current state funding? The answer to these questions will determine the appropriateness and potential effectiveness of various cost containment strategies.

- **What are the cost estimates? Are the benefits worth the cost?** State policymakers should weigh the costs of any strategy being considered against the anticipated benefits. Costs and benefits may be near-term or long-term, direct or indirect, and economic or political. The costs and risks involved in implementing any cost containment strategy include spending money, using other resources to develop and maintain infrastructure, or taking a risk that the number of providers willing to serve Medicaid beneficiaries will decline. For example, the direct benefits of cost savings or improved health of the Medicaid population may also have indirect benefits in the form of positive economic effects for the state as a whole.

- **How will the state measure clinical and fiscal objectives?** How does it propose to measure costs and health consequences? This is essential when the state plans to use private entities to carry out its policies, since there must be a way to define and measure their performance. Ideally, state agencies may be held to performance standards as well if information can be gathered and analyzed at a reasonable cost.

- **What are the risks inherent in the strategy and who will bear them? Does the strategy take advantage of opportunities for containing costs, improving services, and expanding coverage?** Few actions solely affect cost, access or quality. Most policies aimed at one of these dimensions impinge upon the others. For example, cutting reimbursement rates often hurts access. Improving clinical quality may require short-term investments and garner long-term savings.

What information do policymakers need to assess the potential of a particular cost containment strategy? The value of the various strategies depends on specific coverage and cost patterns in a state, and success may be related to a state's previous experience with a given solution. Data are essential in assessing the potential of a given strategy. Does the state have the information it needs? Do policymakers know where to obtain it? Following are some things a policymaker needs to know. The questions should be posed to Medicaid and health agency staff as well as to legislative health committee staff.

- **What does the current Medicaid program look like? What will it look like if a strategy is adopted?** What populations and services are and will be covered? To what extent? Who delivers services and how are they paid? How generous are the payments? Will this change?

- **What is the capacity of the existing health service system? Of the state administrative system?** Do providers or managed care organizations have the capacity and willingness to make implementation possible? Does the state have the capacity to implement and monitor the effect of the changes? What are the capabilities of the Medicaid Management Information System? Does the state have the information it needs to evaluate the potential of the strategy before deciding to adopt it? Will the state be able to obtain the information it needs to assess the strategy once it is in place?

- **How is Medicaid policy changed? What will it take to change the populations and/or services covered or the way in which programs in the state are financed?** Some changes will appear as part of Medicaid budgets. Other policy changes are made through the state Medicaid plan.

Who is responsible for developing the budget? The state plan? Who must approve changes? In some states, executive agencies may play the major role. In others, the legislature may be involved. Since more than one state agency may have to be involved in working out services standards and budgets, the legislature may have to bring together two or more agencies that traditionally have not been linked. Legislative and agency fiscal analysts should be able to provide information about the potential effects of proposed changes.

- **Would the approaches being proposed be politically feasible?** Who are the key interest groups? Would they support or oppose the change? How willing are they to work with you? What would it take to get their support?

Who Knows?

Policymakers need good information about their states as well as about Medicaid in order to make informed decisions. Where can they get that information?

At the National Conference of State Legislatures

This paper was written by staff of the Forum for State Health Policy Leadership, in the Washington office of NCSL.

This Web site—http://www.ncsl.org/programs/health/medfipha.htm—links directly to Medicaid-related matters on the NCSL site. Questions about specific issues may be directed to NCSL policy area specialists here and in the Denver office, as follows.

- **In Washington, D.C.:** (202) 624-5400
  Donna Folkemer (Donna.Folkemer@ncsl.org)
  —Medicaid, pharmaceuticals
  Wendy Fox-Grage (Wendy.Fox-Grage@ncsl.org)
  —Long-term care and disability
  Shelly Gehshan (Shelly.Gehshan@ncsl.org)
  —State Children's Health Insurance Program (SCHIP), behavioral health
  Kala Ladenheim (Kala.Ladenheim@ncsl.org)
  —Financing, access, insurance, the uninsured
  Joy Johnson Wilson (Joy.Wilson@ncsl.org)
  —Federal-state

- **In Denver:** (303) 830-2200
  Martha King (Martha.King@ncsl.org)
  —Medicaid, SCHIP
  Richard Cauchi (Richard.Cauchi@ncsl.org)
  —Insurance, pharmaceuticals

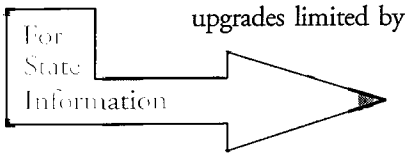
State Resources

State health information often is scattered among a number of departments.

- **State legislative staff:** Health committee staff, legislative fiscal staff and central research staff work with Medicaid information. Most legislative staff rely on state agencies for data but

conduct varying amounts of further analysis with this data. Legislative staff may be called upon to develop forecasts of Medicaid spending under varying policy assumptions.

- **Medicaid agency:** The agency will have information about the program characteristics and history, and data on recipients, services and spending. The detail, currency and quality of this information often depend on the state's investment in management information systems and staff, as well as the quality of reporting by providers and health plans. Some states have suffered from a paradox of early automation. Because Medicaid systems often were among the first to be automated, they may depend on outmoded information systems that are difficult to use, with upgrades limited by efforts to remain compatible with past data and a reluctance to invest again.



State Medicaid directors:
http://medicaid.aphsa.org/members.htm

- **Fiscal and budget agency:** This may be part of the Medicaid agency, or it may be housed elsewhere in the state.

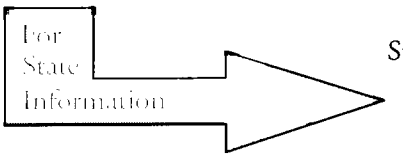
- **Vital statistics and state health data:** Public health data systems and health planning often are separate from the Medicaid program. They may have valuable information about the characteristics of the overall population of the state. All states collect data on births, deaths and certain diseases. Many states collect data on health care billing, discharges, services or other activities by hospitals. States also collect information on health behaviors such as smoking and obesity.

- **State planning:** State planning may be carried out in an economic development department or the governor's office, or may be contracted out to a university. This is a source of information on overall population trends, income, family composition and employment. Trends that affect Medicaid programs that these units may monitor include changes in immigrant and minority populations and workforce changes. These planners also may have technical expertise in population and economic forecasting.

- **Insurance agency:** For Medicaid programs with eligibility set at and above the poverty level, policymakers may need information about insurance. The state insurance department will have information about the state's laws and limits on what can be required of employers. A few states collect data on individual and small group policies sold in the state, but federal law makes it difficult to get information about insurance coverage and plan contents from larger employers.

Federal officials

- **The Center for Medicare and Medicaid Services (CMS),** the federal Medicaid agency formerly called HCFA, is organized into regions. CMS regional offices may be a source for program information, comparisons with neighboring states, and policy interpretation.



State and federal Medicaid contact information can be found on the CMS web page at
http://www.hcfa.gov/medicaid/mcontact.htm
http://www.hcfa.gov/regions/roinfo.htm

Other federal agencies with information on Medicaid: Several other federal agencies are valuable sources of studies and data: The secretary of health and human service's Office of the Inspector General (OIG) (http://oig.hhs.gov) carries out program audits and similar studies. Another source of Medicaid-related policy and analysis is the office of the assistant secretary for planning and evaluation (ASPE) at (http://aspe.hhs.gov). This is also the site of the Catalog of Federal Domestic Assistance Programs, which lists details of the Medicaid program.

The General Accounting office (GAO) (http://www.gao.gov) publishes regular reports with useful information on Medicaid. Other congressional study bodies who often examine Medicaid are the Congressional Budget Office (CBO) (http://www.cbo.gov) and the Congressional Research Service (CRS). CRS reports are not available to the public, but several sites now offer them, most notably Congressman Mark Green of Wisconsin. (http://www.house.gov/markgreen/crs.htm).

Associations

In addition to the NCSL, the National Association of State Medicaid Directors (http://medicaid.aphsa.org) and the National Governors Association (http://www.nga.org) have state-level information and analysis of Medicaid programs. They can be valuable sources for comparisons among states. The National Association of State Budget Officers (NASBO) (http://www.nasbo.org) and the federal funds information for states (FFIS) (http://www.ffis.org) are sources for current, comparative budget data for states.

Private Sector Organizations

A number of foundations, think tanks and advocacy organizations carry out research on Medicaid programs. The following partial list emphasizes organizations with current, factual, state-based information related to cost management that is easily accessible for state researchers.

- **Some foundations also maintain collections of information at their own sites.**
  The Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) (http://www.statecoverage.net) and the Kaiser Family Foundation's Commission on Medicaid and the Uninsured (http://www.kff.org/sections.cgi?section=kcmu) produce a range of reports and compilations of state information about Medicaid for policymakers.

  Other foundations with resources related to Medicaid include the Kellogg Foundation, with a database of grantees' products related to welfare, SCHIP and Medicaid reform (http://www.wkkf.org/Devolution/PubDatabase) and the Commonwealth Fund (http://www.cmwf.org), which posts a number of Medicaid-related studies.

- **Two prominent think tanks that work on Medicaid** are
  The Urban Institute (http://www.urban.org), particularly its project on assessing the new federalism (http://newfederalism.urban.org) carries out surveys, simulations and studies of Medicaid and other programs. Mathematica Policy Research, Inc. (http://www.mathematica-mpr.com) and its affiliate, the Center for Studying Health System Change (http://www.hschange.com) are also known for surveys, simulations and evaluation of Medicaid programs.

- **A number of agenda-oriented organizations carry out Medicaid research and analysis.** The Center on Budget and Policy Priorities (http://www.cbpp.org), a policy organization with a focus on programs for low and moderate income groups, has released several recent analyses on costs and eligibility in Medicaid. Other sources can be found in the footnotes.

Private Sector Consultants

Several consulting firms specialize in Medicaid and several have former Medicaid directors or state health commissioners on staff. States will want to develop their own relationship with consultants who are familiar with their state and its specific concerns. Several who were consulted while writing this paper indicated they would be willing to field questions from states:

Chuck Milligan, Lewin Group.	(703) 269-5627 (chuck.milligan@lewin.com)
MaryJo O'Brien, Capital Health Strategies.	(651) 224-8267 (obrienmjo@aol.com)
Vernon Smith, Health Management Associates.	(517) 482-9236 (vsmith@hlthmgt.com)
Jim Verdier, Mathematica MPR.	(202) 484-4520 (jverdier@mathematica-mpr.com)

We welcome your suggestions about groups and individuals that have expertise in Medicaid cost containment, either generally or in relation to a specific strategy. ▯ *KL*

4. *Cost-Cutting Strategies*

The profiles that accompany this report describe 10 strategies states have used to manage Medicaid costs. They fall into three categories: maximizing available funding for Medicaid; financing and delivery incentives; and fine-tuning managed care and selective contracting.

Maximizing available funding for Medicaid contains four strategies designed to directly or indirectly reduce state Medicaid costs by generating additional federal or private sector funding to enhance state Medicaid budgets. These strategies are:

1. Medicaid maximization
2. Low-match to high-match
3. Intergovernmental transfers
4. Private sector cost sharing

Financing and delivery incentives include three strategies to reduce or contain costs by changing the incentives for providers and encouraging the use of different, potentially cost saving services and delivery mechanisms. These strategies are:

5. Reconfiguring the long-term care delivery system
6. Pharmacy cost containment strategies
7. Rate adjustment

Fine-tuning managed care and contracting for services include three strategies for contracting with providers and plans to reduce costs and improve how care is managed. They include:

8. Managing health care better
9. Expanding managed care
10. Selective contracting

Each profile consists of: a brief description of the strategy and how it is used; the pros, cons, design and policy issues that need to be considered; and any federal or other limits on its use. State examples are provided for each. A table and graphic showing which states currently are using each strategy and some key references—such as important studies or useful Web sites—also are included.

Chapter 2 Notes

[1] Much of this paper also will apply to the State Child Health Insurance Program (SCHIP). However, because of its different structure and the small dollar amount, it is not included in this paper.

[2] National Conference of State Legislatures, *State Fiscal Outlook for 2001: February Update* (Denver: NCSL, March 2001). See http://www.ncsl.org/programs/fiscal/upsfo2001.htm.

[3] The National Governors Association and the National Association of State Budget Officers, *The Fiscal Survey of States: June 2001* (Washington D.C., June 2001). See http://www.nasbo.org/Publications/PDFs/FSJUN2001.pdf.

[4] NCSL, *State Fiscal Outlook for 2001.*

[5] NGA and NASBO, *The Fiscal Survey of States: June 2001.*

[6] Brian Bruen and John Holahan, *Slow Growth in Medicaid Spending Continues in 1997* (Washington, D.C.: Kaiser Family Foundation, November 1999). Published with the permission from the Kaiser Family Foundation. See http://www.kff.org/content/2000/2165/pub2165.pdf.

[7]Center for Medicare and Medicaid Services, *Penetration Rates from 1996 – 2000,* National Summary Table 2000 Medicaid Managed Care Enrollment Report (Washington, D.C.: June 2000). See http://www.hcfa.gov/medicaid/trends00.pdf.

[8] Bruen and Holahan, *Slow Growth.*

[9] Eileen R. Ellis, Vernon K. Smith, and David M. Rousseau, *Medicaid Enrollment in 50 States: June 1997-December 1999* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2000).

[10] Baumol's law: Labor intensive services, such as health care, cannot substitute capital for labor as efficiently as the general economy, so the cost of producing them goes up faster than general inflation. Government ends up taking on these "inefficient" services—public safety, education, long-term care and other care-based health services. Scott Gottlieb, "One Doctor: One Patient: It's Baumol's Disease, and it pretty much guarantees that healthcare will stay expensive." *CQ Online* 7, no.1 (March 2001), See http://www.cost-quality.com/restpast/v7i1a8.html.

[11] Leighton Ku and Jocelyn Guyer, *Medicaid Spending: Rising Again, but not to Crisis Levels* (Washington, D.C.: Center for Budget and Policy Priorities, 2001). See http://www.cbpp.org/4-20-01health.htm.

[12] Ibid.

[13] Bradley Strunk, P.B. Ginsburg, and J.R. Gabel, "Tracking Health Care Costs," *Health Affairs* (Sept. 26, 2001). Obtained from http://www.healthaffairs.org/Strunk_Web_Excl_92601.htm [Health Affairs Web Exclusive] Internet.

[14] Ku and Guyer, *Medicaid Spending.*

[15] States may receive permission from the federal Medicaid agency to experiment with programs that go beyond these definitions through a waiver process that often is difficult and lengthy. There are other variations from the basic rules, such as requiring people to participate in managed care in certain parts of the state or creating programs to move people from nursing facilities to home and community-based long-term care (HCBC), that require simpler, more readily obtained waivers. For more information about Medicaid eligibility policy, see http://www.hcfa.gov/medicaid/obs2.htm.

[16] John Holahan, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2001). See http://www.kff.org/content/2001/2256/2256.pdf.

[17] According to KFF state health facts Total Dual Eligibles, 2000: "Dual eligibles are those who receive Medicare (Part A and Part B) and also some form of Medicaid assistance. This group includes 1) "Full Medicaid", those people receiving full Medicaid benefits (i.e. prescription drugs and nursing home care) and Medicaid coverage of Medicare's financial requirements, and 2) "Buy-Ins", those people receiving some level of assistance with Medicare cost-sharing and premiums only." Problems of dual eligibility are discussed at greater length later in this report.

[18] Bruen and Holahan, *Slow Growth.*

[19] According to the CMS web site, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under age 21. EPSDT includes periodic screening, vision, dental, and hearing services; any medically necessary health care service must be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. See http://www.hcfa.gov/medicaid/epsdthm.htm.

[20] For a discussion of mandatory and optional populations and services see www.kff.org/content/2001/2256.

[21] This act removed the "Boren" amendment, which required states to pay hospitals and nursing homes market rates.

[22] Only $17 billion of $130 billion federal Medicaid dollars are expected to go to managed care in 2001, according to the Congressional Budget Office (CBO).

[23] In fact, Medicare managed care recipients are free to disenroll any month, even if Medicaid requires them to stay in a plan.

[24] Helen Hendrickson and Vic Miller. "States Plan Responses to Olmstead Decision," *FFIS Issue Brief* (Federal Funds Information for States) 1, no. 33 (July 2001).

[25] The Boren amendment required states to pay certain providers market rates for their services.

[26] The federal government's share of the medical assistance expenditures, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed for a smaller share of their costs. By law, the FMAP cannot be

lower than 50 percent or higher than 83 percent of the program's costs. In 1999, the FMAPs varied from 50 percent in 10 states to 77 percent in Mississippi, and averaged 57 percent overall. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as family planning services or development of mechanized claims processing systems. See FMAP at http://aspe.os.dhhs.gov/health/fmap.htm.

[27] FMAPs will rise in 2003 in 23 states and decline in 17, according to FFIS. Vic Miller, "2003 FMAPs:Bureaus Meet Their Match," *FFIS Issue Brief* (Federal Funds Information for States) 1 no. 56 (October 2001). See http://www.ffis.org/exec_sum/issue/ib01-56s.htm.

[28] For example: EDS, Consultec, First Health.

[29] Department of Health and Human Services, Office of Inspector General, *Medicaid Recovery of Pharmacy Payments from Liable Third Parties* (Washington, D.C.: HHS, August 2001). See http://www.hhs.gov/oig/oei/reports/a534.pdf.

[30] Center for Medicaid and Medicare Services, *Estate Recovery Provisions in OBRA* (Washington, D.C.: CMS, 1993). See http://www.hcfa.gov/medicaid/obs1.htm.

[31] Timothy M. Westmoreland, *State Medicaid Directors' Letter on HIPAA Administrative Simplifications Activities*, (Washington, D.C.; HHS, September, 2000). See http://www.hcfa.gov/medicaid/smd90800.htm.

[32] Government Accounting Office, *Medicaid: State Efforts to Control Improper Payments Vary* (Washington, D.C.: GAO, June 2001). See http://energycommerce.house.gov/107/reports/d01662.pdf.

Chapter 3

[1] H.L. Mencken, *The American Language: An Inquiry into the Development of English in the United States*, 2nd ed. New York: A.A. Knopf, 1921; Bartleby.com, 2000. www.bartleby.com/185/. [November 28, 2001].

[2] However, considerable savings may be achieved by restructuring options so that lower cost substitutes are preferred. Such approaches are covered in the managed care approaches in strategies 8 through 10.

[3] This can include cutting growth below inflation rates.

Health Care Sustainability Decision Tree

Goal: to balance revenue

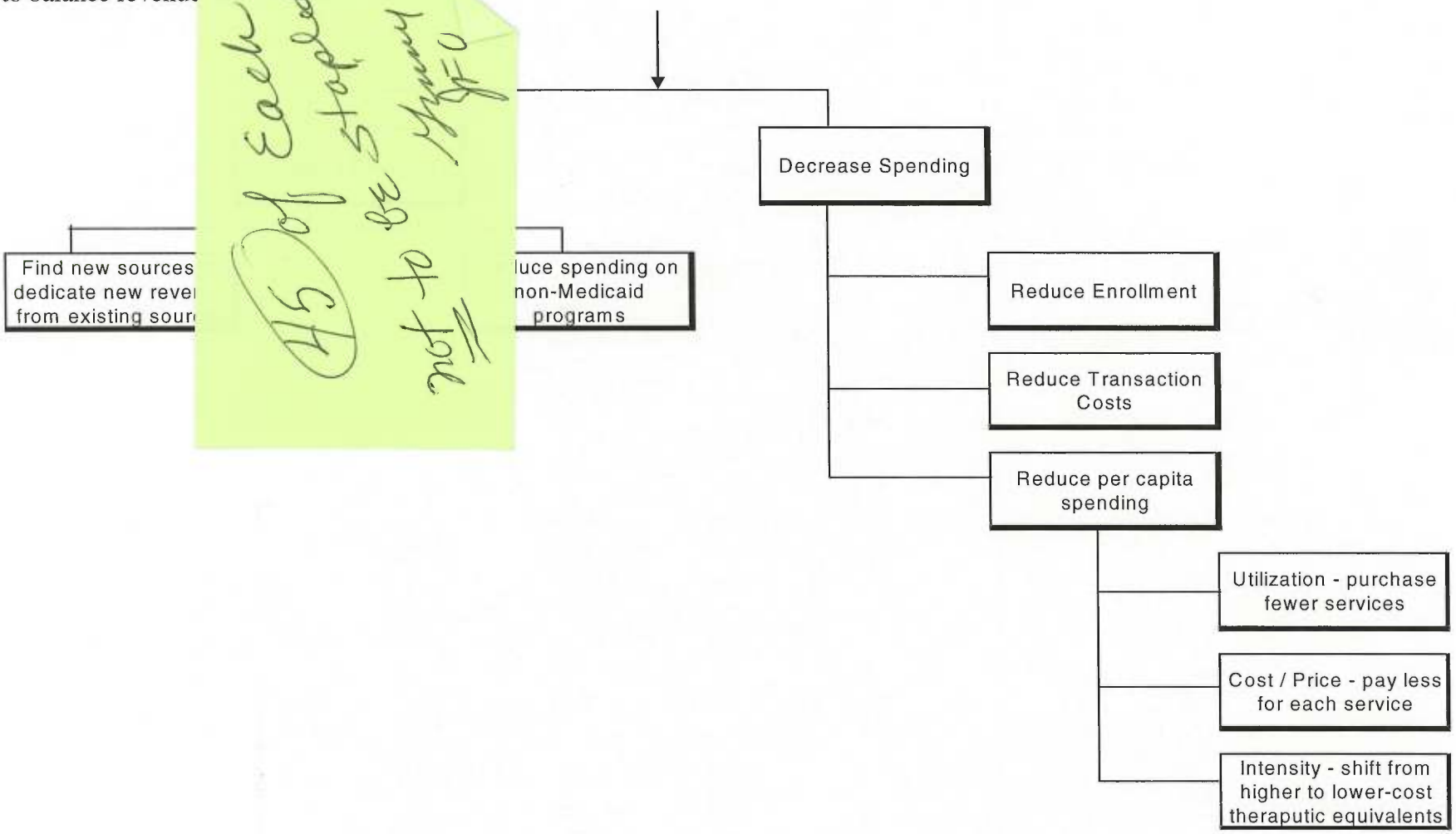


Table 1 – Increase Revenue

Approach	Technique	Examples	Discussion
Enhance Federal Revenue (State Actions) *Reduces state spending, but does not reduce overall program spending*	Maximize match rate	Identifying children on traditional Medicaid who are eligible for SCHIP. Identify administrative activities which qualify for higher match rates.	
	Identify eligible expenditures not currently receiving match	School-based health spending on eligible children. Corrections.	
	Other techniques to increase federal revenue	DSH, Intergovernmental Transfers	
Enhance Federal Revenue (Federal Actions)	Change federal match rate	Federal Fiscal Assistance (FY 2004)	Congress enacted a temporary boost to FMAP.
Enhance State Revenues	Taxes	Dedicate all or part of existing taxes. Increase existing tax rates. Create new taxes.	
	Premiums	Raise existing premiums, possibly by linking to inflation. Create new premiums where permitted by federal law.	Currently, premium revenue is shared with the federal government – reduction in state spending is based on match rate.
	Grants	Funding for development of chronic care programs, information technology	
Reallocate funds from other state programs		Dedicate some or all of new General Fund revenue. Reduce spending in other areas of the budget.	

Table 2 – Decrease Spending

Approach	Technique	Examples	Discussion	Savings
Reduce *Per Capita* Spending	Prevention and Screening	Many, including diet, exercise, mammogram, colonoscopy		Increase in short-term costs. Savings are longer-term.
	Reduce benefits	Eliminate optional services	Elimination of some optional services may actually increase spending (HCBS)	Could be substantial
		Oregon approach	Create benefit structures on a basis other than mandatory / optional, such as cost-effectiveness.	Could be substantial
	Reduce reimbursement to providers	Direct reduction	Will increase cost-shifting and exacerbate access issues	Could be substantial
		Establish or increase cost sharing	May also reduce utilization. Collection issues for providers.	Minimal
	Alternate reimbursement models	DRGs, RBRVS, performance-based	Changes financial incentives.	Minimal
	Selective contracting	Center of excellence		Minimal
		Preferred Drug List	Also can affect utilization.	Moderate to substantial
	Medical management / Quality improvement	Chronic care initiative. Reduction of overuse and misuse.	Right care in the right place at the right time.	Moderate in short run. May be substantial.
	Reduce fraud and abuse			Minimal
Reduce enrollment *Public programs only*	Change waiver program eligibility	Reduce maximum income level.		Could be substantial
	Change eligibility for optional programs	Reduce maximum income or asset level. Change spend-down.		Could be substantial
	Subsidize private coverage	Premium assistance programs	Replaces some state spending with employer contribution	Minimal
Reduce transaction costs	Standardization	Common claims forms		Minimal
	Information technology	Electronic transactions	Opportunities to expand	Minimal

(cont.)

Table 2 (continued)

Approach	Technique	Examples	Discussion	Savings
System Approaches *not used by individual payers*	Budgets	Existing state hospital budget review process		Minimal to moderate
	Certificate of need			Minimal to moderate
	Information Technology	Investment in IT infrastructure, electronic patient record		Moderate
	Improved planning and coordination	Shared administration, coordination of care		

Health Access Trust Fund - Balance Sheet

7/14/2004

DOES NOT INCLUDE EFFECTS OF MEDICARE PHARMACY BENEFIT
DOES NOT INCLUDE ASSUMPTIONS ABOUT REORGANIZATION

					Change	Notes
FY03	Actual	Revenue	$176.8			
		Expenditures	$173.0			
		Operating Result	**$3.8**			
		Balance		$9.7		F&M, 1/6/2004
FY04	Actual	Revenue	$207.5			Includes budget adjustment
		Expenditures	$192.2			Includes revised '04 est.
		Operating Result	**$15.3**			
		Balance		$25.0		Includes $2 million one-time
FY05	Projected	Revenue	$206.3		-0.6%	
	(FY05 budget increased	Expenditures	$231.3		20.3%	Effects of change in FMAP
	by FY04 overspending)	**Operating Result**	**-$25.0**			
		Balance		$0.0		
FY06	Projected	Revenue	$210.5		2.0%	
		Expenditures	$263.2		15.9%	
		Operating Result	**-$52.7**			Effects of change in FMAP
		Balance		-$52.7		
FY07	Projected	Revenue	$216.1		2.7%	
		Expenditures	$284.3		8.0%	
		Operating Result	**-$68.1**			
		Balance		-$120.8		
FY08	Projected	Revenue	$222.1		2.8%	
		Expenditures	$307.0		8.0%	
		Operating Result	**-$84.9**			
		Balance		-$205.7		
FY09	Projected	Revenue	$228.7		3.0%	
		Expenditures	$331.6		8.0%	
		Operating Result	**-$102.9**			
		Balance		-$308.5		

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State of Vermont
Office of the Secretary of State

Deborah L. Markowitz
Secretary of State

William A. Dalton
Deputy Secretary

Jessica G. Porter
Director, Professional Regulation

TO: Joint Fiscal Committee

FROM: Deb Markowitz, Secretary

RE: Update on Funding for HAVA (federal election reform)

DATE: August 23, 2004

The Help American Vote Act (HAVA 2002) enacted by Congress authorized 4 payments to each of the fifty states and territories to improve the administration of federal elections and to meet the requirements set out in Title III of the act. In order to receive any payment, each state was required to set up a special "Election Fund", certify that all payments will be deposited in the special fund, certify that all funds will be used only to improve the administration of federal elections, and certify that all interest earned on the fund will be deposited in the fund.

The first payment, termed "early out, no match, no year money" was received in the spring of 2003 and placed in the Vermont Election Fund. This $5 million payment can be used most broadly to "improve the administration of federal elections." The next three payments authorized by HAVA 2002, termed "requirements payments", were set up to be appropriations in federal FY 2003, FY 2004 and FY 2005 to be used to meet the requirements of Title III. The FY 2003 appropriation was delayed so that the FY 2004 payment of $7.46 million and the FY 2003 payment of $4.15 million were both deposited in the Vermont Election Fund in June 2004. The terms of these requirements payments include maintenance of effort for federal elections at the same level as in FY 2000(called "MOE"), 5% matching state appropriations for all federal requirements payments, compliance with all federal election laws, and using the payments to meet the requirements of Title III.

Although the Vermont State Plan, developed with an advisory committee and four working groups of local officials, provides an overview of how we anticipate needing to spend the Election Fund to meet the requirements of the federal law, we will also continue to provide a detailed spreadsheet of the budget proposal for each Vermont fiscal year to the General Assembly in order to have the funds appropriated from the Election Fund. We will also update the Vermont State Plan within in the next six to nine months so that the updates can be published in the federal register prior to the federal FY 2005 requirements payment.

As of June 30, 2004 (FY 2004) we have deposited $16.61 million in the Vermont Election Fund.

We have spent approximately $600,000 of these funds. The majority (just under $500,000) was used to purchase new optical scanning machines for some towns and to upgrade the existing optical scanning voting machines used by a total of 70 municipalities. (The purpose of this expenditure was to standardize and streamline the ballot creation and ballot counting process.) Approximately $50,000 has been used for voter education and approximately $50,000 has been used to purchase some of the hardware, software and IT training needed to develop the electronic statewide voter registration checklist that is required by HAVA to be in operation by January 1, 2006. We had initially requested larger budget amounts because we had anticipated that we would have had to purchase more equipment, training, and software sooner rather than later.

In December of 2003, we requested that the Office of the State Treasurer take action to maximize the interest earned on the funds in the Vermont Election Fund. The Treasurer's office has assured us that it will continue to do all it can to maximize the interest on this fund while investing in risk free products such as certificates of deposit. Federal law mandates that all interest on these funds be deposited in the fund so that the fund can grow and continue to pay for improvements to federal elections well into the future.

It is impossible to predict exactly what the federal FY 2005 appropriation will be for Vermont. We have heard that the President's budget included a very low number; but there are a number of U.S. senators that continue to want to fully fund election reform.

The Elections Division staff have worked with and will continue to work with local election officials to plan for the best uses of these funds to improve federal elections, meet the mandates of HAVA 2002, and minimize local government expenditures for our primary and general elections. We have used an open and inclusive process that has involved local officials serving on an advisory committee and four working groups to help us develop a plan for meeting the requirements of the federal law, improving federal elections, and assisting local election officials with education, training, and voting equipment. We will continue to work with local officials as we develop a budget request for each fiscal year. We will continue to bring our budget proposal to the General Assembly each year to receive authorization for expenditures from the Election Fund.

The purpose of the three requirements payments is to provide funds to allow states to meet the Title III requirements (some by January, 2004 and all by January, 2006) without serious financial impact on the state or municipalities that administer elections. Without detailing all of the requirements, the five areas where Vermont will need to spend the most to comply are:

- Computerized statewide checklist accessible to all town clerks in real time;
- One voting system (machine?) in each polling place (280) that is accessible to voters who are blind or visually impaired to cast his or her ballot privately and independently;
- Replacement of outdated voting machines in municipalities to bring all polling places using machines to a standard optic scanning machine that can reject a ballot that contains overvotes;
- Voter education;
- Election official training.

We anticipate requesting sufficient funding for FY 2005 and FY 2006 to be able to complete the statewide voter registration checklist and to place one voting system in each polling place that will allow voters who are blind or visually impaired to vote independently and privately. Unless there are some new developments in technology, we expect this to be the largest expense required to comply with HAVA. The statewide checklist project will have a total budget between $600,000 and $1 million.

A voting system for voters who are blind or visually impaired could cost $6000 to $10,000 (including programming and audio tapes) per unit, times 280 units for a total of between $1.6 and $3 million.

We are continuing to work with the Vermont Association for the Blind and Visually Impaired, the Center for Independent Living, Vermont Protection and Advocacy, Inc, venders, and other organizations to try to find or develop the best technology to meet this requirement at a more reasonable price. We are hoping that there will be better technology developed in the next two years. So we are postponing any purchase until the latest possible date (November or December 2005). Therefore we expect that the largest request for appropriation from the Fund for one year will be in FY 2006.

It is our overriding purpose and goal to request and expend the HAVA funds as sparingly as possible so that this resource will be available for continuing to improve the administration of elections in future years.

C: Robert Hofmann, Commissioner, FinMan
Steve Klein, Director, JFO
Beth Pearce, Deputy Treasurer

MANAGING MEDICAID COSTS
A LEGISLATOR'S TOOL KIT

FORUM *for* STATE HEALTH POLICY LEADERSHIP
NATIONAL CONFERENCE *of* STATE LEGISLATURES

DECEMBER 2001

MANAGING MEDICAID COSTS
A LEGISLATOR'S TOOL KIT

by

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December 2001

NATIONAL CONFERENCE
of STATE LEGISLATURES

The Forum for America's Ideas

The **National Conference *of* State Legislatures** (NCSL) serves the legislators and staffs of the nation's 50 states, its commonwealths and territories, and the District of Columbia. NCSL provides research, technical assistance and the opportunity for policymakers to exchange ideas on the most pressing state issues. NCSL is a bipartisan organization with three objectives:

- To improve the quality and effectiveness of state legislatures,
- To foster interstate communication and cooperation, and
- To ensure states a strong, cohesive voice in the federal system.

The Conference operates from offices in Denver, Colorado and Washington, D.C. For information on managing Medicaid costs, contact:

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FOREWORD

Few challenges legislators face are as difficult and complex as the urgent need to wisely manage health care spending, particularly in the Medicaid program. Curtailing spending in an arbitrary way creates the risk of real harm to needy senior citizens, people with disabilities, and adults and children who have few or no other options to have their medical costs covered. Yet, failure to rein in program costs can wreak havoc on all other legal and programmatic state responsibilities such as education, environment, criminal justice, economic development, and non-health related human services.

The cost control challenge can be especially difficult when—as now—rising costs occur in the midst of an economic downturn. Legislators face daunting choices at a time when the need is greatest, and those who may be adversely affected face few viable alternatives. Rising unemployment, increasing public assistance rolls, closing businesses, and businesses canceling health insurance coverage—these all set the context and frame the urgency for legislators to act wisely, carefully, and yet decisively.

Adding to this dilemma is the reality of the past 30 years in U.S. health policy. Between the 1960s and the late 1980s, federal and state governments for the most part pursued a regulatory strategy to control rising costs—both public and private—through devices such as certificate of need, rate setting, and coordinated health planning. In the late 1980s and early 1990s, that strategy came to be seen as a failure and was abandoned or significantly de-emphasized. In the 1990s, policymakers pursued a market-based strategy, relying on managed care and competitive purchasing to restrain costs. At the beginning of the 21st century, that strategy is also now seen as ineffective as health care inflation once again surges.

Thus, we enter this period of renewed inflation with less clarity than ever regarding an overarching approach to cost control. Widespread implementation of managed care, thought by many in the early 1990s to be a silver bullet, has been carried out and has run its course as costs rise and public antipathy solidifies. There is an important lesson in this for all legislators—new and veteran— to be skeptical of the "next big thing," to be cautious in the presence of those who wrap their proposals with grand predictions of huge, painless savings.

Legislators also must keep their objectives in perspective. The growth dynamic in state medical costs is intimately tied to the growth in private sector spending. Small business premiums and Medicaid costs, large business premiums and state employee health insurance costs, all tend to rise in tandem—because all are driven by the same forces. States cannot on their own reverse the overall growth in health sector spending. At the same time, effective, well designed interventions can effectively reduce the rate of growth—reductions that can translate into vitally important savings in millions of dollars. In other words, although it may not be able to drive your rate of cost growth from 15 percent to zero, there can be real benefits in decreasing the rate to 12 percent or 13 percent.

In baseball terms, legislators facing health cost growth realistically should expect to hit more singles and an occasional double than home runs or grand slams. It is in this sense that this report, prepared by the Health Policy Staff at the National Conference of State Legislatures, is particularly timely, important and helpful. The policy directions outlined in this report are realistic, practical and informed by hard experience and history. Legislators who were first elected after 1991 will particularly benefit from the wisdom and experience contained in these pages. Legislators in states

with term limits also will find real value because they serve with few colleagues who have any memory of the prior fiscal crises and health cost explosions.

In the spirit of realism, many legislators will discover that their hard work to find responsible ways to constrain cost growth will win them few fans or friends. But no task in the current environment is more important and needed. Veteran legislators understand that times of fiscal stress are also periods when important reforms can be achieved that are not possible in calmer times. The experiences obtained by those who face these challenges head on may be the supreme challenge one faces in an entire legislative career. The wisdom gained will serve any legislator well in the years ahead when the past fiscal distress becomes a faint memory to others.

The National Conference of State Legislatures has experienced and time-tested staff who are able to assist legislators as they address these challenges. Readers should feel welcome and encouraged to interact with NCSL staff to learn more about specific policy choices and to discover opportunities to engage with other legislators who face similar problems.

Every fiscal crisis in the past 50 years has been followed by fiscal recovery. Every health spending crisis is followed by some degree of spending moderation. Those who aid their publics in this time of stress fulfill the highest obligation to their citizens and to their oath of office.

JOHN MCDONOUGH
Co-Director, Health Chairs Project

ACKNOWLEDGMENTS

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This report is truly a team product. The Forum director, Richard Merritt, conceived and guided the project. In addition to writing individual sections, the various authors helped plan and review other parts of the report. In particular, Donna Folkemer, the Forum's Medicaid expert, served as the in-house consultant to all the authors, providing substantive guidance, review and editing for the individual strategies and was the lead on the strategy section. Phyllis Kaye edited the parts into a whole and, with NCSL's production and editorial staff, including Gregory Martín, Allison Hansen and Leann Stelzer, met constantly shifting deadlines with grace and skill. A number of friends of NCSL and the Forum provided advice, reviewed drafts, and suggested examples of state activities. These include Kurt DeWeese, John Kasprak, Jeanne Lambrew, Cindy Mann, John McDonough, Vic Miller, Chuck Milligan, MaryJo O'Brien, Lee Partridge, Vernon Smith and Alan Weil. We are particularly grateful to our project officers, Julie Hudman at the Kaiser Family Foundation and Pamela Dickson at the Robert Wood Johnson Foundation, for their continuous involvement, support, guidance and inspiration.

1. INTRODUCTION

As rising health care costs meet flattening revenue projections, state health budget-makers will face tough decisions, especially when it comes to Medicaid spending. Although most states are in good financial health overall, state revenue collections are showing signs of slowing and, in many states, the health spending budget is often the first to face a crisis. Spending on direct, personal health care accounts for more than a quarter of total state spending. Almost three-fourths of these dollars—$186 billion in fiscal year (FY) 2000—go to Medicaid, a joint-federal state program.[1] In 23 states, these Medicaid expenditures were emerging as problematic as early as February 2001.[2] By June 2001, two-thirds of the states projected shortfalls in their Medicaid budgets for the current fiscal year.[3]

> For an introduction to Medicaid, see the NCSL Medicaid FAQ at http://www.ncsl.org/programs/health/forum/faqmedicaid.htm

What can a legislator do? How can legislatures help ensure that funds for health care are used wisely? Legislators called back into special session to deal with Medicaid shortfalls, or faced with Medicaid budgets that threaten to crowd out discretionary spending, will want quick solutions. But the underlying causes of cost increases are complex and deeply rooted. Cost control will require a mix of short-term and long-term strategies. Although there is no one solution, many opportunities exist for incremental savings.

This report will help state lawmakers ask the right questions when considering whether a given approach is appropriate for their state. It ends with snapshots of 10 strategies that states typically consider when faced with Medicaid budget crunches.

Chapter 2. (Spending and Costs) This chapter follows the money by taking a close look at what drives Medicaid, the largest piece of health spending in most state budgets. It describes what influences state Medicaid spending and costs, provides a little economic and financial theory, contains national data on where Medicaid money comes from and where it goes, and points readers to sources of information about state-specific costs and spending. Summary tables show which strategies address each of the different factors that are helping to increase spending and costs.

Chapter 3. (Thinking Strategically) This chapter focuses on legislative action. It offers advice on how to obtain and analyze state-specific information that helps legislators and others determine what approaches are suitable for a given state. Health budget strategies tend to have complicated interactions with one another, and an apparently simple decision about state spending can reverberate in the private sector or conflict with another state health policy.

Chapter 4. (Ten Cost-cutting Strategies) This chapter contains brief profiles of 10 strategies that states have used to contain costs. Each profile includes enough information to help you decide whether to explore the strategy in more depth and offers tips on how to tell whether an approach might be right —or very wrong—for your state. The profiles also suggest resources for more information.

2. *Medicaid Spending and Costs*

Influences on State Medicaid Spending

Medicaid spending is on the rise as states forecast flat revenues. After some six years of record low growth, Medicaid spending began to accelerate in 1999. In 2001, the national economy slowed, bringing down government revenues as well. In response to a February 2001 survey, 23 states reported that Medicaid expenditures were emerging as problematic.[4] By June 2001, roughly two-thirds of the states projected Medicaid budget shortfalls in the current fiscal year.[5]

For State Information → *See* http://www.nasbo.org/Publications/PDFs/FSJUN2001.pdf

Low Medicaid spending growth in the 1990s was an anomaly. There are a number of different explanations for the relatively low rates of increase in Medicaid spending during the mid-1990s.

- **There was lower underlying health inflation.** Medical inflation, which was in the double digits from 1990 to 1992, slowed through the second half of the decade, falling as low as 3.2 percent.[6] This decrease was at least in part the result of competition-driven changes in financing and organizing care—both public and private—that often are lumped together as "managed care."

Medicaid Inflation

- According to Ku and Guyer, Medicaid grew at 11.2 percent per annum 1998 to 2000.
- CBO predicts average annual growth from 2000 to 2011 of 8.7 percent for Medicaid
- Twenty-three states in NCSL (February 2001) survey report that Medicaid expenditures are emerging as problematic.
- Two-thirds of the states recently projected Medicaid shortfalls in their current fiscal year according to a 2001 survey by NGA and NASBO.
- In 2000 and 2001, for the first time since 1992, states outspent their Medicaid budget expectations, forcing HCFA to request additional funds to get through the year.

- **Medicaid managed care controlled prices and utilization.** By 2000, 55 percent of beneficiaries were enrolled in managed care—17.8 million, with 13.8 million in risk-based plans and 4.5 million in primary care case management (PCCM) programs. This is up from 10 percent in 1991.[7]

- **Federal laws limited states' expansions of payment mechanisms that resulted in increasing federal payments to the states.** For example, the federal government put a cap on the amount of additional payments available to the states to support disproportionate share hospitals (DSH), i.e., those serving large numbers of Medicaid beneficiaries and uninsured patients.

- **A number of states improved cost control in long-term care, which is one of the most significant components of Medicaid expenditures.** This was accomplished through limits on nursing home beds, tightened payment rates to the facilities, and expanded coverage of home and community-based services.[8]

- **Family enrollment fell as people left the ranks due to a strong economy and welfare reform.** Continued lower Medicaid enrollment, even after state outreach efforts were put in place, coupled with slightly higher rates of employer-based coverage, suggest that some people leaving welfare were finding employer-based coverage. At the same time, a number of people who were eligible for Medicaid appeared to have been improperly dropped from Medicaid rolls.[9]

Why Medicaid Spending Is Rising Now

A number of factors are pushing up state Medicaid spending. The explanations include: general economic theory and normal business cycles; some "usual suspects" such as demographics, technology, and labor costs; managed care backlash; and new concerns such as the cost and use of pharmaceuticals and changes in federal regulations.

> "Medicaid costs are influenced by a variety of factors including the size and health care needs of the eligible population, the scope of medical benefits provided, service utilization levels, and the amount of payment for services provided. The double digit Medicaid increases in the first half of the 1990s were primarily attributable to: (1) increases in eligibility; (2) inflation in the costs of medical services paid for through the program; and (3) special financing measures to maximize federal funds...Other influences include broad social and economic conditions such as increases in the poverty level, unemployment rates, the number of uninsured, the aging of the population, the explosion of new medical technologies, and inflationary trends in the health care system which also place spending pressures on the Medicaid program. Many of these pressures will continue well into the future."
>
> Source: Bill Fairgrieve, Michigan House Fiscal Agency, *Medicaid Costs in Michigan* (Lansing: HFA, 1998) See http://www.house.state.mi.us/hfa/medcost.htm.

Economic Theory and Normal Cycles

- **Baumol's law.**[10] This theory argues that costs for services (such as medical care) rise faster than the economy as a whole because "high touch" goods like care cannot replace labor with technology as easily as manufacturing can. This almost guarantees that health cost inflation (including Medicaid) generally outpaces general inflation.

- **Normal price fluctuations.** Many analysts argue that an overdue upturn in the normal, cyclical fluctuation of prices for both public and private insurance (sometimes known as the insurance or underwriting cycle) is taking place. They believe insurance prices were artificially suppressed in the late 1990s as a result of market share competition described in the previous section.

The Usual Suspects

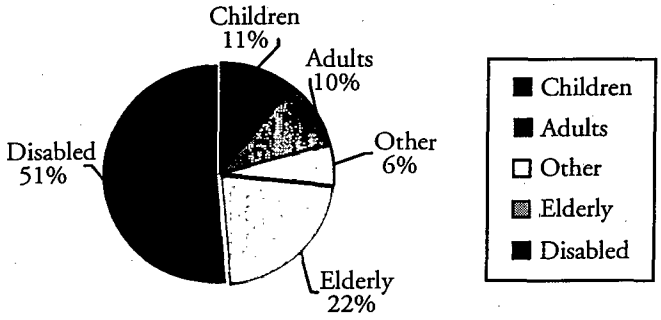
Demographic trends. The mix of people in the program ("case mix") is changing. By 2030, the over-65 population will double, and the over-85 population will triple. Because of this growth,

overall levels of disability in the population as a whole are expected to continue to rise. This change in demographics is expected to increase the average per capita cost of Medicaid overall.

Three-fourths of projected increases in federal Medicaid spending, according to Congressional Budget Office projections, will be due to care for the elderly and disabled. One-fifth of this growth is a result of rising enrollment in these categories. However, more than half is due to expected higher expenditures per enrollee in these categories. Growing proportions of people on Medicaid are higher cost disabled enrollees—average expense: $9,558 in 1998, compared to $1,892 for an adult and $1,225 for a child. [11]

The CBO projects another 900,000 children and 200,000 adults will be enrolled in FY 2001 as a result of outreach and program changes, but this will increase federal expenditure on Medicaid only by 0.8 percent. After that, "enrollment is expected to remain flat for children, with only modest increases for adults" due to demographic changes.[12]

Figure 1.
Components of Projected Federal Medicaid Spending Growth, By Beneficiary Category, 2001-2006



Source: Ku and Guyer, *Medicaid Spending: Rising Again, but Not to Crisis Levels* (Washington, D.C.: Center on Budget and Policy Priorities, 2001).

- **New technology.** New therapies are coming on line, partly because of new technology and new medical procedures. This puts pressure on Medicaid to cover additional services, many of which come with a relatively high price tag. Furthermore, new medical technologies often increase labor costs rather than lowering them.

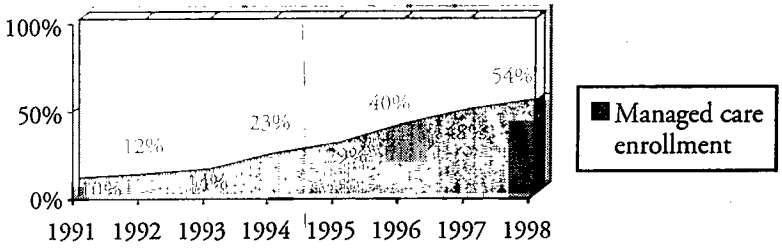
- **Labor costs.** Provider—particularly nurse—shortages drive up labor costs. The average age of the nurse workforce is over 40. Hourly wages in health services establishments increased in 2000 at the highest rate since 1992.[13]

Managed Care Backlash

- **Managed care savings peaked.** The transition to managed care is nearly complete. Markets are highly consolidated, frequently as a result of plan mergers. Some areas have only two or three managed care organizations, so there is little competitive leverage. Savings from managed care already have been achieved or are not occurring as expected.

- **Higher rates.** Providers, managed care plans and carriers are making up for the conservative budgeting of their recent past. Health plans are withdrawing from the Medicaid and Medicare markets, citing excessively low prices. Those that remain are successfully demanding and negotiating higher compensation and rates.

Figure 2.
Growth of Medicaid Managed Care
1991-1998



Source: Center for Medicaid and Medicare Services, Office of Managed Care Medicaid National Summary Statistics: (HCFA-2082 Report) National summary of Medicaid managed care programs and enrollment as of June 30 of each year (Washington, D.C.: CMS, 2001). See http://www.hcfa.gov/medicaid/msis/2082-11.htm (Accessed November 2001).

- **Loosening restrictions.** Managed care plans are loosening the restrictions they traditionally have used to control excess utilization. For example, plans are making it easier for consumers to obtain services without obtaining prior authorization. They also are removing restrictions designed to reduce the use of emergency rooms. Some analysts believe these actions are contributing to the rise in Medicaid spending.

Table 1.

PROGRAMS AND ENROLLMENT AS OF JUNE 30 OF EACH YEAR (POINT-IN-TIME DATA)			
	MEDICAID MANAGED CARE		
YEAR	ELIGIBLES (MILLIONS)	ENROLLEES (MILLIONS)	PERCENT OF TOTAL
1998	30.9	16.6	54%
1997	32.1	15.5	48%
1996	33.2	13.3	37%
1995	33.4	9.8	27%
1994	33.6	7.8	22%
1993	33.4	4.8	14%
1992	30.9	3.6	12%
1991	28.3	2.7	10%

Source: Center for Medicaid and Medicare Services, Office of Managed Care Medicaid National Summary Statistics: (HCFA-2082 Report) National summary of Medicaid managed care programs and enrollment as of June 30 of each year (Washington, D.C.: CMS, 2001). See http://www.hcfa.gov/medicaid/msis/2082-11.htm (Accessed November 2001).

New Developments

- **Pharmaceuticals.** Spending on pharmaceuticals is projected to grow at least 15 percent to18 percent annually through 2004. The Center for Medicare and Medicaid Services (CMS)—formerly HCFA—projects that Medicaid's prescription drug expenditures will grow 70 percent faster than overall Medicaid growth between 2001 and 2006,[14] especially for the elderly and disabled. These estimates do not take into account possible offsetting savings in other areas.

- **Creative financing.** The most important factors in the 2001 increases were states' use of so-called "creative financing"—techniques for drawing down additional federal funds through

accounting methods used to value health care provided through public entities or for uncompensated care (see Strategy 3—Intergovernmental Transfers and Other Alternative Funding Mechanisms). Because these methods, which include intergovernmental transfers, increased the federal matching rates without raising state spending, their main effect was on federal, not state Medicaid spending.

Influences on State Medicaid Costs

Medicaid costs depend on who receives care, what care they receive, who provides it, what the provider is paid, and the basis for the payment. Federal law allows states some flexibility in each of these areas, while requiring that certain categories of low-income people (children, pregnant women; and aged, blind and disabled people) and certain services (long-term care, hospital, physician) be covered. Other populations and services may be covered or excluded at each state's option.[15]

Average Medicaid Spending by Category, 1998

Child	$1,225
Adult	$1,892
Blind and disabled	$9,585
Elderly	$11,235

Source: Kaiser Commission on Medicaid and the Uninsured. Bruen and Holahan, *Slow Growth.*

Total Medicaid Spending by Category, 1998 ($billion)

Child	$24.5
Adult	$16.0
Blind and disabled	$67.7
Elderly	$46.1

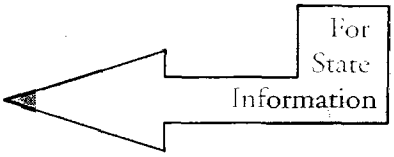
Source: Kaiser Commission on Medicaid and the Uninsured. Bruen and Holahan, *Slow Growth.*

Costs may grow because the size of a group grows, or because services change. A rapidly growing group is not necessarily one whose costs are high. Because different groups use services at different rates, when a group that uses higher levels of services grows faster than other groups, average Medicaid costs also rise faster.

Who Receives Care: Enrollee Mix

Who is covered has more of an effect on Medicaid costs than how many people are covered. On average, Medicaid spends more than nine times as much for an elderly recipient as for a child, and spending for elderly, blind and disabled people accounts for more than 70 percent of health services spending. About half of all poor people are covered under Medicaid; almost 40 percent of births are paid for by Medicaid; about 20 percent of children age 18 and under are covered by Medicaid; and some 6 million people who are poor or disabled rely on Medicaid to supplement Medicare and pay for such things as pharmaceuticals and long-term care. Costs are affected by the number of people enrolled and the services they use.

(For information about state-by-state enrollment see www.statehealthfacts.kff.org)



Most Unpredictable Growth: Children and their Families

- **Changes in Medicaid costs for children and families are largely driven by changes in enrollment, which is a function of state and national eligibility policy, the condition of the economy, outreach, and public perception of the program.** This population is most like the general population covered under employer-based insurance. Although this is the largest group of enrollees, even in aggregate less is spent on these families than for the numerically smaller eligible groups, the elderly and disabled. Nationally, children represent half of all enrollees but only 15 percent of the spending for Medicaid.

> *Myth: Costs are going up because so many children enrolled in Medicaid as a result of SCHIP outreach.*
>
> *Fact:* Children are the cheapest group to cover, and prevention in this age group pays off. Children and their parents make up 73 percent of the Medicaid covered population but only 25 percent of the health care spending.
> According to Ku and Guyer, very little of the growth in Medicaid spending is due to more children, because per capita costs are quite low. In FY 2000, $200 million in increased federal Medicaid spending was due to adding children and adults vs. $1.8 billion due to state fiscal strategies. In FY 2001, greater enrollment success and higher growth are expected. CBO projections are flat for this population after this year (due to demographic changes).
> Source: Ku and Guyer, *Medicaid Spending.*

- **In the late 1990s, states experienced level or declining enrollment for this group. About 200,000 fewer people were on Medicaid in 1998 than in 1997.** This drop was attributed to a strong economy, welfare reform and confusion over continued eligibility for the working poor that led to declines in Medicaid coverage. These falls were offset in some states by higher enrollment due to outreach efforts for the State Children's Health Insurance Program (SCHIP) that also reached people who were eligible, but who were not enrolled in Medicaid.

- **Not all eligible people enroll; it is estimated that three-fourths of uninsured children are eligible for Medicaid or SCHIP but fail to enroll.** There are many reasons why people do not enroll, ranging from the complexity of the enrollment process to their perception of the program. Within this group, however, people who are sickest are likely to enroll first because they are in contact with the health system. For this reason, outreach can lower per capita spending (while raising the overall program spending) because it tends to bring in people who use the same or fewer services, on average, than those currently in the program.

The Most Costly Growth: Poor Elderly People and People with Disabilities

- **The poor elderly and people with disabilities consume a much higher share of the Medicaid budget.** Compared to children and families, these groups are likely to be in poorer health or to need extensive support such as long-term care. Many states make it easier for these groups to enroll by either allowing certain groups to "spend down" to become eligible or using the "medically needy" optional eligibility category available for people with particularly high medical

expenditures—typically people in need of nursing home care; 56 percent of elderly enrollees are in the optional category.[16] Although in theory a state could choose not to offer this coverage, it makes financial, social and political sense to use the Medicaid program to fund this essential care. Medicaid is a way of mobilizing federal resources for health care for groups that otherwise would rely heavily on public services and institutions

- **Spending changes for these groups are largely due to changes in the service mix.** For example, changes in policies related to home and community-based care have led to rapid growth in spending for non-institutional long-term care services. Recently, spending for pharmaceuticals has registered sharp increases. These increases are due in part to changes in prices and prescribing practices, but also to the availability of new therapies that substitute for other treatments.

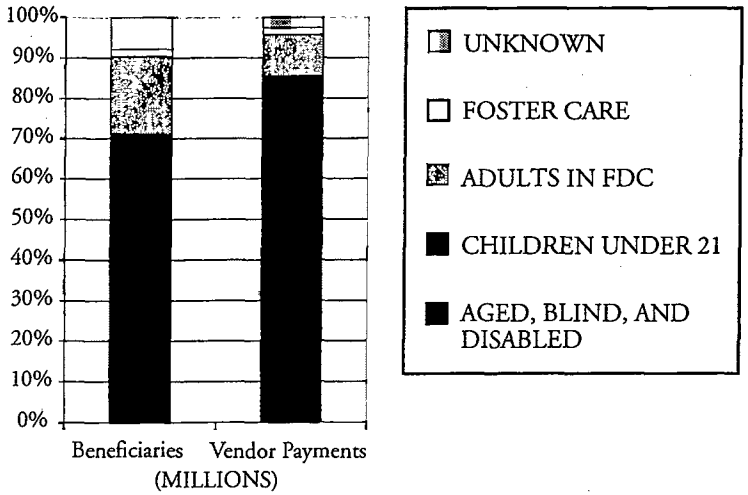
Myth: Aging America will bust the health budget

Fact: Americans are living longer, but they are living longer in better health. A recent study (Manton) found that average lifetime numbers of days with disability had remained constant, even as people's life expectancy rose.

Hard truth: Caring for disabled people is a major area of increased Medicaid spending. Some of this is due to more people with disabilities—due to better medical care that spares people who might have died in the past. Part of this may be an artifact of state financing changes that capture more federal dollars to cover people whose care was previously primarily paid for by states and local governments. Some is due to aging.

Source: K.G. Manton, "Future Trends in Chronic Disability and Institutionalization: Implications for Long-term Care Needs." Health Care Management 3, no. 1 (June 1997) 177-91.

Figure 3.
Medicaid Beneficiaries and Vendor Payments, 1998



Source: Center for Medicare and Mediaide Services, *Medicaid National Summary Statistics* Table 3.
See http://www.hcfa.gov/medicaid/msis/2082-3.htm.

"Medicaid spending for aged, blind, and disabled people dominates the program. While just over one-quarter of Medicaid enrollees in 1997 were aged, blind, or disabled, they accounted for 72 percent ($104.9 out of $145.2 billion) of Medicaid spending on medical services. Long-term care, particularly in institutional settings, is a significant contributor to these expenditures. States spent $57.9 billion on long-term care for the aged, blind, and disabled in 1997, including $42.6 billion for nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs). Other significant contributors to the high cost of coverage for these enrollees are inpatient hospital care ($13.6 billion, mostly for the blind and disabled) and prescription drugs ($8.5 billion)"

Source: Brian K Bruen, Joshua M. Wiener, Johnny Kim, and Ossai Miazad, *State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People.* (Washington, D.C.: The Urban Institute, 1999), 99-109.

Medicaid's relatively generous service mix—better coverage for mental health services, pharmaceuticals, personal care attendants and various rehabilitative therapies—affects enrollment. Medicaid typically provides better coverage than Medicare or private insurance for services that people with disabilities use. As private coverage and Medicare become more restrictive, the sickest people with dual eligibility become likelier to enroll in Medicaid. To the extent that private insurance coverage is restrictive, expensive and even unavailable for persons with disabilities, Medicaid becomes an insurer of last resort for low-income workers with chronic conditions.

Different Enrollees, Different Care: Prevention
For children and their families, prevention is particularly important as an investment against future health costs. For older and disabled populations, prevention emphasizes managing existing conditions to avoid worse outcomes as well as protecting against communicable diseases such as influenza.

- **Once enrolled in Medicaid, a person who is elderly or permanently disabled is likely to remain in the program.** Changes in enrollment are more likely to reflect changes in demographics and program requirements (such as changes in income eligibility levels) than changes in the economy.

- **Costs for the low-income elderly and disabled are difficult to manage because these are particularly vulnerable enrollees and many are dually eligible for Medicaid and Medicare.**[17] Among the more expensive groups covered under Medicaid are individuals with developmental disabilities, chronic and severe mental illnesses, conditions such as HIV/AIDS, and the frail elderly. These groups depend on states to act as their advocates and also to fund their care. This can place state agencies in conflicting roles, with one agency having protective responsibility for the vulnerable patients while another must manage budgetary demands. Legislators face both responsibilities.

What Care Is Provided: Service Mix

Different groups have very different costs because they use different services. For example, people with disabilities accounted for 17 percent of enrollment and 43 percent of medical service expenditures in the program nationwide in 1998.[18] The services and needs of this group differs from those of pregnant women and children, for example. This means that strategies for managing costs will differ among groups.

Services vary across states. Although the federal government requires that states provide medical, hospital and long-term care to all eligible groups, there are other services—such as chiropractic services, hospice care, eyeglasses and rehabilitative services—that states have the option of covering. If a state chooses to offer an optional service, it must be offered to all eligible groups. Some optional services, such as prescription drugs, are universally offered because the cost of providing them is deemed to be less than the cost of treating the more severe illnesses that may result from not covering the cost of the drug.

For information on state expenditures by service, see www.hcfa.gov/pubforms/Martin.pdf

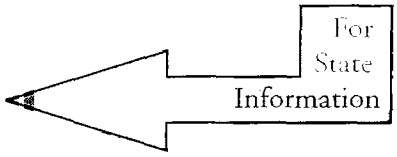
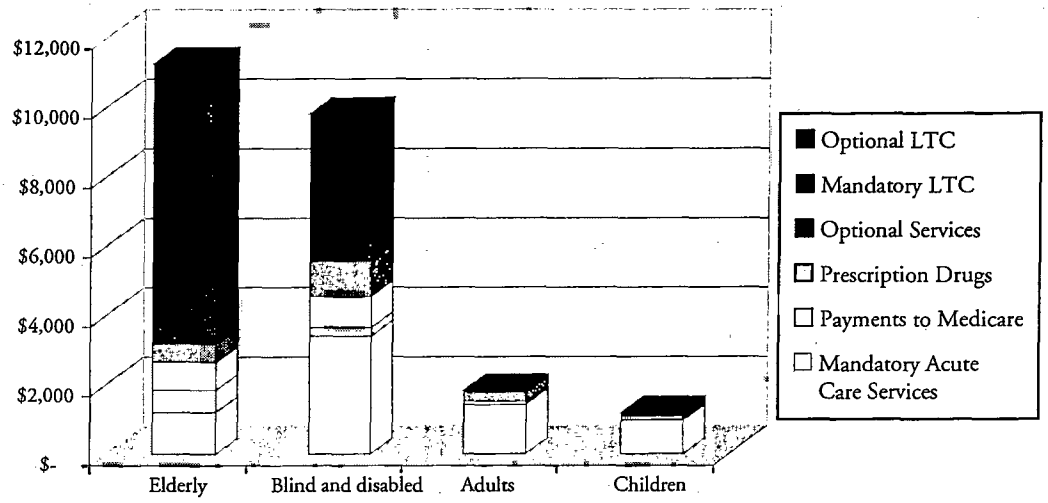


Figure 4.
Medicaid Expenditures by Beneficiary Group and Type of Services



Source: John Holahan, *Restructuring Medicaid Financing: Implications of the NGA Proposal* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2001). See http://www.kff.org/content/2001/2257/2257.pdf

States can, and have, set "reasonable" limits on both mandatory and optional services, such as the number of prescriptions or the number of visits to a particular type of provider. In practice, with the exception of required services for children,[19] states have exercised wide discretion in the amount, duration and scope of services they cover. Research suggests that such limits can be problematic in a small number of cases where there are particularly complex medical needs.[20]

Whether it is done by the Medicaid agency or a health plan, a first step in managing costs and care is to look at categories of spending and changes in spending, by eligibility group, to see where costs are higher than expected. Restrictions and opportunities that apply to specific vendors will affect various groups—elderly or disabled persons versus indigent families—in different ways. Even apparently similar services are used differently. For example, dental care for children has very different requirements, typical services and average costs than dental care for people with disabilities. Strategies that entail changes in what services are offered can be expected to mobilize providers as

well as recipients and their families. Because their needs are complex and family members are advocating for them, children with disabilities have become a touchstone for whether or not care management is coordinating services and thus improving quality, or whether it is chiefly throwing up barriers to access.

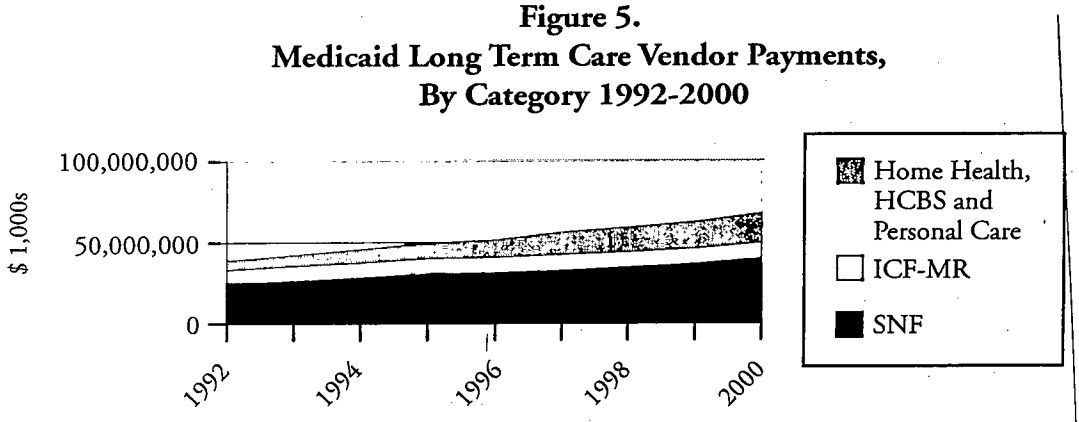
How Trade-offs Are Managed

Rapid growth in one category of spending is not necessarily bad because increasing the use of some services may decrease the use of more expensive services and lower costs over time.

- Outpatient and physician's office visits increased a decade ago due to a shift from inpatient to less expensive outpatient care.

- Pharmaceutical spending has swelled alarmingly in recent years; however, it is not clear that this is undesirable. For at least some conditions, such as chronic mental illness, pharmaceuticals are an alternative to more expensive care or procedures and may slow the costly progression of disease and disability.

Figure 5.
Medicaid Long Term Care Vendor Payments, By Category 1992-2000



Source: Medstat, Home and Community Based Services Resource Network, *Financial Management Medicaid Long Term Care Expenditures in FY 2000* (Washington, D.C.: CMS, 2001).

- Home and community-based care have been growing at double-digit rates, encouraged by the view that it often is less expensive than institutional alternatives. New community-based services create budget problems if they are not offset by decreased use of nursing facilities. More than half of Medicaid long-term care spending goes to nursing homes, although the proportion varies from state to state (see chapter four).

For State Information

Waiver services by state:
See http://medicaid.aphsa.org/waivers/HBCWaiver.htm

To understand the effect of spending for specific services on Medicaid budgets, the entire profile of spending, including offsetting savings and improved outcomes, needs to be considered. Remember, however, that it may be difficult to evaluate savings that result from substituting one service for another.

How Care Is Financed

Another traditional lever for controlling costs has been to limit reimbursement rates. Over the years, rate-setting methodologies have become more complex, with more attention focused on how different payment systems affect providers' choices. Medicaid rarely pays as much as other third parties and is legally the last payer when more than one party is responsible for medical costs. Medicaid rates have tended to be closer to marginal rates—the cost of an additional unit of care—than to a proportionate share of total costs.

> "Why Change to Managed Care?
> The cost of providing health care continues to increase. There is a point at which either fewer persons can be covered or fewer services can be provided, unless there are some measures instituted to control the cost of providing health care. Of all the options available to the state, implementing managed care seemed the best."
> Source: Texas Mental Health Consumers, tmhc.org/managedhc.html, accessed November 2001.

Today, rather than setting prices and limiting services one at a time, most states use managed care to achieve wholesale control of prices and utilization. Mirroring the growth of managed care in the private sector, all states expect Wyoming and Alaska have experimented with financial arrangements designed to manage costs and utilization for at least some of the Medicaid population. The Federal 1997 Balanced Budget Act gave states new flexibility to manage spending by allowing them greater freedom in setting payment rates for institutional care[21] and allowing them to require recipients to enroll in managed care without a waiver. Reimbursement often is based on average per person costs (capitation) paid to an intermediary—a health plan—that then makes various service and payment arrangements with a range of providers. In addition to contracting with health plans, states are experimenting with directly managing care or contracting out components of care management for some populations. The rapid growth of managed care has changed how care is coordinated and how access to services is managed, even outside of managed care plans. Although a majority of enrollees are in managed care, it actually comprises a small portion of the Medicaid budget.[22]

Some analysts have announced the death of managed care. Nonetheless, a creative variety of approaches to bundling and coordinating care continues to grow, as described in the strategy profiles in chapter three. Costs are increasingly controlled by changing the mix of services and the number and type of services that individuals receive based on their medical needs.

Costs for the "dually eligible"—low-income disabled or elderly people who are covered by both Medicaid and Medicare—may be difficult to manage because control is divided. This is because Medicare chiefly covers hospitalization and physician services, while Medicaid is the primary funder for pharmaceuticals and long-term care. Rehabilitation and supportive services, (generally used by the elderly and people with disabilities) may raise state Medicaid spending, even when they lower total health costs by lowering hospital use. It is also difficult to enroll dually eligible people in managed care, since the benefits must be coordinated across the two programs.[23]

Challenges to Controlling Medicaid Budgets

Medicaid was called "the Pacman of state budgets" in the late 1980s because of its propensity to gobble up budget surpluses. The program looms large over state budgets. Because Medicaid is an entitlement,

once rules for eligibility and reimbursement are set, the program cannot be terminated when funds run out without legislative action. Furthermore, providers and plans may effectively resist changes in their payments and contracts. For all these reasons, accurate budgeting is important. This is complicated because it requires accurate forecasting; dealing with uncertainties built into the Medicaid program; understanding how Medicaid interacts with other state spending and leverages federal support; and predicting how Medicaid policies may spill over into the private sector.

Forecasting Issues

Medicaid budgets are difficult to forecast for a number of reasons.

- Medical costs are fungible. Like a water balloon, when pressure is applied to prices in one part of the health system, another part of the system is affected. Providers typically charge purchasers of health services different rates. Before private sector employers began to use managed care to extract low prices, Medicaid sometimes was blamed for shifting costs to the private sector. Today, the pressure may work in either direction. Medicare and private insurance rate changes will affect whether states can negotiate lower Medicaid rates.

- Enrollment increases if the economy slows.

- Complicated connections exist between the number of people covered and the cost of care. Because Medicaid shares the cost of uncompensated care with other payers, Medicaid costs change if there are changes in the number of people receiving unpaid care. States may have to rescue public providers.

- Policy changes—including programmatic and judicial decisions—affect Medicaid enrollment, services and spending in unpredictable ways. Some recent examples are shown here.

Myth: It's all because of unfunded mandates.
Fact: Mandates have been relaxed. The Boren amendment—which required states to pay certain providers market rates—has been repealed. States have more managed care flexibility and more waivers than ever before. No major mandated eligibility increases have occurred since 1990, except fully funded Medicare-related groups. There were minor changes in federally qualified health center (FQHC) payments in 2000. However, states have used administrative devices to drive up their own budgets, making creative use of programs such as disproportionate share hospital payments (DSH) and intergovernmental transfers (IGT) to define a greater part of public health spending as Medicaid and capture a larger federal match.
Source: Ku and Guyer, *Medicaid Spending.*

- A recent Supreme Court decision (*Olmstead*) dictates that states provide the least restrictive possible care for people with disabilities. This has forced many states to restructure their services for people with disabilities and it may lead to increased spending if institutional costs are not contained at the same time.[24]

- Outreach for SCHIP brought new populations into Medicaid. At the same time, TANF eligibility changes resulted in many families being wrongly dropped from Medicaid. States still are re-enrolling these eligibles.

- The same law that repealed the Boren amendment[25] and thus gave states flexibility to lower provider payments also cut Medicare payment rates. Although provider groups succeeded in rolling back some of the cuts, one upshot has been pressure to increase Medicaid rates.

- Medical costs in general are notoriously hard to predict. State-level data needed for projections may be, nonexistent (e.g., health inflation), unreliable (e.g., counts of uninsured persons) or not timely (e.g., expenditure data.)

Programmatic Complexity

The Medicaid program itself makes Medicaid budgets difficult to explain and difficult to project. Much of this stems from programmatic complexity built into Medicaid rules. Although these rules (added incrementally over the years) often were meant to give state programs more flexibility, they also can confusion.

- **Different program partners use different calendars.** Different entities—states, the federal government and health plans with managed care contracts—use different fiscal years. The Medicaid budget is a mix of state and federal (and sometimes local) spending. It is important to know which figure and which time period are being discussed.

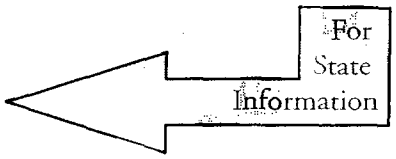
- **A state dollar spent on Medicaid can reduce overall state spending growth.** One of the ways states manage the growth of Medicaid spending is to increase federal financial participation through a variety of techniques. This cost shifting can make the Medicaid budget seem to grow faster, even as it relieves total state spending growth. The rules for these programs are complex and have changed when the federal government determines they are being misused by states. Federal policies that unexpectedly change the availability of these options can challenge state budgets. (See chapter three, strategies 1 and 3.)

- **Federal payments vary.** The extent to which the federal government matches state Medicaid payments varies (see strategy 2 – Low Match to High Match). At least half of Medicaid payments for medical services are paid by the federal government (50 percent in 11 states, up to 76 percent in Mississippi); other costs may be covered at higher rates. As a result, $1 of state general fund money is worth at least $2 on the Medicaid budget and frequently more, depending on the federal matching rate (FMAP) for the state.[26] Designating other state health spending as Medicaid (e.g., expenditures for school-based health services to eligible children) allows the state to draw down matching federal funds to offset other state spending on health (see strategy 1).

Although Medicaid spending in 2000 grew at double-digit rates in nine states, much of that spending growth reflects changes in how states account for health care costs. Only three states with high Medicaid spending growth—Idaho, Kansas and Nebraska—experienced higher than average general fund spending growth as well. In at least one of these states, Kansas, the increase may reflect changes in federal rules that limit the extent to which states can take advantage of another aspect of the Medicaid program known as "disproportionate share hospital" (DSH) payments to offset state spending in mental hospitals

Source: Gloria Timmer, Greg Von Behren, Stacey Mazer, and Jill Schamberger, *1998-1999 State Health Care Expenditure Report*, (New York: Milbank Memorial Fund, National Association of State Budge Officers, and the Reforming States Group, March 2001). 51-53. See http://www.milbank.org/1998shcer/index.html.

See
FMAP's at http://aspe.os.dhhs.gov/health/fmap.htm



- **Federal matching rates change.** The rate at which the federal government will match state payments is set annually. Depending on the period for which the budget is being forecast, or if the average per capita income in the state has changed sharply, there may be some uncertainty over the federal reimbursement rate, and hence the amount of the grant to the state. Even a fraction of a percentage point will have an enormous effect on a state's spending.[27]

- **Determination of actual costs takes time (the problem of estimation and reconciliation).** The federal government quarterly advances state Medicaid programs its estimated share of spending. Actual vendor payments (net of recoveries from such things as third party payers, and fraud and abuse enforcement) then are reconciled, a process that can take an extended period of time if there are disputes over methodologies between the state and providers or between the state and the federal government. When there are rapid fluctuations in Medicaid spending, this can become complicated. The vendor payment data often are produced by MMIS contractors,[28] who receive claims, determine whether they will be approved, and generate the reports needed for federal reimbursement. This either can add another layer of complexity when the systems are not working well or can facilitate the process when they work right. At the end of this process, a state may owe or be owed money, so it is difficult to know the extent of state Medicaid shortfalls or windfalls at any point in time.

- **Federal policy changes are being considered.** Some policy changes that have been discussed in Washington could substantially change states' Medicaid obligations or how they program Medicaid spending either by increasing flexibility or by creating new federal programs that affect some populations that are at least partially covered under Medicaid. These include recent changes in 1115 waiver policies and methodologies and proposals related to easier or expanded SCHIP family coverage, pharmaceutical benefits under Medicare, and changes in the treatment of dually eligible individuals.

Federal Cost Containment Mandates

Although these are not a major focus of policy, the federal government dictates that state Medicaid programs carry out certain activities that are designed to contain costs. The justification for each of these is cost control. State and federal governments both save when they work, but some states have found the pay-off to be low in relationship to their administrative costs. Legislators may want to know how their state is pursuing these activities.

- **Third-Party Liability and Recovery**

  Medicaid is the payer of last resort. State programs are required to recover from other carriers, including noncustodial parents and private insurers. A recent study of pharmaceutical cost recovery by the HHS inspector general's office found that, "States are at risk of losing over 80 percent ($367 million) of the payments they tried to recover ($440 million) in 1999 through the 'pay and chase' approach. However, the cost-avoidance approach prevented $185 million from being at risk"[29] (see strategy 4).

- **Estate Recovery**

  Since 1993, states have been required to recover certain expenditures for hospitalization or long-term care from the estates of deceased Medicaid beneficiaries, typically through a lien on

a home after the death of a surviving spouse.[30] This program often referred to as "grave-robbing" by opponents has spawned an entire legal industry.

- Administrative Simplification-HIPAA

  States are among the payers being called upon to conform to uniform, electronic standards in billing that are designed to lower administrative costs while still protecting privacy. Federal—and, thus, state—rules have been slow to emerge because of seemingly intractable privacy concerns. Changes will require substantial up-front investment in Medicaid information systems.[31] Most states are using vendors to meet these requirements. This investment will be largely reimbursable. Some states have seen this as an opportunity to upgrade and coordinate a variety of health data collection, as well as and reporting activities, including public health and hospital data collection as well as Medicaid systems (see strategy 2).

- Reduce Fraud and Abuse

  Each state has a Medicaid Fraud Control Unit that is funded at 75 percent by the federal government. Estimates of the amount of fraud and abuse vary, but states that have focused on payment irregularities often have been able to find problems and either recover misspent funds or prevent continued problems, according to a recent GAO report.[32] The new MMIS may be a tool for reducing fraud and abuse, since many vendors have developed sophisticated programs to flag patterns of unusual billing activity for scrutiny.

The Medicaid Budget: Consequences

Medicaid budgets are particularly difficult to manage because they interact with other health spending in complicated ways. Even aside from the federal matching share, what a state Medicaid program spends is not the same thing as the cost of coverage to a state.

Cutting Medicaid spending affects other state spending and providers. The cost of Medicaid coverage for the state is the difference between the state's share of Medicaid coverage and what would be spent by the state (through programs such as general assistance, hospital uncompensated care programs, and local health departments and clinics) for the person's health care if he or she is not covered under Medicaid.

- Medicaid spending replaces spending on uncompensated care, which states often pay either directly (through grants and reimbursements to providers of uncompensated care) or indirectly (through intergovernmental transfers to counties and in higher payments for public employees' coverage—state-only spending).

- If a person is not covered by Medicaid or other public funds, care still will be needed. Cost shifting to private insurers and payers may result in higher insurance rates, harming access to insurance and even increasing Medicaid enrollment if low-income workers and their employers drop coverage.

- Not being able to obtain care may cost more than care itself. For example, consider the relative costs of hospitalization for pneumonia vs. a flu shot or amputation of a limb vs. insulin management.

Medicaid budget decisions can affect insurance premiums and reimbursement rates for the entire state. State and federal health spending now makes up approximately half of all health spending (more, according to Employee Benefits Research Institute; less according to Center for Medicaid and Medicare Services), so state decisions on how to buy health care reverberate heavily in the private sector. Because they are so dominant in the market, state and federal decisions about payment rates, contractual terms and reimbursable services may influence what the private sector does or may force other buyers to pay more to compensate for underpayments. As if the push and pull of state, federal and private spending were not complicated enough, economists point out that health spending can be difficult to control because most is through insurance or insurance-like public programs (Medicaid, SCHIP and Medicare) that shield users from the true costs of care. ▯ *KL*

3. *THINKING ABOUT SOLUTIONS*

It has been said that there are 56 different Medicaid programs, with every state and territory's program having a unique set of rules. That means that no single strategy will work for every state. This chapter lays out some core strategic issues, proposes some features to consider when putting together a package, and suggests policy questions to ask when deciding what approach to try. It also offers suggestions about where to go for answers tailored to a specific state.

Some Medicaid Budget Strategies

What keeps health budgets down? In the starkest terms, states can do less, pay less, do for fewer people, or do better. Most so-called cost containment consists of one of these four options.

The obvious solutions—cut people from the program, provide fewer services, pay less—may be examples of Mencken's easy solutions: "Explanations exist; they have existed for all times, for there is always an easy solution to every human problem—neat, plausible, and wrong."[1] Because these are fundamental policy shifts that require political, not technical analysis, this report does not profile reducing eligibility or eliminating service options[2]. Instead, it suggests some strategies that prudent administrators, with the encouragement of watchful legislators, may want to consider as they respond to expected growth in demand and costs.

The Problem with Simply Cutting

- Individuals who are not covered by Medicaid can turn up elsewhere in the system eventually, paid for by state or local governments without the generous federal cost sharing. Moreover, cuts in eligibility or services represent a shift in policy, since most federal and state health policy changes in the 1990s were to make coverage available for more people. States have wooed employers, insurers and providers to be partners in new financing arrangements such as managed care and buy-ins. If states are seen as unreliable partners, their abdication could crush carefully cultivated ties.

- Doing less or for fewer people can depend on someone else paying for services. Deferred or denied services can result in higher treatment costs in the future. If the state pays for those costs as well (through uncompensated care and indigent care or lower workforce productivity), it needs to consider which is the better way to pay. In the case of Medicaid, getting someone else—the federal government, employers or individuals-to pay part of the bill also is an important option.

- Paying less[3] can have unexpected effects on the rest of the system, as the excess costs are absorbed by other payers. Underpaid providers may shift costs to private insurance or refuse to treat Medicaid patients altogether. If providers and plans find lower payments unacceptable, paying less can reduce access as well.

Doing It Better

- **Ideally, costs are saved by giving care more efficiently, eliminating unnecessary and wasteful systems, and keeping people well by preventing rather than treating illnesses.** Unfortunately for states that are facing budget crunches, the best of these are long-run strategies that may require investment: for example, public health, information systems, and quality improvement systems all promise long-term savings and better quality, but require up-front expenditures that may not be possible in a year of budgetary constraints.

No Simple Solutions

- **Just as the growth in Medicaid spending has many faces and complex causes, state responses will have to be nuanced and multi-faceted.** Usually, lawmakers will want to tackle costs on more than one front, rather than trying to achieve budget goals through a single strategy. In that case, lawmakers need to consider how the approaches complement one another—for example, balancing long- and short-term strategies, or mixing ones that have the greatest effect on providers and ones that change rules for managed care plans. Where strategies depend upon one another—for example, increasing home and community-based services while constraining the availability of beds—lawmakers may even consider adding nonseverability provisions to avoid problems that could arise if only one strategy is implemented.

- **Health budget strategies tend to have complicated interactions with one another.** An apparently simple decision about state spending can reverberate in the private sector or conflict with another state health policy. Medicaid provides literally vital—life-giving—services to the most vulnerable populations. Managing its budget without doing harm is one of the most-difficult challenges a lawmaker faces. Strategies include increasing the flow of money into the Medicaid program from non-state sources—especially the federal government—as well as slowing increases in spending.

Ways to Cut the Pie

States will want to consider a number of factors in developing the strategies that best fit their needs. Strategies vary in their effect, in who is affected, in the kind of environment they require to work, and in the mechanisms they use. States are likely to want to use a mixture of strategies. These categories may be helpful to policymakers as they think through the best mix for their states.

- **Long-term or short-term strategies.** How long does it take to implement and how soon is there a pay-off? Many strategies that are likely to accomplish long-term savings require investments in the short-term: prevention, changes in the long-term care delivery system, or disease management. Strategies that maximize federal and private funding—such as Medicaid maximization—may have a quick budgetary pay-off, but do nothing about underlying cost inflation. A strategic mix of short- and long-term approaches may give a state the leverage to begin fundamental cost-saving changes, such as a shift to community-based care, by providing a financial bridge to carry the state through start-up costs.

- **Macro or micro strategies.** Does the strategy work by changing systems at a health plan or statewide level—for example through health planning—or does it affect individual decisions at the patient or treatment decision level—for example through financial incentives and managed care?

- **How extensive or intensive is the strategy?** Does it make a small difference across a large number of people or cases (for example, substituting generic pharmaceuticals for all), or are the effects very concentrated (for example, managed care for people with disabilities)? Are activities coordinated or selectively targeted? The answer will have implications for the politics of change. For example, a narrowly targeted change may mobilize a group if it feels unfairly targeted.

- **Is the strategy collective or individual?** This is related to the previous two concerns. Does the strategy have widely shared or individualized costs? One collective, widely shared strategy is to spread the costs of health care more widely across the entire population—for example, using general revenues to cover Medicaid expansions or requiring health insurance companies to community-rate. Making eligibility standards more stringent individualizes costs for people who lose eligibility.

- **Regulate or compete?** Does the strategy depend on state administrative action or on market competition for its effect? This is a key decision in designing managed care strategies, and will be affected by which approach is most familiar to providers, health plans, and the state Medicaid agency.

- **Who has to act, and who is affected?** Although states initiate cost saving, they almost always need cooperation from others to carry out their plans. Who else is key? Providers? If so, which ones—doctors, hospitals, long-term care providers? Patients? Health plans? Strategies that change where care is provided—such as reimbursement changes that move people from hospitals to the community, or experiments that divert people from nursing facilities to community-based care—generate winners and losers. When multiple strategies are adopted, their effects and costs need to be balanced so they all do not fall on one group.

- **Levels of risk and certainty.** Every new strategy involves some risk. Insurance is about risk; one of the biggest unknowns is how much health costs will change in the future. States have tried to minimize uncertainty through "public-private partnerships," such as managed care contracts in which health plans assume some of the risk. The federal government has encouraged states to develop information systems to gather data and improve their understanding of their own spending in order to find opportunities to lower costs. For example, many have tried to reduce uncertainty about clinical practices by identifying medical practices that vary significantly in different parts of the state.

- **What state and federal laws apply?** The federal environment is the same for every state, but Medicaid law permits considerable state flexibility. Some strategies—such as home and community-based care—may require a federal waiver. Other areas—such as pharmaceutical coverage or eligibility for unemployed workers—are being debated at the federal level. State Medicaid policies exist in law and also in state Medicaid plans that are approved by the federal government.

Questions to Ask

Each of the 10 strategy profiles that follow includes a set of key questions to consider in deciding whether to adopt that strategy and in designing its details. Several of these questions seemed especially important to ask when approaching any of these Medicaid budget strategies. Another set of questions should be asked in order to assess a specific state's starting point and capability:

- **What is the reason for trying to use a given strategy? What is its goal?** To generate funds to maintain current access and reduce state funding? To increase access and maintain current state funding? The answer to these questions will determine the appropriateness and potential effectiveness of various cost containment strategies.

- **What are the cost estimates? Are the benefits worth the cost?** State policymakers should weigh the costs of any strategy being considered against the anticipated benefits. Costs and benefits may be near-term or long-term, direct or indirect, and economic or political. The costs and risks involved in implementing any cost containment strategy include spending money, using other resources to develop and maintain infrastructure, or taking a risk that the number of providers willing to serve Medicaid beneficiaries will decline. For example, the direct benefits of cost savings or improved health of the Medicaid population may also have indirect benefits in the form of positive economic effects for the state as a whole.

- **How will the state measure clinical and fiscal objectives?** How does it propose to measure costs and health consequences? This is essential when the state plans to use private entities to carry out its policies, since there must be a way to define and measure their performance. Ideally, state agencies may be held to performance standards as well if information can be gathered and analyzed at a reasonable cost.

- **What are the risks inherent in the strategy and who will bear them? Does the strategy take advantage of opportunities for containing costs, improving services, and expanding coverage?** Few actions solely affect cost, access or quality. Most policies aimed at one of these dimensions impinge upon the others. For example, cutting reimbursement rates often hurts access. Improving clinical quality may require short-term investments and garner long-term savings.

What information do policymakers need to assess the potential of a particular cost containment strategy? The value of the various strategies depends on specific coverage and cost patterns in a state, and success may be related to a state's previous experience with a given solution. Data are essential in assessing the potential of a given strategy. Does the state have the information it needs? Do policymakers know where to obtain it? Following are some things a policymaker needs to know. The questions should be posed to Medicaid and health agency staff as well as to legislative health committee staff.

- **What does the current Medicaid program look like? What will it look like if a strategy is adopted?** What populations and services are and will be covered? To what extent? Who delivers services and how are they paid? How generous are the payments? Will this change?

- **What is the capacity of the existing health service system? Of the state administrative system?** Do providers or managed care organizations have the capacity and willingness to make implementation possible? Does the state have the capacity to implement and monitor the effect of the changes? What are the capabilities of the Medicaid Management Information System? Does the state have the information it needs to evaluate the potential of the strategy before deciding to adopt it? Will the state be able to obtain the information it needs to assess the strategy once it is in place?

- **How is Medicaid policy changed? What will it take to change the populations and/or services covered or the way in which programs in the state are financed?** Some changes will appear as part of Medicaid budgets. Other policy changes are made through the state Medicaid plan.

Who is responsible for developing the budget? The state plan? Who must approve changes? In some states, executive agencies may play the major role. In others, the legislature may be involved. Since more than one state agency may have to be involved in working out services standards and budgets, the legislature may have to bring together two or more agencies that traditionally have not been linked. Legislative and agency fiscal analysts should be able to provide information about the potential effects of proposed changes.

- **Would the approaches being proposed be politically feasible?** Who are the key interest groups? Would they support or oppose the change? How willing are they to work with you? What would it take to get their support?

Who Knows?

Policymakers need good information about their states as well as about Medicaid in order to make informed decisions. Where can they get that information?

At the National Conference of State Legislatures

This paper was written by staff of the Forum for State Health Policy Leadership, in the Washington office of NCSL.

This Web site—http://www.ncsl.org/programs/health/medfipha.htm—links directly to Medicaid-related matters on the NCSL site. Questions about specific issues may be directed to NCSL policy area specialists here and in the Denver office, as follows.

- **In Washington, D.C.:** (202) 624-5400
  - Donna Folkemer (Donna.Folkemer@ncsl.org) —Medicaid, pharmaceuticals
  - Wendy Fox-Grage (Wendy.Fox-Grage@ncsl.org) —Long-term care and disability
  - Shelly Gehshan (Shelly.Gehshan@ncsl.org) —State Children's Health Insurance Program (SCHIP), behavioral health
  - Kala Ladenheim (Kala.Ladenheim@ncsl.org) —Financing, access, insurance, the uninsured
  - Joy Johnson Wilson (Joy.Wilson@ncsl.org) —Federal-state

- **In Denver:** (303) 830-2200
  - Martha King (Martha.King@ncsl.org) —Medicaid, SCHIP
  - Richard Cauchi (Richard.Cauchi@ncsl.org) —Insurance, pharmaceuticals

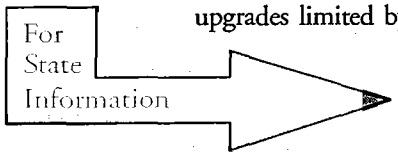
State Resources

State health information often is scattered among a number of departments.

- **State legislative staff:** Health committee staff, legislative fiscal staff and central research staff work with Medicaid information. Most legislative staff rely on state agencies for data but

conduct varying amounts of further analysis with this data. Legislative staff may be called upon to develop forecasts of Medicaid spending under varying policy assumptions.

- **Medicaid agency:** The agency will have information about the program characteristics and history, and data on recipients, services and spending. The detail, currency and quality of this information often depend on the state's investment in management information systems and staff, as well as the quality of reporting by providers and health plans. Some states have suffered from a paradox of early automation. Because Medicaid systems often were among the first to be automated, they may depend on outmoded information systems that are difficult to use, with upgrades limited by efforts to remain compatible with past data and a reluctance to invest again.



State Medicaid directors:
http://medicaid.aphsa.org/members.htm

- **Fiscal and budget agency:** This may be part of the Medicaid agency, or it may be housed elsewhere in the state.

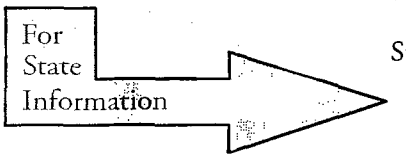
- **Vital statistics and state health data:** Public health data systems and health planning often are separate from the Medicaid program. They may have valuable information about the characteristics of the overall population of the state. All states collect data on births, deaths and certain diseases. Many states collect data on health care billing, discharges, services or other activities by hospitals. States also collect information on health behaviors such as smoking and obesity.

- **State planning:** State planning may be carried out in an economic development department or the governor's office, or may be contracted out to a university. This is a source of information on overall population trends, income, family composition and employment. Trends that affect Medicaid programs that these units may monitor include changes in immigrant and minority populations and workforce changes. These planners also may have technical expertise in population and economic forecasting.

- **Insurance agency:** For Medicaid programs with eligibility set at and above the poverty level, policymakers may need information about insurance. The state insurance department will have information about the state's laws and limits on what can be required of employers. A few states collect data on individual and small group policies sold in the state, but federal law makes it difficult to get information about insurance coverage and plan contents from larger employers.

Federal officials

- **The Center for Medicare and Medicaid Services (CMS),** the federal Medicaid agency formerly called HCFA, is organized into regions. CMS regional offices may be a source for program information, comparisons with neighboring states, and policy interpretation.



State and federal Medicaid contact information can be found on the CMS web page at
http://www.hcfa.gov/medicaid/mcontact.htm
http://www.hcfa.gov/regions/roinfo.htm

Other federal agencies with information on Medicaid: Several other federal agencies are valuable sources of studies and data: The secretary of health and human service's Office of the Inspector General (OIG) (http://oig.hhs.gov) carries out program audits and similar studies. Another source of Medicaid-related policy and analysis is the office of the assistant secretary for planning and evaluation (ASPE) at (http://aspe.hhs.gov). This is also the site of the Catalog of Federal Domestic Assistance Programs, which lists details of the Medicaid program.

The General Accounting office (GAO) (http://www.gao.gov) publishes regular reports with useful information on Medicaid. Other congressional study bodies who often examine Medicaid are the Congressional Budget Office (CBO) (http://www.cbo.gov) and the Congressional Research Service (CRS). CRS reports are not available to the public, but several sites now offer them, most notably Congressman Mark Green of Wisconsin. (http://www.house.gov/markgreen/crs.htm).

Associations

In addition to the NCSL, the National Association of State Medicaid Directors (http://medicaid.aphsa.org) and the National Governors Association (http://www.nga.org) have state-level information and analysis of Medicaid programs. They can be valuable sources for comparisons among states. The National Association of State Budget Officers (NASBO) (http://www.nasbo.org) and the federal funds information for states (FFIS) (http://www.ffis.org) are sources for current, comparative budget data for states.

Private Sector Organizations

A number of foundations, think tanks and advocacy organizations carry out research on Medicaid programs. The following partial list emphasizes organizations with current, factual, state-based information related to cost management that is easily accessible for state researchers.

- **Some foundations also maintain collections of information at their own sites.**
  The Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) (http://www.statecoverage.net) and the Kaiser Family Foundation's Commission on Medicaid and the Uninsured (http://www.kff.org/sections.cgi?section=kcmu) produce a range of reports and compilations of state information about Medicaid for policymakers.

  Other foundations with resources related to Medicaid include the Kellogg Foundation, with a database of grantees' products related to welfare, SCHIP and Medicaid reform (http://www.wkkf.org/Devolution/PubDatabase) and the Commonwealth Fund (http://www.cmwf.org), which posts a number of Medicaid-related studies.

- **Two prominent think tanks that work on Medicaid** are
  The Urban Institute (http://www.urban.org), particularly its project on assessing the new federalism (http://newfederalism.urban.org) carries out surveys, simulations and studies of Medicaid and other programs. Mathematica Policy Research, Inc. (http://www.mathematica-mpr.com) and its affiliate, the Center for Studying Health System Change (http://www.hschange.com) are also known for surveys, simulations and evaluation of Medicaid programs.

- **A number of agenda-oriented organizations carry out Medicaid research and analysis.** The Center on Budget and Policy Priorities (http://www.cbpp.org), a policy organization with a focus on programs for low and moderate income groups, has released several recent analyses on costs and eligibility in Medicaid. Other sources can be found in the footnotes.

Private Sector Consultants

Several consulting firms specialize in Medicaid and several have former Medicaid directors or state health commissioners on staff. States will want to develop their own relationship with consultants who are familiar with their state and its specific concerns. Several who were consulted while writing this paper indicated they would be willing to field questions from states:

Chuck Milligan, Lewin Group.	(703) 269-5627 (chuck.milligan@lewin.com)
MaryJo O'Brien, Capital Health Strategies.	(651) 224-8267 (obrienmjo@aol.com)
Vernon Smith, Health Management Associates.	(517) 482-9236 (vsmith@hlthmgt.com)
Jim Verdier, Mathematica MPR.	(202) 484-4520 (jverdier@mathematica-mpr.com)

We welcome your suggestions about groups and individuals that have expertise in Medicaid cost containment, either generally or in relation to a specific strategy. ▯ *KL*

4. *Cost-Cutting Strategies*

The profiles that accompany this report describe 10 strategies states have used to manage Medicaid costs. They fall into three categories: maximizing available funding for Medicaid; financing and delivery incentives; and fine-tuning managed care and selective contracting.

Maximizing available funding for Medicaid contains four strategies designed to directly or indirectly reduce state Medicaid costs by generating additional federal or private sector funding to enhance state Medicaid budgets. These strategies are:

1. Medicaid maximization
2. Low-match to high-match
3. Intergovernmental transfers
4. Private sector cost sharing

Financing and delivery incentives include three strategies to reduce or contain costs by changing the incentives for providers and encouraging the use of different, potentially cost saving services and delivery mechanisms. These strategies are:

5. Reconfiguring the long-term care delivery system
6. Pharmacy cost containment strategies
7. Rate adjustment

Fine-tuning managed care and contracting for services include three strategies for contracting with providers and plans to reduce costs and improve how care is managed. They include:

8. Managing health care better
9. Expanding managed care
10. Selective contracting

Each profile consists of: a brief description of the strategy and how it is used; the pros, cons, design and policy issues that need to be considered; and any federal or other limits on its use. State examples are provided for each. A table and graphic showing which states currently are using each strategy and some key references—such as important studies or useful Web sites—also are included.

Chapter 2 Notes

[1] Much of this paper also will apply to the State Child Health Insurance Program (SCHIP). However, because of its different structure and the small dollar amount, it is not included in this paper.

[2] National Conference of State Legislatures, *State Fiscal Outlook for 2001: February Update* (Denver: NCSL, March 2001). See http://www.ncsl.org/programs/fiscal/upsfo2001.htm.

[3] The National Governors Association and the National Association of State Budget Officers, *The Fiscal Survey of States: June 2001* (Washington D.C., June 2001). See http://www.nasbo.org/Publications/PDFs/FSJUN2001.pdf.

[4] NCSL, *State Fiscal Outlook for 2001.*

[5] NGA and NASBO, *The Fiscal Survey of States: June 2001.*

[6] Brian Bruen and John Holahan, *Slow Growth in Medicaid Spending Continues in 1997* (Washington, D.C.: Kaiser Family Foundation, November 1999). Published with the permission from the Kaiser Family Foundation. See http://www.kff.org/content/2000/2165/pub2165.pdf.

[7]Center for Medicare and Medicaid Services, *Penetration Rates from 1996 – 2000,* National Summary Table 2000 Medicaid Managed Care Enrollment Report (Washington, D.C.: June 2000). See http://www.hcfa.gov/medicaid/trends00.pdf.

[8] Bruen and Holahan, *Slow Growth.*

[9] Eileen R. Ellis, Vernon K. Smith, and David M. Rousseau, *Medicaid Enrollment in 50 States: June 1997-December 1999* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2000).

[10] Baumol's law: Labor intensive services, such as health care, cannot substitute capital for labor as efficiently as the general economy, so the cost of producing them goes up faster than general inflation. Government ends up taking on these "inefficient" services—public safety, education, long-term care and other care-based health services. Scott Gottlieb, "One Doctor: One Patient: It's Baumol's Disease, and it pretty much guarantees that healthcare will stay expensive." *CQ Online* 7, no.1 (March 2001), See http://www.cost-quality.com/restpast/v7i1a8.html.

[11] Leighton Ku and Jocelyn Guyer, *Medicaid Spending: Rising Again, but not to Crisis Levels* (Washington, D.C.: Center for Budget and Policy Priorities, 2001). See http://www.cbpp.org/4-20-01health.htm.

[12] Ibid.

[13] Bradley Strunk, P.B. Ginsburg, and J.R. Gabel, "Tracking Health Care Costs," *Health Affairs* (Sept. 26, 2001). Obtained from http://www.healthaffairs.org/Strunk_Web_Excl_92601.htm [Health Affairs Web Exclusive] Internet.

[14] Ku and Guyer, *Medicaid Spending.*

[15] States may receive permission from the federal Medicaid agency to experiment with programs that go beyond these definitions through a waiver process that often is difficult and lengthy. There are other variations from the basic rules, such as requiring people to participate in managed care in certain parts of the state or creating programs to move people from nursing facilities to home and community-based long-term care (HCBC), that require simpler, more readily obtained waivers. For more information about Medicaid eligibility policy, see http://www.hcfa.gov/medicaid/obs2.htm.

[16] John Holahan, *Medicaid "Mandatory" and "Optional" Eligibility and Benefits* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2001). See http://www.kff.org/content/2001/2256/2256.pdf.

[17] According to KFF state health facts Total Dual Eligibles, 2000: "Dual eligibles are those who receive Medicare (Part A and Part B) and also some form of Medicaid assistance. This group includes 1) "Full Medicaid", those people receiving full Medicaid benefits (i.e. prescription drugs and nursing home care) and Medicaid coverage of Medicare's financial requirements, and 2) "Buy-Ins", those people receiving some level of assistance with Medicare cost-sharing and premiums only." Problems of dual eligibility are discussed at greater length later in this report.

[18] Bruen and Holahan, *Slow Growth.*

[19] According to the CMS web site, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under age 21. EPSDT includes periodic screening, vision, dental, and hearing services; any medically necessary health care service must be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. See http://www.hcfa.gov/medicaid/epsdthm.htm.

[20] For a discussion of mandatory and optional populations and services see www.kff.org/content/2001/2256.

[21] This act removed the "Boren" amendment, which required states to pay hospitals and nursing homes market rates.

[22] Only $17 billion of $130 billion federal Medicaid dollars are expected to go to managed care in 2001, according to the Congressional Budget Office (CBO).

[23] In fact, Medicare managed care recipients are free to disenroll any month, even if Medicaid requires them to stay in a plan.

[24] Helen Hendrickson and Vic Miller. "States Plan Responses to Olmstead Decision," *FFIS Issue Brief* (Federal Funds Information for States) 1, no. 33 (July 2001).

[25] The Boren amendment required states to pay certain providers market rates for their services.

[26] The federal government's share of the medical assistance expenditures, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed for a smaller share of their costs. By law, the FMAP cannot be

lower than 50 percent or higher than 83 percent of the program's costs. In 1999, the FMAPs varied from 50 percent in 10 states to 77 percent in Mississippi, and averaged 57 percent overall. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as family planning services or development of mechanized claims processing systems. See FMAP at http://aspe.os.dhhs.gov/health/fmap.htm.

[27] FMAPs will rise in 2003 in 23 states and decline in 17, according to FFIS. Vic Miller, "2003 FMAPs:Bureaus Meet Their Match," *FFIS Issue Brief* (Federal Funds Information for States) 1 no. 56 (October 2001). See http://www.ffis.org/exec_sum/issue/ib01-56s.htm.

[28] For example: EDS, Consultec, First Health.

[29] Department of Health and Human Services, Office of Inspector General, *Medicaid Recovery of Pharmacy Payments from Liable Third Parties* (Washington, D.C.: HHS, August 2001). See http://www.hhs.gov/oig/oei/reports/a534.pdf.

[30] Center for Medicaid and Medicare Services, *Estate Recovery Provisions in OBRA* (Washington, D.C.: CMS, 1993). See http://www.hcfa.gov/medicaid/obs1.htm.

[31] Timothy M. Westmoreland, *State Medicaid Directors' Letter on HIPAA Administrative Simplifications Activities*, (Washington, D.C.; HHS, September, 2000). See http://www.hcfa.gov/medicaid/smd90800.htm.

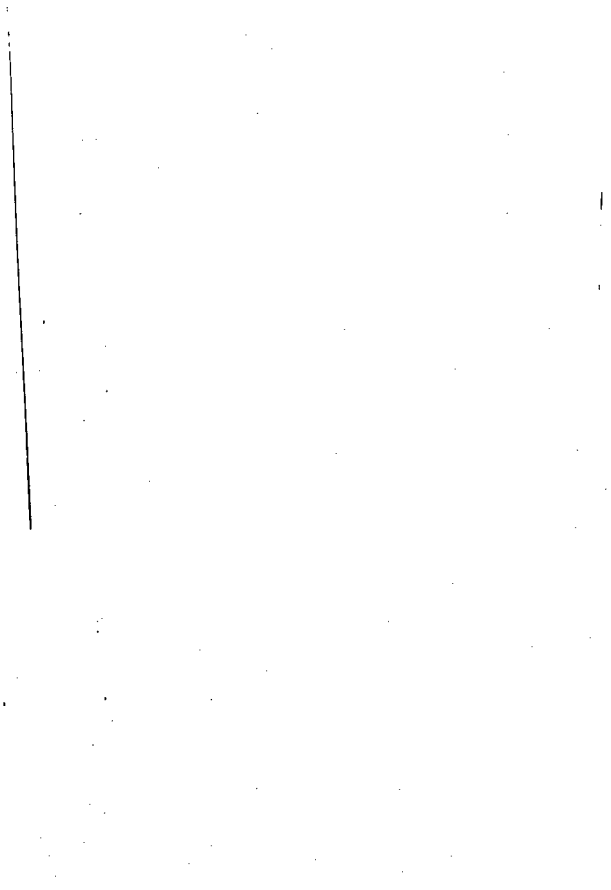
[32] Government Accounting Office, *Medicaid: State Efforts to Control Improper Payments Vary* (Washington, D.C.: GAO, June 2001). See http://energycommerce.house.gov/107/reports/d01662.pdf.

Chapter 3

[1] H.L. Mencken, *The American Language: An Inquiry into the Development of English in the United States*, 2nd ed. New York: A.A. Knopf, 1921; Bartleby.com, 2000. www.bartleby.com/185/. [November 28, 2001].

[2] However, considerable savings may be achieved by restructuring options so that lower cost substitutes are preferred. Such approaches are covered in the managed care approaches in strategies 8 through 10.

[3] This can include cutting growth below inflation rates.



POLICY & PLANNING DIVISION

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MEMORANDUM

TO: Joint Fiscal Committee
FROM: Mel Adams, Director Policy & Planning
DATE: September 9, 2004
RE: Inflation index to convert past transportation appropriations into current dollars

Attached is the Administration's recommendation regarding the inflation index called for in Sec.30 of Act 160 (2004 session) amending 19 V.S.A. §10g(d). The suitability of the index for its intended purpose has been confirmed by the administration economist Jeff Carr and by the Department of Finance and Management Commissioner. This recommendation has been coordinated through Tom Kavet and the Joint Fiscal Office.

While the attachment describes the recommended index, the Joint Fiscal Committee is also required to approve the procedure for using the index to adjust historical appropriations data. At the September meeting we will describe for JFC approval the process for applying the requisite inflation index.

The relevant text of Sec. 30 of Act 160, amending 19 V.S.A. §10g(d), is as follows (emphasis added):

(d)(1) In addition to the multiyear transportation program described in subsection (a) of this section, the agency shall annually present to the general assembly an analysis of the balance between the state's commitments to transportation projects and total available resources for projects over the ten-year period commencing with the fiscal year of the transportation program. The analysis shall include, on a current dollar basis, an estimate of the total remaining cost of all projects in construction, development, and evaluation or candidate status in the agency's proposed multiyear transportation program, including individual estimates and projected schedules for all projects with a total project cost estimate in excess of $10 million, and an estimate, on a current dollar basis, of the total resources projected to be available to cover project expenses during the ten-year period.

(2) The projection of available resources called for in subdivision (1) of this subsection shall be determined in the following manner. Total appropriations to the agency exclusive of internal service funds for each of the five previous fiscal years shall be determined. From that total for each fiscal year shall be deducted appropriations for annual programs and other noncapital project agency activities. Appropriations for administration, overhead, and other ongoing agency functions required for the support of capital project activities shall be apportioned on a reasonable basis and added back to the total which shall represent the total of appropriations for and in support of the agency's capital project activities for that fiscal year. *The resulting appropriations totals of capital project-related appropriations shall be adjusted for inflation in a procedure approved by the joint fiscal committee.* The resulting inflation adjusted figures for the five previous fiscal years shall be averaged, and the average multiplied by ten shall be used as the estimate of the total resources projected to be available to cover project expenses during the ten-year period.

(3) To the extent the estimate of remaining costs exceeds the estimate of available resources, the agency shall submit to the general assembly a plan to bring costs and resources into balance. The plan shall include recommendations regarding the scheduling, suspension, or cancellation of projects, cost saving initiatives, revenue raising initiatives, and other organizational, project design, project execution, or financial measures or initiatives which shall ensure that the state's commitments will be adequately and realistically funded.

MEMO

To: Mel Adams, Director of Policy & Planning VTrans

From: Jeff Carr, Economic & Policy Resources, Inc.
Tom Kavet, Kavet-Rockler & Associates, Inc.

CC: Robert Hofmann, Commissioner of Finance & Management
Steve Klein, Joint Fiscal Officer

Date: September 8, 2004

Re: Updated VTrans Appropriation Price Index Recommendation for 10-Year Needs Assessment

Pursuant to your request, we have developed an acceptable approach for accomplishing the required deflation calculation associated with the VTrans 10-year needs assessment process. It is as follows:

> Use the national Producer Price Index for Highways and Streets Construction (hereafter the "PPI Index") instead of the NIPA[1] Chain-Weighted Price Index State & Local Price Index for Gross Fixed Investment—Highways and Streets (hereafter the "NIPA S&L Index").

The strength of this approach is that the data are published in a more timely manner. In addition, monthly data are available (with the four most recent monthly observations subject to revision) so this index can be configured to correspond to the state's fiscal years, and/or be used on a less than annual basis (quarterly or even monthly). The index tracks relatively closely on a calendar year basis with the NIPA S&L Index (see the attached chart), although it has experienced negative year-to-year change in 4 of the last 16 calendar years (or one-quarter of the time). In addition, the PPI Index also tracks well with the FWHA bid price index—trending in the same direction but with less volatility than that bid price index. Lastly, this option is the most straight-forward, involving relatively little effort to track and update annually.

[1] NIPA refers to the National Income Product Accounts or the GDP statistical series from the U.S. Department of Commerce.

If this recommended approach is adopted, the time series index data used to deflate the VTrans' appropriations would be as follows:

Dept. of Labor PPI Table
Source: http://data.bls.gov/servlet/SurveyOutputServlet?jrunsessionid=1094179448790172891

CALENDAR YEAR	1997	1998	1999	2000	2001	2002	2003
Highway & Streets construction	124.6	123.5	126.6	136.5	137	133.7	136.6
Percent Change		-0.88%	2.51%	7.82%	0.37%	-2.41%	2.17%

FISCAL YEARS	1997	1998	1999	2000	2001	2002	2003
Highway & Streets construction	123.775	124.1583	123.85	132.0083	138.1167	134.4083	135.2417
Percent Change		0.31%	-0.25%	6.59%	4.63%	-2.68%	0.62%

CALENDAR YEAR

Year	86:6=100	% change
1993	111.7	--
1994	114.3	2.33%
1995	118.4	3.59%
1996	122.1	3.12%
1997	124.6	2.05%
1998	123.5	-0.88%
1999	126.6	2.51%
2000	136.5	7.82%
2001	137	0.37%
2002	133.7	-2.41%
2003	136.6	2.17%
10 YR ANN. AVE.		2.07%
GEOMETRIC MEAN		2.03%

FISCAL YEARS

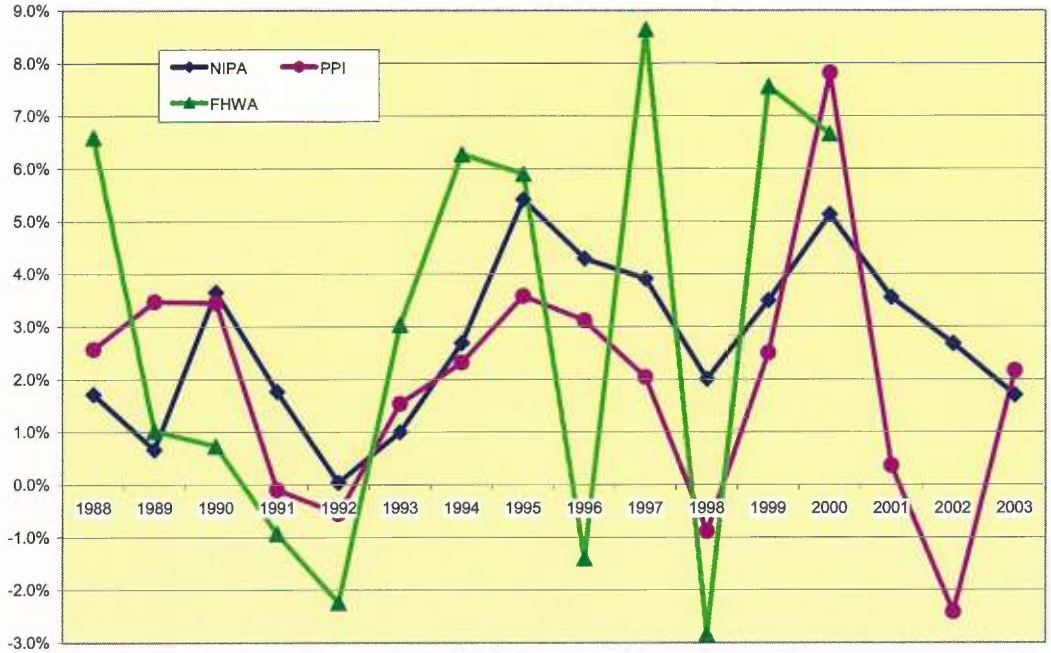
Year	86:6=100	% change
1993	110.8917	--
1994	112.5667	1.51%
1995	116.6667	3.64%
1996	120.0417	2.89%
1997	123.775	3.11%
1998	124.1583	0.31%
1999	123.85	-0.25%
2000	132.0083	6.59%
2001	138.1167	4.63%
2002	134.4083	-2.68%
2003	135.2417	0.62%
10 YR ANN. AVE.		2.04%
GEOMETRIC MEAN		2.00%

For fiscal year 2004, the PPI Index would be +3.9% using three months of preliminary data (for April 2004-June 2004) that are still subject to further revision. As such, the 10 fiscal year compound annual rate of change (Geometric Mean) would be +2.2%. Monthly data are provided on the following page.

Further, this index also has the flexibility to be converted to a fiscal 2003 or fiscal 2004 base year (essentially re-stating VTrans appropriations in constant dollars) by creating a re-based deflator to the desired fiscal or calendar year. This is accomplished by calculating a conversion factor from the 1986:6 base year values to the desired base year. This re-based index could then be employed to deflate appropriations into the desired base year in constant dollars.

Please feel free to call either of us (Jeff Carr at 878-0346 Ext. 15 or Tom Kavet at 433-1360) with any questions or comments.

Percent Change vs. Year Ago - Street & Highway Price Indices



Series Id: PCUBHWY--BHWY--Industry
Highway and street constructionProduct:
Highway and street construction Base Date: 8606

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
1986						100	98	97.6	98.3	97.7	97.6	97.6	
1987	98.5	99.2	99.4	100	100.1	100.7	101.2	101.8	101.6	101.9	102.6	102.4	100.8
1988	102.2	102.4	102.5	103.3	103.8	103.8	103.8	103.9	103.6	103.4	104	104.3	103.4
1989	105	105.4	105.9	107.4	108.1	107.8	107.4	106.7	107.2	107.6	107.5	107.4	107
1990	109.4	108.4	108.2	108.4	108.6	108.4	108.3	110.4	113.1	115.4	115.9	114.2	110.7
1991	113.3	112	110.3	110.1	110.5	110.4	109.9	110.3	110.4	110.1	110.2	109.3	110.6
1992	108.8	109.1	109.3	109.4	109.9	110.5	110.4	110.4	110.6	110.5	110.6	110.1	110
1993	110.4	110.7	111.2	111.7	112	112.1	111.8	111.7	112.1	112.6	112.5	111.7	111.7
1994	112.1	112.7	112.8	113.2	113.5	114.1	114.8	115.7	115.5	115.3	115.9	115.6	114.3
1995	116.5	116.8	117.1	118.5	119	119.3	118.9	119	119.2	118.7	118.7	119.1	118.4
1996	119.9	119.8	120.6	122	122.6	122	122	122.3	123	123.5	123.8	124	122.1
1997	124.6	124.7	124.2	124.3	124.5	124.4	124.2	124.9	125	124.9	124.9	124.3	124.6
1998	123.8	123.4	123	123.6	124	123.9	124	123.4	123.6	123.6	123.3	122.3	123.5
1999	122.8	122.6	123.3	125.4	125.9	126	126.9	128.1	129	128.8	129.6	130.7	126.6
2000	132	134	136	135.6	135.8	137.6	137.1	136.6	138.9	138.5	138.4	137.3	136.5
2001	137.8	138.2	137.4	138.5	139.9	138.8	136.6	137	138.4	135.4	134.1	132.4	137
2002	132.9	132.4	132.7	133.3	133.8	133.9	134.1	134.2	134.4	134.4	133.9	133.7	133.7
2003	134.7	135.7	136.8	137.1	137	136.9	136.7	136.9	136.8	136.7	137.1	137.2	136.6
2004	140.5	141.2	142.5	145	148	147.1	149.3						

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STATE OF VERMONT
OFFICE OF THE STATE TREASURER

TO: **Joint Fiscal Committee**

FROM: **State Treasurer's Office; Department of Finance and Management; and the Vermont Economic Development Authority ("VEDA")**

DATE: **September 15, 2004**

Memorandum Subject

There are two issues: (1) the existence of $1.954 million of "Advances to Component Units," a receivable on the State's balance sheet , and (2) how to treat future funds that may need to be advanced to support VEDA's insurance programs under Title 10, Chapter 12, Subchapter 2 § 223, and Title 10, Chapter 12, Subchapter 8, § 279b in a manner that preserves the program and meets the various financial reporting needs in a productive way.

Background of VEDA Insurance Programs

The Mortgage Insurance Program ("MIP"- Subchapter 2) has been in existence since before VEDA was formed through the combination of several State programs in 1974. The Financial Access Program ("FAP" - Subchapter 8) was created in 1993. Under both programs, a portion of loans made by banks is insured against loss. Upon notification and substantiation of a loss by a bank, the MIP or FAP reimburses the bank for its loss up to the insured amount from available cash in the program accounts. If the funds in the accounts are insufficient to pay the claim, the MIP or FAP receives the necessary funds from the State as outlined in the statute. The banks rely on the full faith and credit pledge of the State outlined in the statute to make the insurance creditworthy.

Program History

When losses have occurred in the programs, the State Treasurer reimburses the MIP or FAP from the General Fund. The State has always recorded these payments as "Advances to Component Units," a receivable from VEDA, on the State's balance sheet, rather than recording the disbursement as an appropriation. The MIP and FAP programs have been used effectively as economic development programs. The MIP and FAP were never constructed so that the fees charged the borrowers would fully cover the cost of the programs, including losses.

As of June 30, 2004, a total of $1,656,049 in "Advances to Component Units" is recorded on the balance sheet of the State for the MIP. Just over $1 million of this amount represents three MIP losses that occurred between 1982 and 1986; the remaining $595 thousand was a single advance that occurred in 1993. From 1993 to today, no advances have been made by the State to the MIP.

As of June 30, 2004, a total of $298,484 in "Advances to Component Units" is recorded on the balance sheet of the State for the FAP. This amount represents the entire amount of advances since the program's inception in 1993 (an average of $25 thousand per year over the 12-year program life).

In 1977, the Attorney General of Vermont issued an opinion (see attached) that nothing in the statute indicated that VEDA was legally obligated to repay the State for payments made to support the activities of the MIP. This opinion has been attached for reference. The AG's office recently reviewed the statute and the 1977 opinion, and came to the same conclusion regarding the advances made to the MIP and FAP.

What the Programs Contribute to the State

The MIP insures up to a maximum of 90% of a bank loan(s). Of the current $10.4 million of outstanding insurance contracts, six are over $900,000 and total $8.9 million in aggregate. The MIP is primarily used to insure working capital for companies, a purpose not allowed under VEDA's other programs. Many of the insured companies are large employers who are struggling and need working capital to survive. Four examples of recent projects and the jobs impacted are detailed below:

- Vermont Quality Wood Products in Brandon (a/k/a "Vermont Tubbs"); $400,000; 58 jobs.
- Specialty Filaments in Burlington; $2,000,000; 336 jobs.
- Lucille Farms in Swanton; $1,000,000; 77 jobs.
- Mountain Operations in Bolton (a/k/a Bolton Valley Resort); $270,000; 386 jobs.

The Vermont Financial Access Program (FAP) is a program that utilizes a "pooled reserve" concept to enhance opportunities for small businesses to access commercial credit. Premiums, which are based on a percentage of the loan amount, are paid to VEDA by a participating bank and are deposited into a reserve account on behalf of that bank. VEDA matches between 3% and 7% of the bank's loan. The bank and borrower contribute equally in the payment of the premium; however, the bank may pass its portion of the premium onto the borrower. VEDA matches this premium with insurance. This reserve account is dedicated to cover losses that may be incurred by the bank on loans that are enrolled in FAP, thus giving the bank an incentive to make loans it may not otherwise be willing to consider. The maximum loan size that can be insured under the FAP is $200,000. Since its inception in 1993, the FAP has insured a portion of over 832 bank loans totaling $15.5 million to small businesses that would not otherwise have had access to credit.

The loss rate of the MIP over the 30-year life of the program has been 1.54% of the average outstanding contracts. The FAP loss rate has been higher at 3.23% of the average outstanding liability over the 11-year program life, but the rates have declined recently, with losses over the past five years representing 2.04% of the outstanding liability under the FAP contracts.

Recommendations

The State Treasurer's Office and the Commissioner of Finance and Management recommend that the $1.954 million of past advances to the MIP and FAP be expensed as an adjustment to fiscal year 2004.

The State Treasurer's Office, the Commissioner of Finance and Management, and the Staff of VEDA (collectively, "the Group") have been meeting to develop a plan to fund future program operations over the long term. The plan is not yet finalized, but the group is expected to recommend a plan that includes the creation of an "indemnification fund" from which funds could be disbursed as needed to fund the

operations of the MIP and FAP. The plan will likely include a recommendation that the corpus of the fund come from three sources:

1. The existing monies in the MIP and FAP.
2. Future net revenues of the MIP and FAP.
3. Interest payments made by VEDA's Vermont Jobs Fund on its existing $6.2 million of debt to the State. The debt matures on December 31, 2008, and the aggregate amount of interest payments over that period is $994,513.

Current projections, subject to final approval by the VEDA Board, are that revenues generated from these sources would exceed $3.4 million dollars through fiscal year 2024. Based on projected loss rates, inflows will exceed outflows over the course of this long-term projection, and the indemnification fund would be the primary source of funding in the event of a loss. VEDA would forward these proceeds to the State and the State would create a legally constituted indemnification fund on its books (with legislative approval).

The Group recommends that the full faith and credit of the State remain pledged to support the program, but only in the event that the indemnification fund is depleted. A legislative change would be proposed identifying the indemnification fund as the primary backup to the insurance programs.

The State's financial advisor will review the plan with the rating agencies to ensure that the solvency created by an indemnification fund will keep the MIP and FAP contracts as contingent liabilities on the State's debt statement and *not* require classification as tax-supported debt.

This proposal is presented to the Joint Fiscal Committee for consideration and action, contingent on the VEDA board accepting the recommendation and associated fees as proposed. VEDA staff is bringing the Group's recommendations (including changes to the MIP and FAP fees) to the members of the Authority for approval at the VEDA board meeting scheduled for September 24, 2004.

Attachments:

The applicable sections of the MIP and FAP statutes.
The 1977 opinion of the Attorney General of the State.

Applicable Sections of VEDA Statute

Title 10, Chapter 12, Subchapter 2, § 223. Credit of the state pledged

The full faith and credit of the state is pledged to the support of the activities of the authority under this subchapter. In furtherance of the pledge, the state treasurer is authorized and directed to advance to the fund, without further approval, from available cash in the treasury or from the proceeds of bonds or notes issued under this section, such additional amounts as may be requested from time to time by the authority to enable it to perform all insurance contracts punctually and in accordance with their terms. The authority shall request such advances from time to time as additional amounts are required for such purposes. The treasurer is authorized and directed, without further approval, to issue full faith and credit bonds of the state, from time to time, in amounts equal to advances made under this section and section 279b of this title, but not to exceed an aggregate of $35,000,000.00 at any one time outstanding, and to borrow upon notes of the state in anticipation of the proceeds of such bonds. Any bonds under this subchapter shall be issued pursuant to the provisions of chapter 13 of Title 32 except that the approval of the governor shall not be required previous to their issuance by the treasurer. (Added 1973, No. 197 (Adj. Sess.), § 1; amended 1993, No. 89, § 8.)

Title 10, Chapter 12, Subchapter 2, § 229. Use of recoveries

All recoveries from the liquidation of assets or capital facilities which are not required to maintain or manage property under the control of the authority shall, with available balances from the authority's insurance accounts, be used to pay the amortization and interest payments on bonds issued by the state treasurer for the purposes of this subchapter. If the recoveries and insurance accounts are insufficient to provide for these debt service payments, the necessary amounts shall be paid from the general fund. (Added 1977, No. 10, § 1, eff. March 10, 1977.)

Title 10, Chapter 12, Subchapter 8, § 279b. Credit of the state pledged

(a) Upon registration by the authority of an eligible loan, the full faith and credit of the state shall be pledged in an amount equal to the reserve premium payment deposited to the fund by the participating bank in connection with such loan. The aggregate amount of the credit of the state which may be pledged pursuant to the provisions of this subchapter shall not exceed $2,000,000.00 at any time.

(b) The state treasurer is authorized and directed to advance to the fund, without further approval, from available cash in the treasury or from the proceeds of full faith and credit bonds or notes issued pursuant to section 223 of this title, such amounts as may be requested from time to time by the authority to enable it to perform its obligations under this subchapter.

(c) Upon entering into a contract with a participating bank, the full faith and credit of the state shall be pledged in the amount of $50,000.00 to the reserve account of such bank, created under section 279 of this title. Such amount shall be reduced on a pro rata basis for actual reserve fund contributions resulting from loans made under this subchapter. (Added 1993, No. 89, § 7; amended 1993, No. 221 (Adj. Sess.), § 8; 1997, No. 156 (Adj. Sess.), § 57, eff. April 29, 1998; 1999, No. 131 (Adj. Sess.), § 3.)

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December 7, 1977

Mr. Everett C. Bailey, Chairman
Vermont Industrial Development Authority
Pavilion Office Building
Montpelier, Vermont 05602

Re: Opinion No. 25-78

Dear Mr. Bailey:

You have requested an opinion on behalf of the Vermont Industrial Development Authority as to whether principal payments made, or to be made, by the State from the general fund on the bond issue authorized by Section 10, of No. 253, Acts of 1971 (Adjourned Session) are obligations of the Authority to the State.

I conclude that they are not.

The answer requires an interpretation of Section 10(b) of the above cited act which reads:

> "The state treasurer is hereby authorized to issue bonds totalling $4,000,000.00 for the purposes of this section. All recoveries from liquidation of assets or capital facilities or both together with all future available balances from the Vermont industrial building authority's insurance accounts, shall be first applied to the necessary debt service appropriations for the amortization and interest payments on the above bonds. In the event that these balances are insufficient to provide for these debt service payments, the necessary amounts shall be provided from the general fund."

When the wording in a statute admits of only one reasonable interpretation, we have no alternative but to apply that construction in its implementation. Nolan v. Davidson, 134 Vt. 295, 298 (1976).

In this instance a construction which makes payments from the general fund a debt due from the Authority to the State, would require that we read

language into the enactment which is simply not there. Expressed another way, we would have to say that such language is implied. This can be done only in the face of a patent ambiguity, a conflict in terms, or to make a statute meaningful. In other words it must be reasonably necessary to do so in order to eliminate fair doubts or defects arising from the language actually employed by the Legislature. Rules of statutory construction are to be applied to resolve doubts, not to create them.

Section 10(b) does not need additional language to render it meaningful. It is operative as it stands without more, and since I find no suggestion that payments made from the general fund must be reimbursed by the Authority to the State, I can only conclude as indicated above that repayment is not required.

If my conclusion is considered an undesirable result the remedy, of course, is through the Legislature, not through an interpretation which is not otherwise justified. State v. Racine, 133 Vt. 111, 114 (1974).

Very truly yours,

Louis P. Peck

LOUIS P. PECK
Chief Assistant Attorney General

LPP/f

APPROVED:

_____
Attorney General

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STATE OF VERMONT
OFFICE OF THE STATE TREASURER

TO: **Joint Fiscal Committee**

FROM: **State Treasurer's Office; Department of Finance and Management; and the Vermont Economic Development Authority ("VEDA")**

DATE: **September 15, 2004**

Memorandum Subject

There are two issues: (1) the existence of $1.954 million of "Advances to Component Units," a receivable on the State's balance sheet , and (2) how to treat future funds that may need to be advanced to support VEDA's insurance programs under Title 10, Chapter 12, Subchapter 2 § 223, and Title 10, Chapter 12, Subchapter 8, § 279b in a manner that preserves the program and meets the various financial reporting needs in a productive way.

Background of VEDA Insurance Programs

The Mortgage Insurance Program ("MIP"- Subchapter 2) has been in existence since before VEDA was formed through the combination of several State programs in 1974. The Financial Access Program ("FAP" - Subchapter 8) was created in 1993. Under both programs, a portion of loans made by banks is insured against loss. Upon notification and substantiation of a loss by a bank, the MIP or FAP reimburses the bank for its loss up to the insured amount from available cash in the program accounts. If the funds in the accounts are insufficient to pay the claim, the MIP or FAP receives the necessary funds from the State as outlined in the statute. The banks rely on the full faith and credit pledge of the State outlined in the statute to make the insurance creditworthy.

Program History

When losses have occurred in the programs, the State Treasurer reimburses the MIP or FAP from the General Fund. The State has always recorded these payments as "Advances to Component Units," a receivable from VEDA, on the State's balance sheet, rather than recording the disbursement as an appropriation. The MIP and FAP programs have been used effectively as economic development programs. The MIP and FAP were never constructed so that the fees charged the borrowers would fully cover the cost of the programs, including losses.

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As of June 30, 2004, a total of $298,484 in "Advances to Component Units" is recorded on the balance sheet of the State for the FAP. This amount represents the entire amount of advances since the program's inception in 1993 (an average of $25 thousand per year over the 12-year program life).

In 1977, the Attorney General of Vermont issued an opinion (see attached) that nothing in the statute indicated that VEDA was legally obligated to repay the State for payments made to support the activities of the MIP. This opinion has been attached for reference. The AG's office recently reviewed the statute and the 1977 opinion, and came to the same conclusion regarding the advances made to the MIP and FAP.

What the Programs Contribute to the State

The MIP insures up to a maximum of 90% of a bank loan(s). Of the current $10.4 million of outstanding insurance contracts, six are over $900,000 and total $8.9 million in aggregate. The MIP is primarily used to insure working capital for companies, a purpose not allowed under VEDA's other programs. Many of the insured companies are large employers who are struggling and need working capital to survive. Four examples of recent projects and the jobs impacted are detailed below:

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The loss rate of the MIP over the 30-year life of the program has been 1.54% of the average outstanding contracts. The FAP loss rate has been higher at 3.23% of the average outstanding liability over the 11-year program life, but the rates have declined recently, with losses over the past five years representing 2.04% of the outstanding liability under the FAP contracts.

Recommendations

The State Treasurer's Office and the Commissioner of Finance and Management recommend that the $1.954 million of past advances to the MIP and FAP be expensed as an adjustment to fiscal year 2004.

The State Treasurer's Office, the Commissioner of Finance and Management, and the Staff of VEDA (collectively, "the Group") have been meeting to develop a plan to fund future program operations over the long term. The plan is not yet finalized, but the group is expected to recommend a plan that includes the creation of an "indemnification fund" from which funds could be disbursed as needed to fund the

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1. The existing monies in the MIP and FAP.
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The Group recommends that the full faith and credit of the State remain pledged to support the program, but only in the event that the indemnification fund is depleted. A legislative change would be proposed identifying the indemnification fund as the primary backup to the insurance programs.

The State's financial advisor will review the plan with the rating agencies to ensure that the solvency created by an indemnification fund will keep the MIP and FAP contracts as contingent liabilities on the State's debt statement and *not* require classification as tax-supported debt.

This proposal is presented to the Joint Fiscal Committee for consideration and action, contingent on the VEDA board accepting the recommendation and associated fees as proposed. VEDA staff is bringing the Group's recommendations (including changes to the MIP and FAP fees) to the members of the Authority for approval at the VEDA board meeting scheduled for September 24, 2004.

Attachments:

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Applicable Sections of VEDA Statute

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Title 10, Chapter 12, Subchapter 2, § 229. Use of recoveries

All recoveries from the liquidation of assets or capital facilities which are not required to maintain or manage property under the control of the authority shall, with available balances from the authority's insurance accounts, be used to pay the amortization and interest payments on bonds issued by the state treasurer for the purposes of this subchapter. If the recoveries and insurance accounts are insufficient to provide for these debt service payments, the necessary amounts shall be paid from the general fund. (Added 1977, No. 10, § 1, eff. March 10, 1977.)

Title 10, Chapter 12, Subchapter 8, § 279b. Credit of the state pledged

(a) Upon registration by the authority of an eligible loan, the full faith and credit of the state shall be pledged in an amount equal to the reserve premium payment deposited to the fund by the participating bank in connection with such loan. The aggregate amount of the credit of the state which may be pledged pursuant to the provisions of this subchapter shall not exceed $2,000,000.00 at any time.

(b) The state treasurer is authorized and directed to advance to the fund, without further approval, from available cash in the treasury or from the proceeds of full faith and credit bonds or notes issued pursuant to section 223 of this title, such amounts as may be requested from time to time by the authority to enable it to perform its obligations under this subchapter.

(c) Upon entering into a contract with a participating bank, the full faith and credit of the state shall be pledged in the amount of $50,000.00 to the reserve account of such bank, created under section 279 of this title. Such amount shall be reduced on a pro rata basis for actual reserve fund contributions resulting from loans made under this subchapter. (Added 1993, No. 89, § 7; amended 1993, No. 221 (Adj. Sess.), § 8; 1997, No. 156 (Adj. Sess.), § 57, eff. April 29, 1998; 1999, No. 131 (Adj. Sess.), § 3.)

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December 7, 1977

Mr. Everett C. Bailey, Chairman
Vermont Industrial Development Authority
Pavilion Office Building
Montpelier, Vermont 05602

Re: Opinion No. 25-78

Dear Mr. Bailey:

You have requested an opinion on behalf of the Vermont Industrial Development Authority as to whether principal payments made, or to be made, by the State from the general fund on the bond issue authorized by Section 10, of No. 253, Acts of 1971 (Adjourned Session) are obligations of the Authority to the State.

I conclude that they are not.

The answer requires an interpretation of Section 10(b) of the above cited act which reads:

> "The state treasurer is hereby authorized to issue bonds totalling $4,000,000.00 for the purposes of this section. All recoveries from liquidation of assets or capital facilities or both together with all future available balances from the Vermont industrial building authority's insurance accounts, shall be first applied to the necessary debt service appropriations for the amortization and interest payments on the above bonds. In the event that these balances are insufficient to provide for these debt service payments, the necessary amounts shall be provided from the general fund."

When the wording in a statute admits of only one reasonable interpretation, we have no alternative but to apply that construction in its implementation. Nolan v. Davidson, 134 Vt. 295, 298 (1976).

In this instance a construction which makes payments from the general fund a debt due from the Authority to the State, would require that we read

language into the enactment which is simply not there. Expressed another way, we would have to say that such language is implied. This can be done only in the face of a patent ambiguity, a conflict in terms, or to make a statute meaningful. In other words it must be reasonably necessary to do so in order to eliminate fair doubts or defects arising from the language actually employed by the Legislature. Rules of statutory construction are to be applied to resolve doubts, not to create them.

Section 10(b) does not need additional language to render it meaningful. It is operative as it stands without more, and since I find no suggestion that payments made from the general fund must be reimbursed by the Authority to the State, I can only conclude as indicated above that repayment is not required.

If my conclusion is considered an undesirable result the remedy, of course, is through the Legislature, not through an interpretation which is not otherwise justified. State v. Racine, 133 Vt. 111, 114 (1974).

Very truly yours,

Louis P. Peck

LOUIS P. PECK
Chief Assistant Attorney General

LPP/f

APPROVED:

_____
Attorney General

MINUTES

Joint Fiscal Committee
Meeting of September 15, 2004

Senator Bartlett, in the absence of the Chair and Vice Chair (who joined the meeting in progress), called the Joint Fiscal Committee meeting to order at 11:10 a.m. in Room 11, State House.

Also present: Senators Bloomer and Sears
Representatives Marron, Rusten, Schiavone, and Westman

Others in attendance included Legislative Fiscal Office staff; Administration Officials and staff; Elizabeth Pierce, Deputy State Treasurer; and representatives of several regional public transportation entities and various other organizations.

ADMINISTRATION UPDATE ON FISCAL YEAR 2005 REVENUES AND SPENDING PRESSURES:

1. Department of Finance and Management Commissioner Rob Hofmann reported that fiscal year 2005 revenues to date exceed official forecasts, with the General Fund receipts $9 million ahead and Transportation Fund collections $2.3 in excess of the forecast.

After touching on certain issues related to revenues of which he wanted the Committee to be aware, Mr. Hoffman talked about current fiscal year budget pressures. Human services needs will be predominant, and he described some of the specific areas and issues, which will face the General Assembly in the upcoming budget adjustment process.

The Commissioner also described some of the Administration's plans to address the expected budgetary issues, including Transportation Fund expenditures.

In response to Senator Bartlett's inquiry about the status of federal funding to help Vermont towns with emergency road work necessitated by the summer's heavy rainfalls, Commissioner Hofmann affirmed the Administration's strong commitment to assist local communities. After Senator Sears said that towns need to be informed now if emergency aid will not be forthcoming, the Commissioner stated that the general sentiment within the Administration is that this is an issue that will be solved satisfactorily. He added that during the Committee's noon recess he would try to obtain some information on the subject.

Mr. Hoffman also briefly mentioned certain aspects of the instructions to State departments for preparing their fiscal year 2006 budget requests.

VERMONT ECONOMIC DEVELOPMENT AUTHORITY (VEDA) WRITE-OFF AGREEMENT:

2. Mr. Hoffman was joined by David Carter, Chief Financial Officer of VEDA, and Beth Pierce, Deputy State Treasurer, for a discussion of the nearly $2 million closeout issue pertaining to VEDA receivables that was outlined at the July meeting. A report at today's meeting on recommended strategy and any accounting adjustments in the Mortgage Insurance Program and the Financial Access Program operating expenses was called for in formal Committee action at the prior meeting. *[See Item 9, pp. 5-6, of the July 15 minutes for that discussion and the Committee's action.]*

Distributed at the outset of the discussion was a memorandum of this date addressed to the Joint Fiscal Committee from the State Treasurer's Office, the Department of Finance and Management, and VEDA. Referenced in and attached to that document (which is attached to these minutes), was a 1977 opinion from the Attorney General pertinent to the proposals now offered.

Ms. Pierce observed that the VEDA board would not be meeting until September 24, at which time it would be asked to accept the recommendation and associated fees proposed in the memorandum referred to above. In the meantime, Joint Fiscal Committee approval in principle of the elements of the proposal was sought, contingent upon VEDA's positive action next week. Formal approval of the Fiscal Committee would then be included on the agenda for the November meeting.

The Deputy State Treasurer made a detailed oral presentation amplifying the information contained in the memorandum. In explaining the proposal's various components, she discussed issues implicit in the recommended courses of action, including certain implications as they might be viewed by the State's bond rating agencies.

A key piece for which the Committee's support was asked would be the diversion from the General Fund over the next four years of interest payments from VEDA's Vermont Jobs Fund interest payments on its existing debt to the State. Those funds, totaling approximately one million dollars, would be used to create a loan loss and indemnification program to support the operations of the Mortgage Insurance Program ("MIP") and the Financial Access Program ("FAP") described in the memorandum. This recommendation was a focal point of the Committee's discussion, initiated by Representative Westman who opposed to using General Fund monies for the programs' future operations.

What if any action this Committee might take at today's meeting was discussed at length, with a variety of opinions offered. Senator Sears, for example, citing the Attorney General's 1977 opinion that the remedy to issues pertinent to the current proposals, addressed in that document is "through the Legislature," suggested that the best course of action might be to forestall action on the proposals presented today until January when the General Assembly convenes.

Commissioner Hofmann and Deputy Treasurer Pierce urged the Committee to give its approval in principle to the approach of creating the reserve fund, if not the method of funding it. The members who spoke on the subject seemed to reach such a consensus.

The discussion drew to a close with the tacit understanding that the parties involved should proceed generally as outlined in the memorandum, without the Committee's endorsing the diversion of General Fund monies for the indemnification fund. The entire subject of the VEDA write-off agreement will be included on the Committee's November agenda.

HUMAN SERVICES CASELOAD RESERVE:

3. James Reardon, Deputy Commissioner of Finance and Management, presented a report on the status of the Human Services Caseload Reserve, as required annually in accordance with 32 V.S.A. Sec. 308b(b). The information he presented was set forth in a brief memorandum from Secretary of Administration to the Committee dated August 30.

There was no transfer of General Fund carry forward directly attributable to Temporary Assistance to Needy Families (TANF) caseload reductions; however, the amount of $3,000,000 was transferred to the Human Services Caseload Reserve as part of the State's fiscal year 2004 closeout procedures. As of June 30, 2004, the balance of the reserve is $18,543,422. The $3,000,000 transfer was made in accordance with the fiscal year 2004 designated balance from the so-called "waterfall" provision set forth in Act 122 of 2004, Sec. 288(a)(6).

In response to an inquiry from Representative Schiavone, Mr. Reardon outlined pressures on the State's child care budget.

VERMONT STATE HOSPITAL UPDATE:

4. Dr. Paul Jarris, Commissioner of Health, reported on the status of federal recertification of the Vermont State Hospital (VSH), at the request of Senator Bartlett at the prior meeting.

The presentation focused on two issues: (1) the recertification process and the related upward pressures on the budget; and (2) the process of renewal of the psychiatric contract for VSH and potential fiscal ramifications.

(1) Recertification: As a result of all the corrective actions which have been taken at the hospital, a positive outcome is expected this fall with respect to recertification. Commissioner Jarris observed that the federal recertification team has been impressed with the remarkable improvements made at VSH in the past year under Dr. Wehry's leadership. After detailing certain relatively recent corrective actions taken to address remaining issues, Dr. Jarris outlined the time elements and attendant budget pressures related to recertification. By late November federal officials are expected to revisit the facility.

A related issue which Dr.Jarris described pertains to billing issues for emergency care. Although the State had hoped for recovery from the Center for Medicare and Medicaid Services (CMS) of fifty percent (50%) of costs, he explained the unresolved issues that the State now anticipates may result in significantly less than that level of reimbursement. While efforts will continue to press for recovery of as much as possible, the Commissioner was not optimistic.

(2) Psychiatric services: Dr. Jarris explained that because the State cannot afford the cost of hiring a psychiatrist of the caliber needed, it contracts with an outside entity which can pay competitive salaries. It has become clear that what is essentially a pass-through arrangement no longer is acceptable, for reasons he outlined. He stressed the Administration's recognition of and commitment to the need to improve clinical services at VSH. Fletcher Allen Health Care (FAHC) is the organization with which VSH has contracted for the past three years, and that contract expired on June 30 although FAHC agreed to a two-month extension.

Discussions have been taking place with FAHC and another group which submitted a bid, about issues and requirements that the State now regards as essential to the provision of psychiatric services and an improved situation at the State Hospital.

Senator Bartlett asked for an update on the State Hospital at the Committee's November meeting. Commissioner Jarris indicated that more information will be available by then.

TRANSPORTATION OF ELDERS AND PERSONS WITH DISABILITIES:

5. Committee members heard from several individuals on the subject of transportation issues affecting certain populations in Vermont, especially older persons and people with disabilities. Testifying were Becky Walsh (by telephone), a social worker in the radiation and oncology unit at Fletcher Allen Health Care; Camille George, representing the Agency of Human Services on

behalf of Cathy Voyer, AHS Director of Housing and Transportation; Chris Cole, General Manager, Chittenden County Transportation Authority (CCTA); and Trini Brassard, Public Transit Administrator, Agency of Transportation.

Basically, the problem they all described pertained to loss of expected funding for transportation services for elderly and disabled persons in certain areas of the state. Transportation to medical appointments and a variety of other kinds of non-medical transportation needs have been adversely affected.

Ms. Walsh's comments centered on direct effect of curtailing services especially for the elderly clientele she serves, including people who do not qualify for rides under the Medicaid program. *[Committee members received a copy of her written statement.]*

According to Ms. George, the State has approximately $152,000 in unpaid billing and about $81,000 available to reallocate, which leaves a gap of $71,000 for transportation services that AHS will be unable to provide to Medicaid clients. As part of her presentation, she distributed a letter from Cathy Voyer, AHS Director of Housing and Transportation. It described the reasons the Federal Transit Administration (FTA) ruled Vermont's "Elders and Persons with Disabilities Transportation" program to be out of compliance with federal guidelines. The letter also outlined the fiscal ramifications of this ruling and the collaborative efforts of AHS and the Transportation Agency to address the problems. Attachments to the letter and a separate statistical summary, which also was distributed to the members, depicted the problems facing the transportation program.

Chris Cole first described the cost of providing the type of transportation under discussion, such as taking dialysis patients for their treatments. Given what he described as huge needs for transportation services, CCTA decided to forego related administrative costs, which he estimated at approximately $14,000. Nevertheless, to meet the most critical needs CCTA has been forced to make difficult decisions, such as capping the number of dialysis patients it can serve and eliminating shopping trips for groceries and prescription drugs. His agency is awaiting final reallocation of funds at the end of the fiscal year from the Department of Advocacy and Independent Living.

The Transportation Agency's efforts to address the local public transit difficulties were outlined by Trini Brassard. She told the Committee of the agency's efforts to gather more information on the transportation needs in the various regions of the state and how the local agencies are trying to manage their available resources. By January more data on the needs and priorities by region should be available.

The various reports were interspersed with questions and comments from Committee members.

TRANSPORTATION AGENCY INFLATION INDEX REPORT:

6. On behalf of the Administration, Mel Adams, Director of Policy and Planning, Agency of Transportation, presented for action a recommended procedure for using an inflation index to adjust historical appropriations data in the State's multi-year transportation program. Joint Fiscal Committee approval of the index is required by Sec. 30 of Act 160 of 2004 (transportation program), which amends 19 VSA. §10g(d) and sets forth complex new requirements for calculating transportation budget needs as balanced against available resources.

Mr. Adams' report consisted essentially of highlighting certain information contained in two memoranda, which the members received. One of them was from him to the Committee, transmitting the Administration's recommendation regarding the inflation index and advising that the Administration's economist, Jeff Car, and Commissioner Hofmann had confirmed the index's suitability for its intended purpose. The other memorandum was sent to Mr. Carr and Tom Kavet, the Committee's economic and revenue consultant, setting forth a recommended approach and justification for it. *[Copies of both memoranda are on file in the Joint Fiscal Office with the permanent file for this meeting.]*

Representative Marron moved that the Joint Fiscal Committee approve the use of the national Producer Price Index for Highways and Street Construction (hereafter the "PPI Index") instead of the National Income Product Accounts (NIPA) Chain-Weighted Price Index State & Local Price Index for Gross Fixed Investment—Highways and Streets (hereafter the "NIPA S&L Index"). The motion was seconded and adopted.

APPROVAL OF MINUTES:

7. On a motion by Senator Sears, seconded by Representative Westman, the Committee approved the minutes of the July 15 meeting as submitted.

FEDERAL HOUSING PROGRAMS – REQUEST FOR FOLLOWUP INFORMATION:

8. Representative Rusten called attention to the fact that the July minutes reflect a pledge by representatives of the Vermont State Housing Authority to provide additional information concerning the federal housing assistance voucher program for low-income households. After he pointed out that the members have not yet received that data, Chief Fiscal Officer Stephen Klein promised to follow up on the matter.

VERMONT HYDROELECTRIC POWER AUTHORITY UPDATE:

9. John Sayles, Deputy Commissioner of the Public Service Department, and interim manager of the Vermont Hydroelectric Authority, apprised the

Committee of the status of the Connecticut River dams purchase. This update was at the request of Senator Bartlett.

Mr. Sayles' report focused on the ongoing process in the courts, which relates to the proposed acquisition of the dams. He assured the members that the State and its partners have been keeping fully informed and are active participants in that process and will continue to be.

JOINT FISCAL OFFICE REPORT:

10. Chief Fiscal Officer Stephen Klein referred the members' to his written report mailed prior to the meeting. He said that at the November meeting fiscal analyst Stephanie Barrett would discuss computerization of the budget process.

The regular meeting of the Joint Fiscal Committee was adjourned at 12:00 p.m.

Respectfully submitted:

_____

Virginia F. Catone
Joint Fiscal Office

Sec. 273 . Sec. 87f of No. XXX of the Acts of 2005 is amended to read:

Sec. 87f. VEDA; INDEMNIFICATION FUND CAPITALIZATION

~~(a) $100,000.00 of the payments of interest received annually during fiscal years 2005, 2006 and 2007 from the Vermont economic development authority upon the authority's note to the state dated May 15, 2003, shall be paid into the VEDA indemnification fund created in 10 V.S.A. § 222a.~~

(a) Capitalization of the indemnification fund created in 10 V.S.A. § 222a is from the annual interest received from the Vermont economic development authority upon the authority's note to the state dated May 15, 2003 as follows:

(1) In fiscal year 2005, $100,000.00 of the payments of interest received shall paid into the indemnification fund,
(2) In fiscal year 2006, if the available general fund forecast for fiscal year 2006 adopted by the emergency board at their July 2005 meeting exceeds $1,014,650,000.00, then the interest payments received for fiscal year 2006 shall be paid into the indemnification fund, otherwise $100,000.00 of the payments of interest received shall paid into the indemnification fund,
(3) In fiscal year 2007 and thereafter the annual interest received shall be paid into the indemnification fund.

Fund comparison

	BAA as passed	HAC amend
FY05	$100,000	$100,000
FY06	$100,000	$248,190 assuming forecast up
FY07	$100,000	$210,350
FY08	$0	$152,800
FY09	$0	$68,950
	$300,000	$780,290
		if no forecast up then $632,100

FY04 5310 Program Annual YTD Summary

7/28/2004

STATEWIDE STATISTICS

Summary Vermont

Grant: cfda# 20.513

Service Month: YTD Summary

Unduplicated Clients Served Year to Date for:				
1. Kidney Dialysis Transportation Only:			131	
2. All categories of transportation services, including kidney dialysis:			5813	
SERVICE CATEGORY and MODE	**# ONE-WAY TRIPS**	**(Hours, Miles, $$s) QUANTITY**	**RATE ($)**	**COST/MODE ($)**
Kidney Dialysis				
A = Van/Minibus Vehicle hours	2,065	1,389.20	0.00	46,563.65
B = Bus Vehicle Hours	181	188.25	0.00	6,362.25
C = Taxi	1,706	29,327.75		29,327.75
D = Transit Ticket	463	8,551.25	0	8,715.25
E=	0	0.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	12,093	647,682.18	0.36	233,171.94
H= Volunteer Driver Hours	0	21,351.34	6.25	133,463.13
Non-Medicaid Medical				
A = Van/Minibus Vehicle hours	4,521	3,236.35	0.00	104,770.00
B = Bus Vehicle Hours	1,375	579.25	0.00	21,402.75
C = Taxi	3,104	31,126.25		31,126.25
D = Transit Ticket	2,605	29,569.50	0	33,381.50
E=	1,253	46,310.00	0	15,745.40
F=	0	46,310.00	0	3,149.08
G = Reimbursable Volunteer Driver Miles	14,754	555,157.40	0.36	199,932.22
H= Volunteer Driver Hours	0	15,975.54	6.25	100,054.11
Senior Meals Programs				
A = Van/Minibus Vehicle hours	41,165	13,875.21	0.00	478,432.38
B = Bus Vehicle Hours	2,240	1,285.50	0.00	42,421.50
C = Taxi	119	1,473.48		1,473.48
D = Transit Ticket	0	0.00	0	-
E=	0	0.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	626	19,659.03	0.36	7,077.25
H= Volunteer Driver Hours	0	743.00	6.25	4,771.75
Adult Day Programs				
A = Van/Minibus Vehicle hours	24,733	9,315.42	0.00	330,646.29
B = Bus Vehicle Hours	264	80.05	0.00	3,041.90
C = Taxi	1,418	15,489.65		15,489.65
D = Transit Ticket	1,778	45,665.40	0	47,270.40
E=	0	0.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	3,378	71,523.70	0.36	25,748.53
H= Volunteer Driver Hours	0	2,269.95	6.25	14,201.81
Shopping Trips				
A = Van/Minibus Vehicle hours	7,398	3,179.72	0.00	99,790.50
B = Bus Vehicle Hours	2,469	180.25	0.00	6,623.19
C = Taxi	596	4,101.75		4,101.75
D = Transit Ticket	756	10,581.00	0	10,581.00
E=	796	22,535.00	0	7,661.90
F=	1,628	27,156.00	0	2,687.63
G = Reimbursable Volunteer Driver Miles	1,982	40,924.95	0.36	14,732.98
H= Volunteer Driver Hours	0	2,915.07	6.25	18,221.92
Vocational/ Personal				
A = Van/Minibus Vehicle hours	8,560	5,168.78	0.00	166,878.01
B = Bus Vehicle Hours	28	49.35	0.00	1,663.55
C = Taxi	2,099	15,852.72		15,852.72
D = Transit Ticket	8,882	54,194.50	0	53,601.45
E=	4,270	92,739.75	0	31,531.18
F=	90	93,068.75	0	6,388.74
G = Reimbursable Volunteer Driver Miles	8,731	256,490.82	0.36	92,340.07
H= Volunteer Driver Hours	0	19,923.20	6.25	124,607.65
Excursion/ Group				
A = Van/Minibus Vehicle hours	9,475	3,329.96	0.00	105,028.27
B = Bus Vehicle Hours	3,035	572.76	0.00	22,456.10
C = Taxi	4	139.25		139.25
D = Transit Ticket	0	20.00	0	340.00
E=	50	1.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	216	8,763.00	0.36	3,154.68
H= Volunteer Driver Hours	0	177.00	6.25	1,106.25

Total Dollars & Trips by Service Category

	Total Dollars	%	Total Trips	%
Kidney Dialysis	$457,604	16.78%	16,508	9.13%
Non-Medicaid Medical	$509,561	18.68%	27,612	15.26%
Senior Meals Programs	$534,176	19.59%	44,150	24.40%
Adult Day Programs	$436,399	16.00%	31,571	17.45%
Shopping Trips	$164,401	6.03%	15,625	8.64%
Vocational/ Personal	$492,863	18.07%	32,660	18.05%
Excursion/ Group	$132,225	4.85%	12,780	7.06%
TOTAL	$2,727,229		180,906	

FY04 5310 Program Monthly Invoice and Report

7/28/2004

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Summary Vermont

Grant: cfda# 20.513

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MODE:	# ONE-WAY TRIPS	QUANTITY	RATE ($)	COST/MODE ($)
A = Transit Vehicle Hours (van/minibus)	97,917	39,494.63	0.00	1,332,109.10
B = Bus Vehicle Hours	9,592	2,935.41	0.00	106,883.24
C = Taxi Trips total from previous page		97,510.85		97510.85
Taxi Ride referral fee	9,046		3.00	27138
D = Misc Mode	14,484	148,581.65	0.00	153,889.60
E= Misc Mode	6,369	161,585.75	0.00	54,938.48
F= Misc Mode	1,718	166,534.75	0.00	12,225.45
G = Reimbursable Volunteer Driver Miles	41,780	1,600,201.08	0.36	576,157.68
Volunteer Driver Admin 20% of mileage			0.07	115,231.54
Mode Sub Total				2,476,083.92
Minus adjustment or (Credit)				6,787.03
Net Transportation Provided	YES			2,469,296.89
	NO			
H= Volunteer Driver Hours	YES	9,058.10	$ 6.25	396,426.63
In-Kind Match Received from other regional partner ($)				20,618.76
Total Amount Eligible 100%				2,739,682.31
Requested from DA&D 80%				$ 2,191,745.85
Local Match 20%				$ 708,288.06
Rider donations used as cash match				14,307.95
Local Share paid in cash (not donations)				$ 423,594.69
Local Share paid for with in-kind match				$ 270,385.42
Remaining In-Kind Match				$ 146,659.97

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Remaining In-Kind Match				$ 146,659.97

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7/28/2004

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1. Kidney Dialysis Transportation Only:	131
2. All categories of transportation services, including kidney dialysis:	5813

SERVICE CATEGORY and MODE	# ONE-WAY TRIPS	(Hours, Miles, $$s) QUANTITY	RATE ($)	COST/MODE ($)	Total Dollars	%	Total Trips	%
Kidney Dialysis					Total Dollars & Trips by Service Category			
A = Van/Minibus Vehicle hours	2,065	1,389.20	0.00	46,563.65				
B = Bus Vehicle Hours	181	188.25	0.00	6,362.25				
C = Taxi	1,706	29,327.75		29,327.75				
D = Transit Ticket	463	8,551.25	0	8,715.25				
E=	0	0.00	0	-				
F=	0	0.00	0	-				
G = Reimbursable Volunteer Driver Miles	12,093	647,682.18	0.36	233,171.94				
H= Volunteer Driver Hours	0	21,351.34	6.25	133,463.13	$457,604	16.78%	16,508	9.13%
Non-Medicaid Medical								
A = Van/Minibus Vehicle hours	4,521	3,236.35	0.00	104,770.00				
B = Bus Vehicle Hours	1,375	579.25	0.00	21,402.75				
C = Taxi	3,104	31,126.25		31,126.25				
D = Transit Ticket	2,605	29,569.50	0	33,381.50				
E=	1,253	46,310.00	0	15,745.40				
F=	0	46,310.00	0	3,149.08				
G = Reimbursable Volunteer Driver Miles	14,754	555,157.40	0.36	199,932.22				
H= Volunteer Driver Hours	0	15,975.54	6.25	100,054.11	$509,561	18.68%	27,612	15.26%
Senior Meals Programs								
A = Van/Minibus Vehicle hours	41,165	13,875.21	0.00	478,432.38				
B = Bus Vehicle Hours	2,240	1,285.50	0.00	42,421.50				
C = Taxi	119	1,473.48		1,473.48				
D = Transit Ticket	0	0.00	0	-				
E=	0	0.00	0	-				
F=	0	0.00	0	-				
G = Reimbursable Volunteer Driver Miles	626	19,659.03	0.36	7,077.25				
H= Volunteer Driver Hours	0	743.00	6.25	4,771.75	$534,176	19.59%	44,150	24.40%
Adult Day Programs								
A = Van/Minibus Vehicle hours	24,733	9,315.42	0.00	330,646.29				
B = Bus Vehicle Hours	264	80.05	0.00	3,041.90				
C = Taxi	1,418	15,489.65		15,489.65				
D = Transit Ticket	1,778	45,665.40	0	47,270.40				
E=	0	0.00	0	-				
F=	0	0.00	0	-				
G = Reimbursable Volunteer Driver Miles	3,378	71,523.70	0.36	25,748.53				
H= Volunteer Driver Hours	0	2,269.95	6.25	14,201.81	$436,399	16.00%	31,571	17.45%
Shopping Trips								
A = Van/Minibus Vehicle hours	7,398	3,179.72	0.00	99,790.50				
B = Bus Vehicle Hours	2,469	180.25	0.00	6,623.19				
C = Taxi	596	4,101.75		4,101.75				
D = Transit Ticket	756	10,581.00	0	10,581.00				
E=	796	22,535.00	0	7,661.90				
F=	1,628	27,156.00	0	2,687.63				
G = Reimbursable Volunteer Driver Miles	1,982	40,924.95	0.36	14,732.98				
H= Volunteer Driver Hours	0	2,915.07	6.25	18,221.92	$164,401	6.03%	15,625	8.64%
Vocational/ Personal								
A = Van/Minibus Vehicle hours	8,560	5,168.78	0.00	166,878.01				
B = Bus Vehicle Hours	28	49.35	0.00	1,663.55				
C = Taxi	2,099	15,852.72		15,852.72				
D = Transit Ticket	8,882	54,194.50	0	53,601.45				
E=	4,270	92,739.75	0	31,531.18				
F=	90	93,068.75	0	6,388.74				
G = Reimbursable Volunteer Driver Miles	8,731	256,490.82	0.36	92,340.07				
H= Volunteer Driver Hours	0	19,923.20	6.25	124,607.65	$492,863	18.07%	32,660	18.05%
Excursion/ Group								
A = Van/Minibus Vehicle hours	9,475	3,329.96	0.00	105,028.27				
B = Bus Vehicle Hours	3,035	572.76	0.00	22,456.10				
C = Taxi	4	139.25		139.25				
D = Transit Ticket	0	20.00	0	340.00				
E=	50	1.00	0	-				
F=	0	0.00	0	-				
G = Reimbursable Volunteer Driver Miles	216	8,763.00	0.36	3,154.68				
H= Volunteer Driver Hours	0	177.00	6.25	1,106.25	$132,225	4.85%	12,780	7.06%
				TOTAL	$2,727,229		180,906	

FY04 5310 Program Monthly Invoice and Report

7/28/2004

STATEWIDE STATISTICS

Summary Vermont

Grant: cfda# 20.513

Service Month: YTD Summary

MODE:	# ONE-WAY TRIPS	QUANTITY	RATE ($)	COST/MODE ($)
A = Transit Vehicle Hours (van/minibus)	97,917	39,494.63	0.00	1,332,109.10
B = Bus Vehicle Hours	9,592	2,935.41	0.00	106,883.24
C = Taxi Trips total from previous page		97,510.85		97510.85
Taxi Ride referral fee	9,046		3.00	27138
D = Misc Mode	14,484	148,581.65	0.00	153,889.60
E= Misc Mode	6,369	161,585.75	0.00	54,938.48
F= Misc Mode	1,718	166,534.75	0.00	12,225.45
G = Reimbursable Volunteer Driver Miles	41,780	1,600,201.08	0.36	576,157.68
Volunteer Driver Admin 20% of mileage			0.07	115,231.54
Mode Sub Total				2,476,083.92
Minus adjustment or (Credit)				6,787.03
Net Transportation Provided	YES			2,469,296.89
	NO			
H= Volunteer Driver Hours	YES	9,058.10	$ 6.25	396,426.63
In-Kind Match Received from other regional partner ($)				20,618.76
Total Amount Eligible 100%				2,739,682.31
Requested from DA&D 80%				$ 2,191,745.85
Local Match 20%				$ 708,288.06
Rider donations used as cash match				14,307.95
Local Share paid in cash (not donations)				$ 423,594.69
Local Share paid for with in-kind match				$ 270,385.42
Remaining In-Kind Match				$ 146,659.97

State of Vermont

AGENCY OF HUMAN SERVICES

OFFICE OF THE SECRETARY
103 South Main Street
Waterbury, Vermont 05671-0204

Telephone: (802) 241-2220
Fax: (802) 241-2979

September 13, 2004

Joint Fiscal Committee
Attn: Steve Klein
115 State Street
Montpelier, VT 05633-5301

Dear Joint Fiscal Committee,

Thank you for inviting me to the Joint Fiscal committee on September 15, 2004. Unfortunately I am unable to attend due to a prior commitment out of state. As I stated during a phone conversation with Senator Bartlett, Commissioner Flood and Camille George from the Department of Aging and Independent Living (DAIL) will be testifying for the Agency of Human Services (AHS).

The two issues you wanted me to discuss was my position as the Director of Housing and Transportation and the merging of 5310 and 5311 funds (Elders and Persons with Disabilities Transportation).

As you are aware, AHS created a position (with legislative approval) in the Secretary's office for a Director of Housing and Transportation. During the information gathering period of reorganizing AHS, there was tremendous outcry for coordination of housing and transportation in the agency. As of July 1, 2004, my job has become multifaceted. I have the responsibility to compile a database which indicates how much we are spending on housing and transportation, for what type of housing and transportation and to build a unified system for the agency on both issues. I will be helping to set policy and priorities and will be testifying on both issues for the Agency of Human Services. While trying to build a unified system for housing and transportation, I will be working closely with the staff of AHS, the legislature, community partners, state agencies and federal agencies.

During my first three months, I have been entrenched in the transition of Elders and Persons with Disabilities Transportation (E&D Transportation). In July, the Federal Transit Administration (FTA) ruled our program to be out of compliance with two major issues. The first was the procurement process and the second was the way we were using volunteer drivers as a match (in-kind match).

Therefore, AHS has been working closely with the Agency of Transportation (VTrans) to bring us back into compliance. Not being able to use in-kind match would effectively cost the state an additional $300,000 in matching funds. This was not a positive solution so the alternative solution presented was to merge the funding presently in 5310 with the 5311 program.

AHS and VTrans have been working incredibly close to hold regional meetings, create detailed guidelines for the new programs, to bring the FTA to Vermont for them to here from our community partners, and to give some assurance to our community partners, AHS will continue to be a strong partner in Elders and Persons with Disabilities Transportation, AHS and VTrans created a memorandum of understanding between the two agencies. This MOU clearly outlines our intent to continue to collect the same data, AHS and VTrans will review and approve the applications and local agreements for funding jointly, create quality standards, create detailed guidelines and continue to provide technical assistance jointly.

Commissioner Flood and Camille George will answer any additional questions you may have as well as present to you the FY'04 data. Please feel free to contact me at 241-2462, or cathyv@ahs.state.vt.us anytime. Again, I apologize for not being able to attend the hearing.

Sincerely,

Cathy Voyer cg

Cathy Voyer
AHS Director of Housing and Transportation

cc: Senator Welch, Chair
Representative Westman, Vice Chair
Senator Bloomer, Clerk
Senator Bartlett
Senator Cummings
Senator Sears
Representative Marron
Representative O'Donnell
Representative Rusten
Representative Schiavone

Proposed Allocation of Remaining SFY04 Section 5310 Funds

Grantee Name	Original Award	% of Original Award Total	Unpaid Billing	**Final Allocation**
Addison County Transit Resources	111,220	13.17%	60,517.49	**12,502**
Champlain Islanders Developing Essential Resources, Inc.	56,252	6.66%	5,800.45	**5,800**
CCTA/Green Mountain Transit Agency	300,760	35.60%	57,201.04	**33,807**
Rural Community Transportation, Inc. - Lamoille	93,176	11.03%	7,739.15	**7,739**
Special Services Transportation Agency	203,895	24.14%	20,754.86	**20,755**
VT Association for the Blind and Visually Impaired, Inc.	79,460	9.41%	714.87	**715**
TOTAL	**$844,763**	**100%**	**$152,727.86**	**$81,318**

Unspent SFY04 5310 funds 56,317.66
Waterfall funds 25,000.00
Total available $81,317.66

The grantees ending SFY04 with a negative balance are listed above. The sum of their original grant awards is divided by each grantee's original award to get a percentage of the whole for each grantee. Each grantee is then allocated that same percentage of the available pool of funds (made up of unspent SFY04 5310 funds and waterfall funds). The final allocation is capped to be no more than the grantee's SFY04 deficit amount.

Section 5310 SFY04 and early SFY05 Regional Budget Constraint Highlights

Region (transit provider, original SFY04 allocation)	Service Changes	Reasons	Voluntary increases or (decreases) in SFY04 budget, spending notes
Orange County (Stagecoach, $222,945)	1. Ticket to Ride program* funds expended March 31 2. Ride Referral program (primarily serves seniors) eliminated all but dialysis and cancer tx trips as of March 31. More than 200 trip requests per month for shopping, other medical, etc. were denied.	1. Some of these funds had to be used for the Ride-Referral critical medical rides. 2. Greater demand for rides and increased costs of service led to extreme rationing toward the end of SFY04.	+ $6,400, enabling continuation of dialysis and cancer tx trips the last 2 months of SFY04
Windham and Windsor Counties (CRT, $157,955 for 8 months)	Of the non-Medicaid medical trips, only dialysis trips will be provided after 8/20, and then only with existing dialysis clients.	Greater demand for rides and increased costs of service.	+ $10,960 from neighboring DVTA, which also serves the region. DVTA was able to bill Medicaid more than anticipated, and also utilized private funds.

Grand Isle (CIDER, $56,252)	Social trips have been cut in half, leaving a number of individuals unable to participate.	CIDER is fortunate to have many volunteer drivers who don't ask for mileage reimbursement. With increases in gas prices they anticipate that will change. That along with the aging population and an increase in demand for all types of rides is putting pressure on their budget.	CIDER overspent their SFY04 budget by $5,800
Lamoille and NEK (RCT, $379,473)	Rides provided only in situations where riders have no other means of transportation.	Increased demand required directing resources to the most needy riders.	RCT overspent their SFY04 budget by $7,739
Rutland (MVRTD $52,420, SVCOA $218,31)	Non-medical transportation is capped at $1,000/year per person. People needing dialysis or other critical medical services are asked to seek assistance from friends or family whenever possible. Shopping and social trips for seniors are considered vital as well.		($16,900)
Chittenden County (SSTA, $203,895)	Some areas are limiting riders to 2 round trips/week. Dialysis trips limited to 2 per week. Constant "fine-tuning" for efficiency.		SSTA overspent their SFY04 budget by $20,755

Central Vermont (GMTA, $300,760)	At the end of May, all shopping and social trips were eliminated, leaving many seniors without a ride to the grocery store. Medical trips were provided only to existing riders. At least one new dialysis patient was turned away.	GMTA saw a dramatic increase in demand for service, which required them to prioritize and limit rides.	+ $15,000, enabling continuation of most critical needs trips. Even after this increase, GMTA still overspent their SFY04 budget by $57,201
Addison County (ACTR, $111,220)	Generally riders are limited to 8 trips per month, except this month (9/04) only 2 non-dialysis medical trips per month are allowed (all needed dialysis and cancer tx trips are provided)	Greater demand for rides and increased costs of service.	ACTR overspent their SFY04 budget by $60,517
Bennington County (GMC/ARC $56,258)	No outstanding service issues.		(5,000)
Franklin County (the Network)	No outstanding service issues		
Statewide service for the blind and visually impaired, VABVI	No outstanding service issues		

*Ticket to Ride is a highly regarded program designed primarily for people with disabilities but also serves some seniors. It allocates an annual dollar amount per rider to be used on any types of rides. Riders simply call their regional public transit provider to reserve their ride.

Section 5310 Transportation Program Estimated SFY05 Van Costs at SFY04 Service Levels.

	SFY04 hourly	SFY05 hourly	SFY04	SFY04	Approximate
provider	van rate	van rate	van hours	van cost	SFY05 vancost
actr	33	33.25	2350	$77,550.00	$78,137.50
cider	31	31	2232	$69,192.00	$69,192.00
ssta	33	39	3519	$116,127.00	$137,241.00
red cross	35	35	2248	$78,680.00	$78,680.00
rct	35	38	3621	$126,735.00	$137,598.00
marble valley	38	40.5	505	$19,190.00	$20,452.50
network	32	34	1614	$51,648.00	$54,876.00
gmta	38	38	7000	$266,000.00	$266,000.00
svcoa	32	40.5	6313	$202,016.00	$255,676.50
coasev	28	43	789	$22,092.00	$33,927.00
dvta	32	35	1665	$53,280.00	$58,275.00
crt	35	43	4011	$140,385.00	$172,473.00
stagecoach	31.5	33	6454	$203,301.00	$212,982.00
Average/Total	$36.13	$40.27	42321	$1,426,196.00	$1,575,510.50
				04/05 cost difference	**$149,314.50**

FY04 5310 Program Annual YTD Summary

7/28/2004

STATEWIDE STATISTICS

Summary Vermont

Grant: cfda# 20.513

Service Month: YTD Summary

Unduplicated Clients Served Year to Date for:				
1. Kidney Dialysis Transportation Only:			131	
2. All categories of transportation services, including kidney dialysis:			5813	
SERVICE CATEGORY and MODE	# ONE-WAY TRIPS	(Hours, Miles, $$s) QUANTITY	RATE ($)	COST/MODE ($)
Kidney Dialysis				
A = Van/Minibus Vehicle hours	2,065	1,389.20	0.00	46,563.65
B = Bus Vehicle Hours	181	188.25	0.00	6,362.25
C = Taxi	1,706	29,327.75		29,327.75
D = Transit Ticket	463	8,551.25	0	8,715.25
E=	0	0.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	12,093	647,682.18	0.36	233,171.94
H= Volunteer Driver Hours	0	21,351.34	6.25	133,463.13
Non-Medicaid Medical				
A = Van/Minibus Vehicle hours	4,521	3,236.35	0.00	104,770.00
B = Bus Vehicle Hours	1,375	579.25	0.00	21,402.75
C = Taxi	3,104	31,126.25		31,126.25
D = Transit Ticket	2,605	29,569.50	0	33,381.50
E=	1,253	46,310.00	0	15,745.40
F=	0	46,310.00	0	3,149.08
G = Reimbursable Volunteer Driver Miles	14,754	555,157.40	0.36	199,932.22
H= Volunteer Driver Hours	0	15,975.54	6.25	100,054.11
Senior Meals Programs				
A = Van/Minibus Vehicle hours	41,165	13,875.21	0.00	478,432.38
B = Bus Vehicle Hours	2,240	1,285.50	0.00	42,421.50
C = Taxi	119	1,473.48		1,473.48
D = Transit Ticket	0	0.00	0	-
E=	0	0.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	626	19,659.03	0.36	7,077.25
H= Volunteer Driver Hours	0	743.00	6.25	4,771.75
Adult Day Programs				
A = Van/Minibus Vehicle hours	24,733	9,315.42	0.00	330,646.29
B = Bus Vehicle Hours	264	80.05	0.00	3,041.90
C = Taxi	1,418	15,489.65		15,489.65
D = Transit Ticket	1,778	45,665.40	0	47,270.40
E=	0	0.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	3,378	71,523.70	0.36	25,748.53
H= Volunteer Driver Hours	0	2,269.95	6.25	14,201.81
Shopping Trips				
A = Van/Minibus Vehicle hours	7,398	3,179.72	0.00	99,790.50
B = Bus Vehicle Hours	2,469	180.25	0.00	6,623.19
C = Taxi	596	4,101.75		4,101.75
D = Transit Ticket	756	10,581.00	0	10,581.00
E=	796	22,535.00	0	7,661.90
F=	1,628	27,156.00	0	2,687.63
G = Reimbursable Volunteer Driver Miles	1,982	40,924.95	0.36	14,732.98
H= Volunteer Driver Hours	0	2,915.07	6.25	18,221.92
Vocational/ Personal				
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D = Transit Ticket	8,882	54,194.50	0	53,601.45
E=	4,270	92,739.75	0	31,531.18
F=	90	93,068.75	0	6,388.74
G = Reimbursable Volunteer Driver Miles	8,731	256,490.82	0.36	92,340.07
H= Volunteer Driver Hours	0	19,923.20	6.25	124,607.65
Excursion/ Group				
A = Van/Minibus Vehicle hours	9,475	3,329.96	0.00	105,028.27
B = Bus Vehicle Hours	3,035	572.76	0.00	22,456.10
C = Taxi	4	139.25		139.25
D = Transit Ticket	0	20.00	0	340.00
E=	50	1.00	0	-
F=	0	0.00	0	-
G = Reimbursable Volunteer Driver Miles	216	8,763.00	0.36	3,154.68
H= Volunteer Driver Hours	0	177.00	6.25	1,106.25
			TOTAL	

Total Dollars & Trips by Service Category

	Total Dollars	%	Total Trips	%
Kidney Dialysis				
Non-Medicaid Medical	$457,604	16.78%	16,508	9.13%
Senior Meals Programs	$509,561	18.68%	27,612	15.26%
Adult Day Programs	$534,176	19.59%	44,150	24.40%
Shopping Trips	$436,399	16.00%	31,571	17.45%
Vocational/ Personal	$164,401	6.03%	15,625	8.64%
Excursion/ Group	$492,863	18.07%	32,660	18.05%
	$132,225	4.85%	12,780	7.06%
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7/28/2004

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E= Misc Mode	6,369	161,585.75	0.00	54,938.48
F= Misc Mode	1,718	166,534.75	0.00	12,225.45
G = Reimbursable Volunteer Driver Miles	41,780	1,600,201.08	0.36	576,157.68
Volunteer Driver Admin 20% of mileage			0.07	115,231.54
Mode Sub Total				2,476,083.92
Minus adjustment or (Credit)				6,787.03
Net Transportation Provided	YES			2,469,296.89
	NO			
H= Volunteer Driver Hours	YES	9,058.10	$ 6.25	396,426.63
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Local Match 20%				$ 708,288.06
Rider donations used as cash match				14,307.95
Local Share paid in cash (not donations)				$ 423,594.69
Local Share paid for with in-kind match				$ 270,385.42
Remaining In-Kind Match				$ 146,659.97