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- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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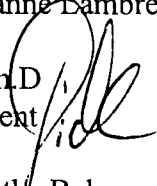
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

September 10, 1999

TO: Chris Jennings and Jeanne Lambrew

FROM: Richard M. Knapp, Ph.D.
Executive Vice President 

RE: Data on the Impact of the Balanced Budget Act of 1997

This cover memorandum and attachment represents the Association of American Medical College's (AAMC's) response to your data request dated August 13, 1999. The AAMC represents approximately 300 major teaching hospitals that receive Medicare payments; all 125 accredited U.S. medical schools; 86 professional and academic societies; and the nation's medical students and residents.

As we have discussed with you and your staff, provisions in the Balanced Budget Act of 1997 (BBA)—particularly cuts in the indirect medical education (IME) adjustment and disproportionate share (DSH) payments—are contributing to a financial crisis at teaching hospitals. This situation threatens to affect the special contributions of teaching hospitals, including training our nation's future physicians, providing care to the uninsured, and providing an environment in which clinical research can flourish. Moreover, these institutions provide highly specialized services, such as regional trauma centers, burn units, and pediatric intensive care units. The future of these unique services and missions of teaching hospitals is in jeopardy, as many teaching hospitals have already reduced their work forces and are now considering scaling back these essential services.

We believe the following attached documents provide an important data assessment of the BBA on teaching hospitals. In addition, we are continuing to seek information concerning the financial status of our member hospitals. We would be happy to review with you any findings we obtain from our initiatives.

1. **An AAMC chart series entitled "Assessing the Impact of the Balanced Budget Act of 1997 (BBA'97) on the Financial Status of AAMC Council of Teaching Hospital (COTH) Member Hospitals" and a companion document that describes methodological details and assumptions.**

This series uses Medicare data from the Medicare Cost Report PPS XIV (1997) Minimum Dataset to project total margins. This dataset is the most recently available source of Medicare data. We previously had provided you with this same analysis

using data from the PPS XIII (1996) Minimum Dataset. The results we obtained from the more recent analysis are virtually identical with our earlier results.

Our results complement those conducted by other entities: if not modified, the BBA could result in devastating consequences for teaching hospitals. Among other findings, our analysis indicates that:

- The total margin for the typical major teaching hospital (an intern and resident to bed ratio (IRB) of 0.25 or more) could fall to nearly zero by 2002, and
- Half of major teaching hospitals could face **negative** overall margins in 2002.

2. A report prepared by the Health Care Advisory Board entitled “Medicare Payment Reform: Executive Briefing on Health System Financial Performance Under the Balanced Budget Act of 1997.”

This report examines and makes observations about a number of BBA provisions juxtaposed with a number of financial and other health care indicators. Specific observations concerning major teaching hospitals can be found on pages 22-23 of the report.

CC: Robert M. Dickler, AAMC Senior Vice President



Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

Ernest Valente, Ph.D.

Karen Fisher, J.D.

Robert D'Antuono

Robert Dickler

Division of Health Care Affairs

Association of American Medical Colleges

September, 1999 Update Using FY 1997 Data

Assessing the Impact of the
Balanced Budget Act of 1997 (BBA '97)
on the Financial Status
of COTH Member Hospitals

METHODOLOGICAL DETAILS:

What was the analytical approach?

What data were used?

What assumptions were made for the analysis?

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals:

Analysis Plan

BBA PROVISIONS	ANALYTICAL APPROACH
• INPATIENT – PPS Update Reductions – DSH Reductions – IME Multiplier Reductions – Capital Payment Reductions – Change in Transfer Definition • OUTPATIENT – FDO Elimination – Outpatient PPS	• MARGIN ANALYSIS – Projected Margins Under BBA • REVENUE REDUCTION PROJECTIONS – Project Status Quo and BBA PPS Standardized Operating Amounts – Project IME and DSH Reductions – Project Other BBA Provisions as Possible

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals:

BBA Provisions Included in Analysis

BBA Provision	Fully Projected	Provisionally Projected	Not Included
PPS Update	X		
DSH	X		
IME	X		
Transfers		X	
Outliers			X
Medicare Mgd. Care			X
Capital		X	
FDO		X	
Outpatient		X	
Bad Debt			X
PPS Excluded Subprov (Psych., Rehab.)			X
SNF Units Hospital-Based HHAs			X

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals: *Data Details*

- Used Medicare Cost Report PPS XIV Minimum Dataset (FFY 1997)
- Used MedPAC margin calculations
- Used MedPAC data edits for extreme values
- Built upon projection methodology developed by the Greater New York Hospital Association
- Excluded non-PPS hospitals
- Excluded hospitals in regulated States (Maryland)
- Excluded rural hospitals
- Excluded sole community provider hospitals
- Excluded hospitals with fewer than 90 beds
- 1,904 hospitals included (230 COTH, 660 other teaching, 1,014 non-teaching)

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals:

Assumptions

- **Assumed Constant 1997 - 2002:**
 - Non-Medicare Market Conditions
 - Casemix Index (used FFY¹ 1999)
 - Area Wage Index (used FFY 1999)
 - IRB Ratio (used FFY 1997)
 - Outlier Payments as a Percent of Other Than Outlier Payments (used CRY² 1997)
 - IME Payments as a Percent of PPS DRG Payments (used CRY1997)
 - DSH Payments as a Percent of PPS DRG Payments (used CRY 1997)
- **Assumed to Increase at HCFA Projected Market Basket Rate:**
 - Status Quo Inpatient Revenues and Expenses (PPS and Total)
 - Non-Medicare Inpatient Revenue
 - Medicare and non-Medicare Costs
 - Status Quo Outpatient Payments
- **Other Assumptions:**
 - Medicare Admissions Increase by HCFA Projections

¹Federal Fiscal Year

²Cost Report Year (Hospital Fiscal Year)

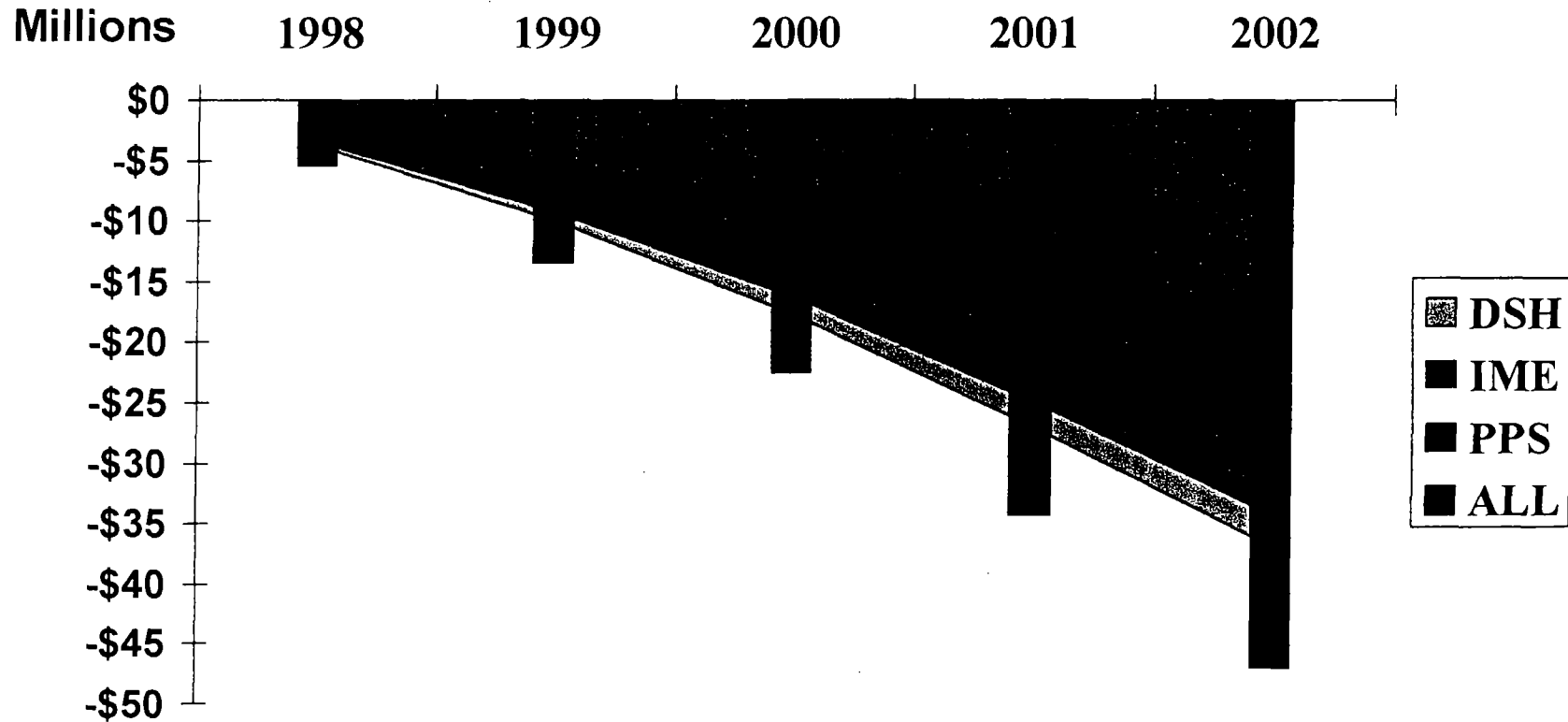
Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

BBA IMPACT:

How much revenue will the typical hospital lose
when BBA 1997 is in full effect?

Impact of BBA '97 on Hospital Financial Status

Cumulative Financial Impact of BBA '97 on Typical COTH Hospital 1998-2002



SOURCE:

PPS XIV Medicare Cost Report Minimum Dataset.

NOTE:

Difference between projected payments under "status quo" and "BBA" scenarios.

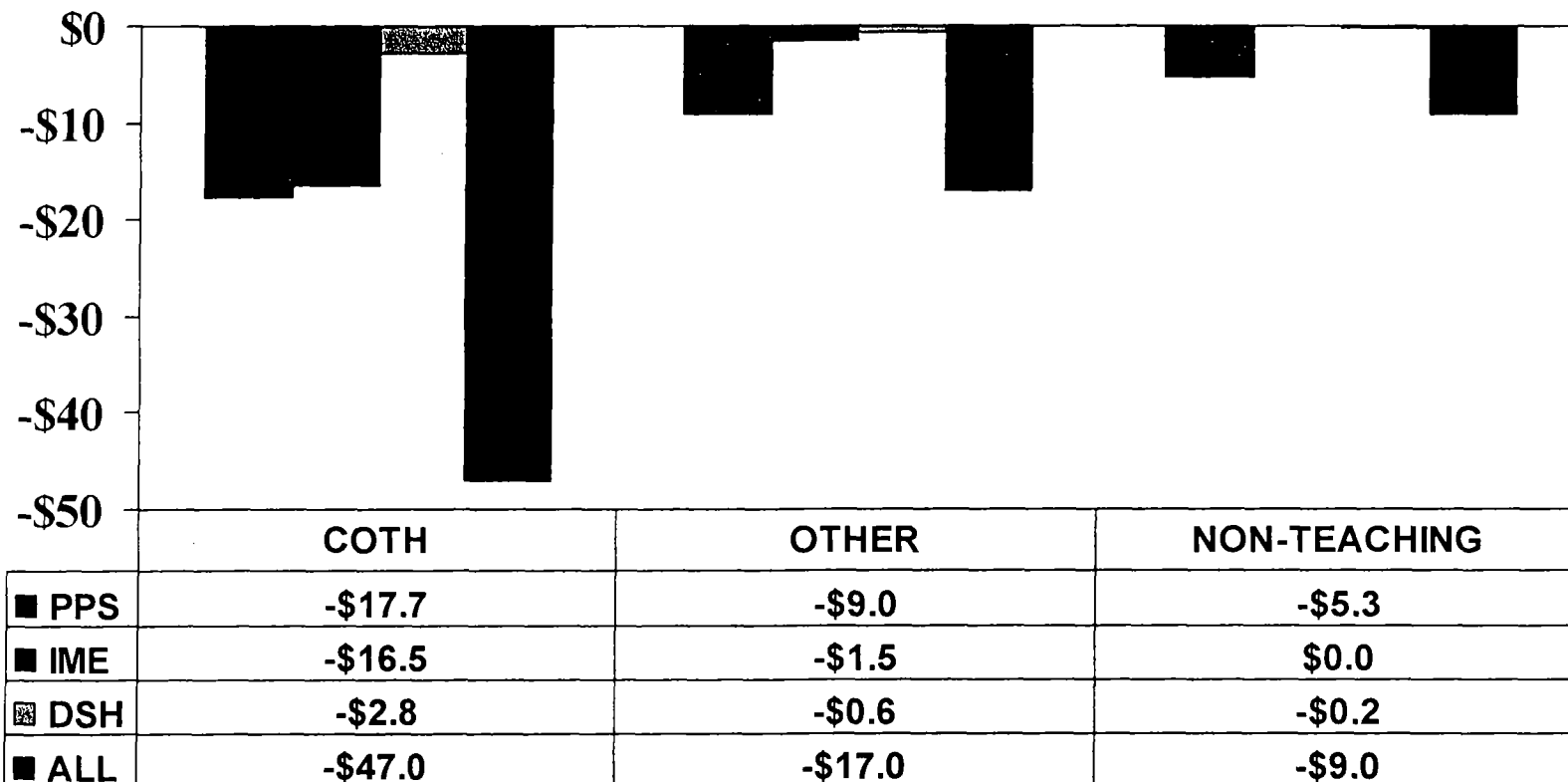
ALL includes PPS, IME, DSH, Capital and Outpatient payment reductions.

Impact of BBA '97 on Hospital Financial Status

COTH, Other Teaching, Non-Teaching

Cumulative Financial Impact on Typical Hospital, 1998-2002

Millions

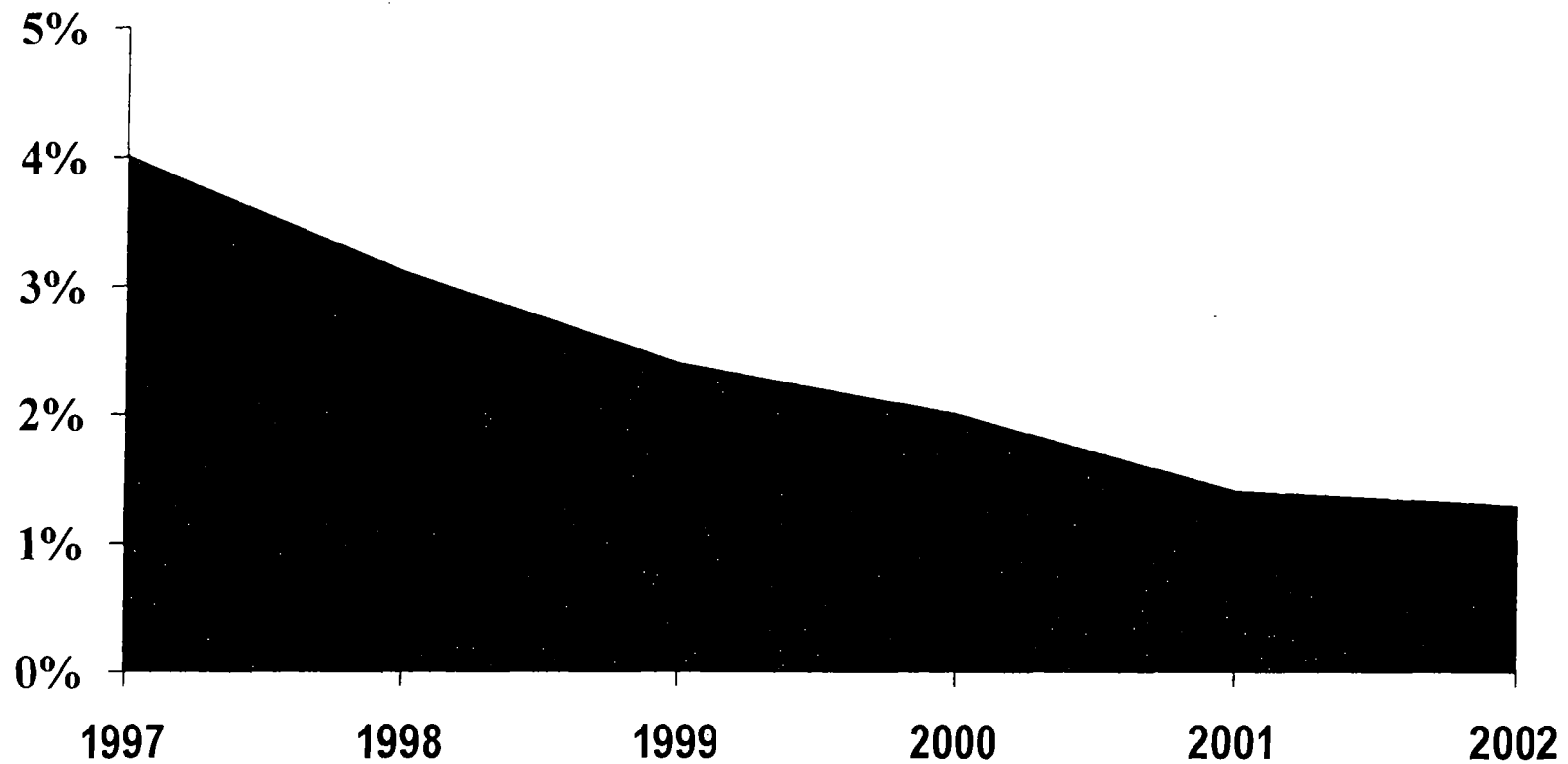


Assessing the Impact of the
Balanced Budget Act of 1997 (BBA '97)
on the Financial Status
of COTH Member Hospitals

BBA IMPACT ON COTH HOSPITALS:

What is the combined impact of all currently
projected BBA '97 provisions on the financial
status of a typical COTH member hospital
1997 -2002?

Impact of BBA '97 on Projected Median COTH Total Margins

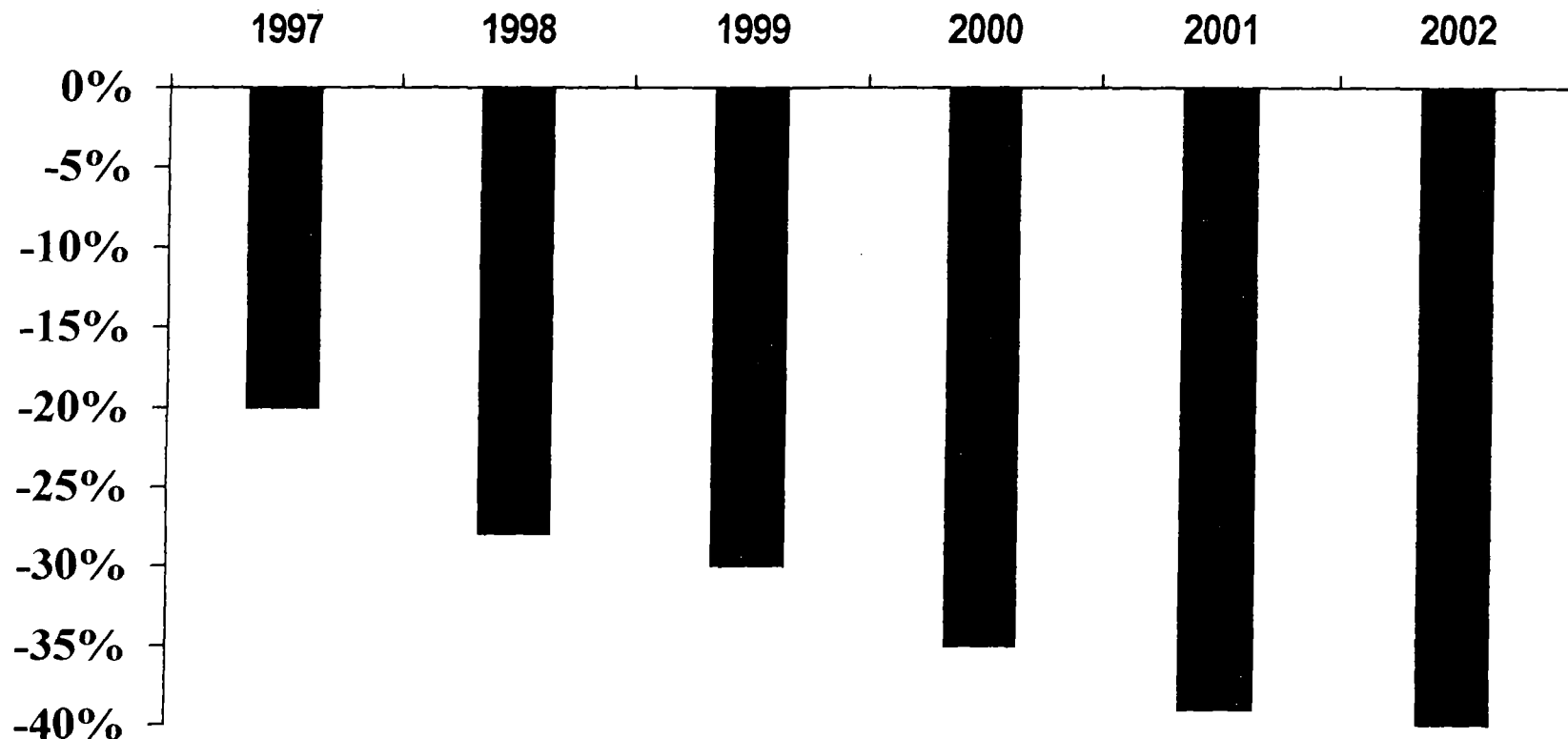


SOURCE:
NOTE:

PPS XIV Medicare Cost Report Minimum Dataset.
Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

Impact of BBA '97 on Projected COTH Total Margins

Percent of COTH Hospitals with Negative Projected Margins



SOURCE:

PPS XIV Medicare Cost Report Minimum Dataset.

NOTE:

Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.

Total margins include total hospital revenues and expenses.

BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.

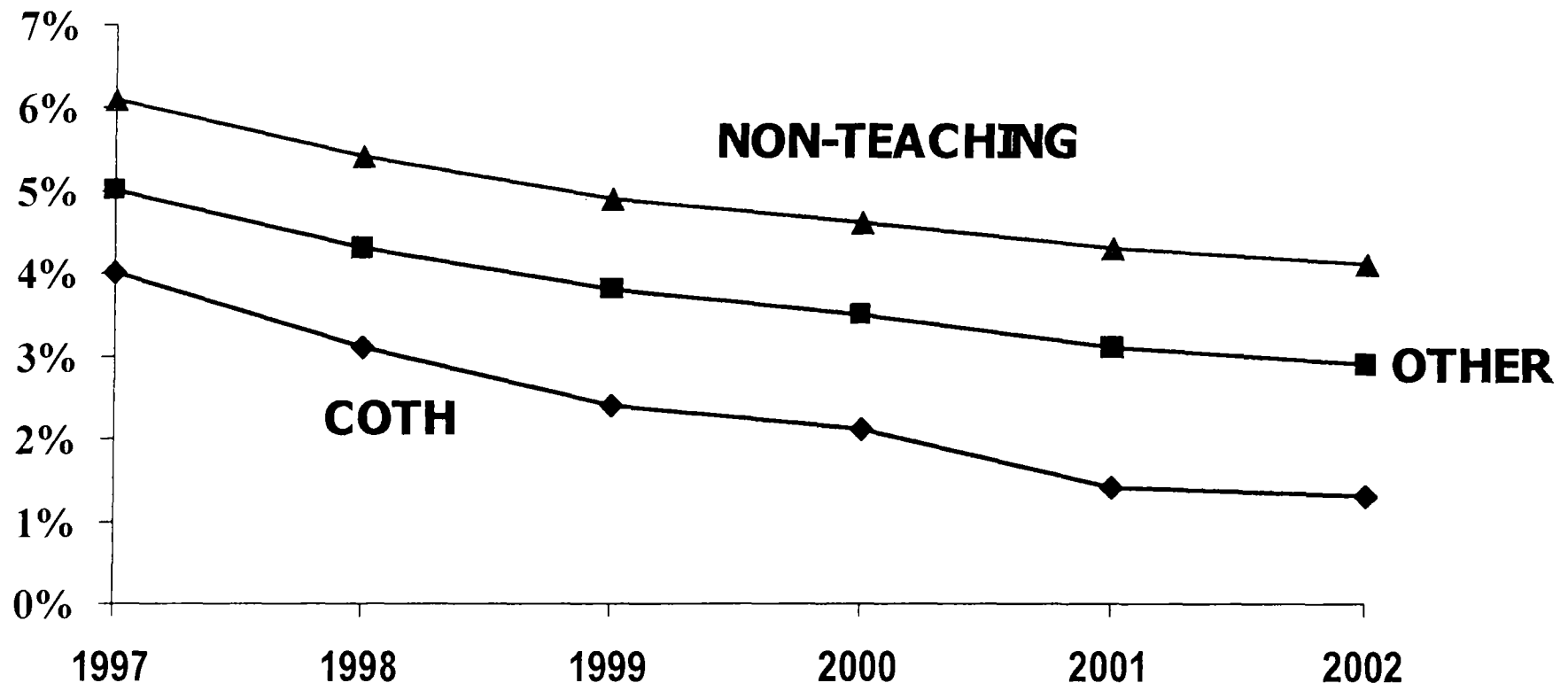
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

Assessing the Impact of the
Balanced Budget Act of 1997 (BBA '97)
on the Financial Status
of COTH Member Hospitals

BBA IMPACT ON COTH, OTHER TEACHING,
AND NON-TEACHING HOSPITALS:

Does BBA '97 differentially affect the financial
status of COTH hospitals, other teaching
hospitals, and non-teaching hospitals?

Impact of BBA '97 on Projected Median Total Margins, 1997-2002 *COTH, Other Teaching, Non-Teaching*



SOURCE:
NOTE:

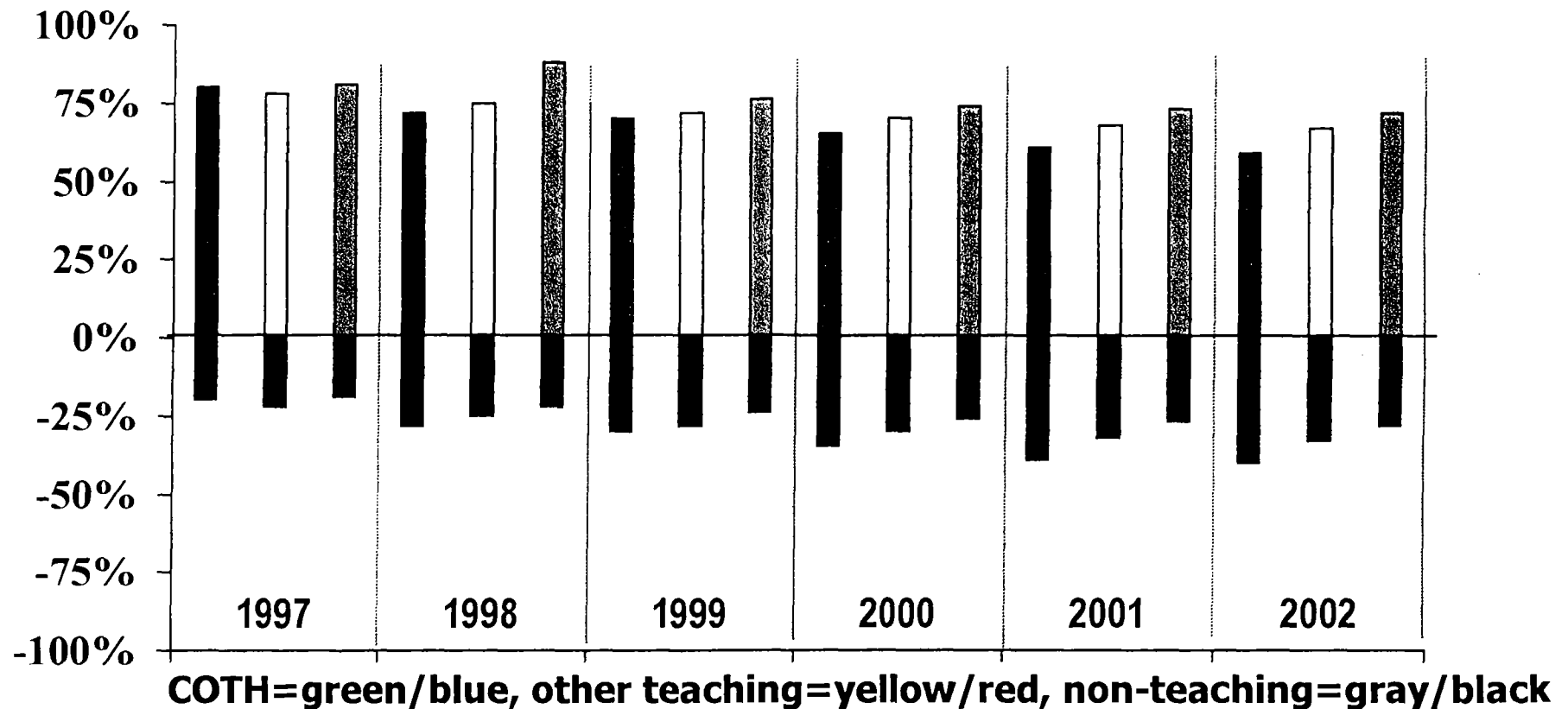
PPS XIV Medicare Cost Report Minimum Dataset.
Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.



Impact of BBA '97 on Projected Total Margins, 1997-2002

COTH, Other Teaching, Non-Teaching

Percent of Hospitals with Positive and Negative Projected Margins



SOURCE:
NOTE:

PPS XIV Medicare Cost Report Minimum Dataset.
Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

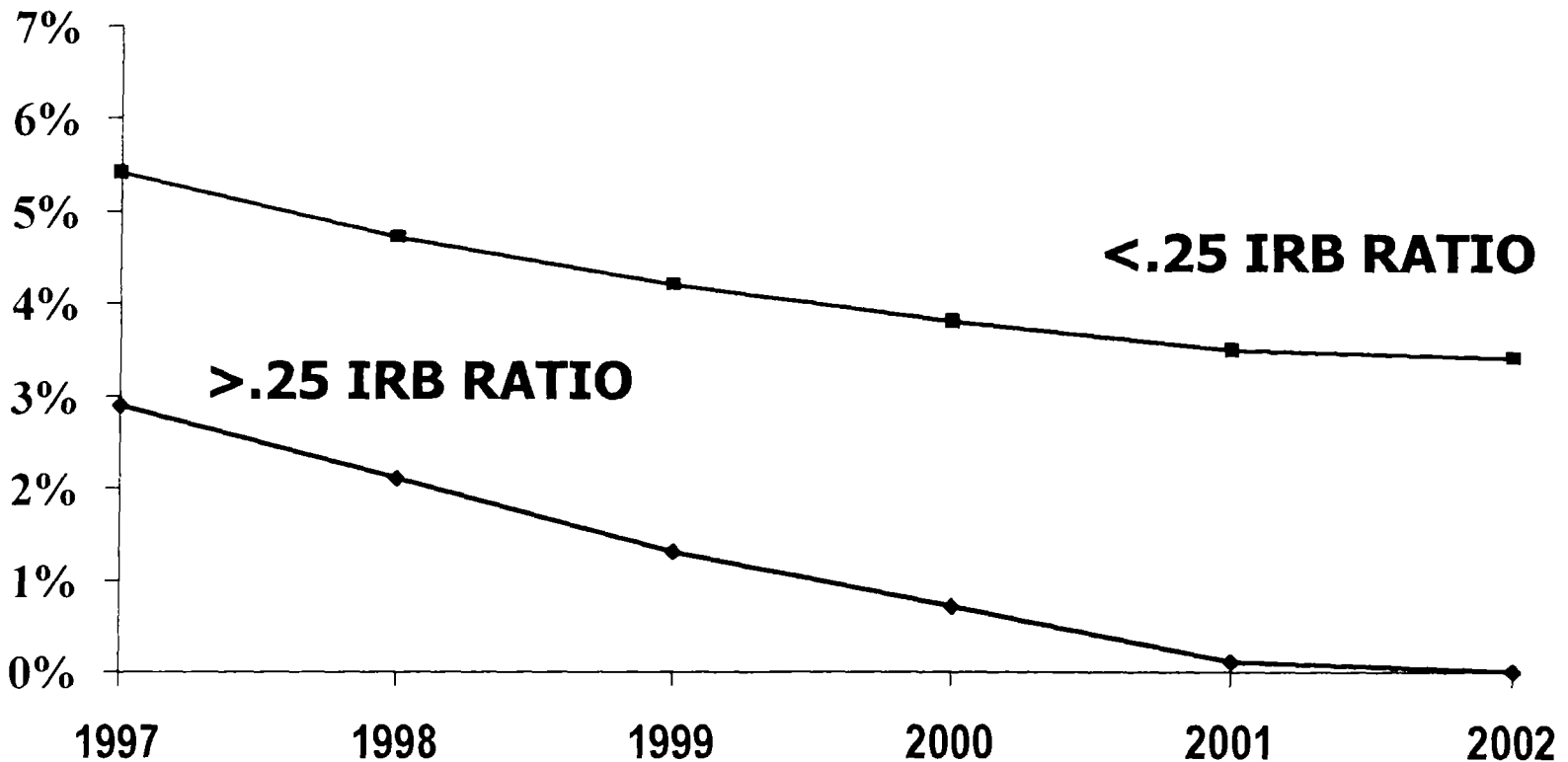
Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

BBA IMPACT ON COTH AND OTHER TEACHING HOSPITALS:

What is the combined impact of all currently
projected BBA '97 provisions on the financial
status of a typical hospital, 1997 -2002?

Impact of BBA '97 on Projected Median Total Margins

Hospitals with IRB Ratios Greater than or Less Than .25

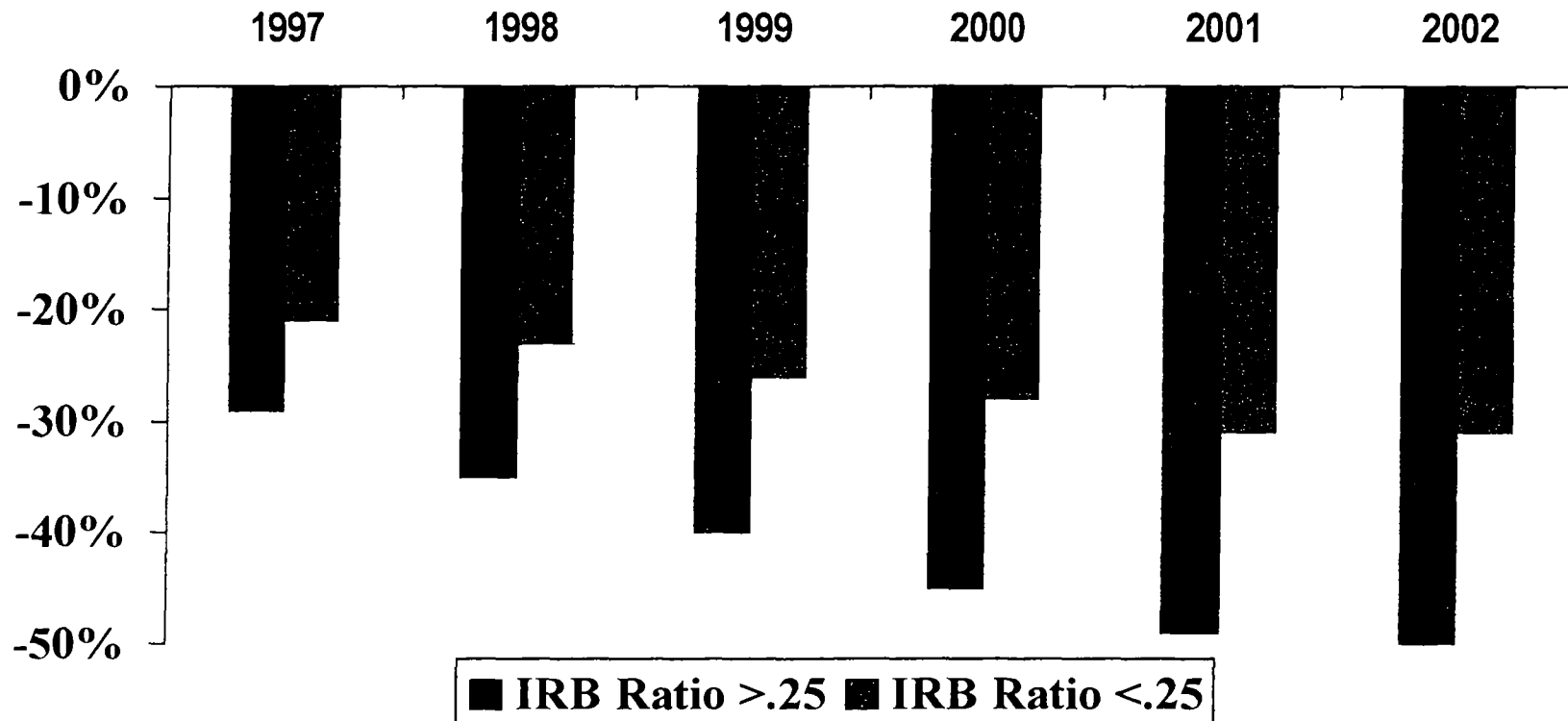


SOURCE:
NOTE:

PPS XIV Medicare Cost Report Minimum Dataset.
Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

Impact of BBA '97 on Projected Total Margins

Percent of Hospitals with Negative Projected Margins
Hospitals with IRB Ratios Greater than or Less Than .25



SOURCE:
NOTE:

PPS XIV Medicare Cost Report Minimum Dataset.
Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

September 1999

**Assessing the Impact of the Balanced Budget Act of 1997 (BBA)
On the Financial Status of COTH Member Hospitals:
Methodology Summary**

The Balanced Budget Act of 1997 (BBA) contained numerous changes to the Medicare program, many of which affect hospital payments. The Association of American Medical Colleges (AAMC) has analyzed the impact of the BBA on the AAMC's Council of Teaching Hospitals and Health Systems (COTH) revenues and financial status by simulating its effects between 1997 and 2002. This document summarizes the methodology for this simulation.

Most of the provisions of the BBA began to take effect in Federal fiscal year (FFY) 1998 (October 1, 1997). Some of the provisions are phased in over a five-year period; all of the provisions are to be fully implemented by 2002. Financial data for the analysis were obtained from the Medicare Hospital Cost Report Information System (HCRIS) which contains data from all hospitals participating in the prospective payment system (PPS) for hospital fiscal years ending before September 30, 1998 ("PPS 14"). The basic approach of the analysis was to project what Medicare reimbursement would have been during each year between 1997 and 2002 if the BBA changes had not been implemented ("status quo"), and contrast these reimbursement levels with projections of reimbursement under the BBA. For analyses of dollar losses under the BBA, the impact was expressed as the difference in Medicare payment projections under the "status quo" and "BBA" Medicare payment projections. Total margins under the BBA were calculated by adding estimated Medicare payments to estimated non-Medicare payments and subtracting Medicare and non-Medicare estimated costs. Medicare payments were estimated using the parameters specified in the BBA. Actual values were used for costs where possible. All future costs and non-Medicare payments were incremented by the Health Care Financing Administration's (HCFA) projected hospital inpatient market basket inflator each year.

Simulation results are presented for three categories of hospitals: COTH members, other teaching hospitals, and non-teaching hospitals. For several of the simulations, results for teaching hospitals (COTH and other teaching combined) were differentiated by whether they had an intern/resident-to-bed (IRB) ratio of greater than or less than 0.25.

In interpreting the analysis projections, it is important to remember several features of the simulation:

- The BBA changes included in this analysis were isolated as the sole source of modifications to revenue and financial status. All other features of the financial

environment were held constant; that is, non-Medicare payments (Medicaid and private-payer) were assumed to be unchanged, except for inflation, throughout the five-year period.

- Where rates of growth were not known from actual data, all revenues and expenses were projected to grow at the rate of increase for the HCFA hospital inpatient market-basket¹ over time, except where anticipated rates of growth were determined by provisions of the BBA.
- About half of PPS hospitals were excluded from the simulation² to make all the hospitals included in the analysis comparable to COTH hospitals. The resulting group of 1,904 hospitals included 230 general acute, non-federal COTH hospitals³, 660 other teaching hospitals, and 1,014 non-teaching hospitals.
- BBA changes occur on Federal fiscal year (FFY) cycles, which are frequently not the same as hospital fiscal years; thus, hospital cost report years often overlap two FFYs. The BBA effects were indexed to hospital fiscal years, so that the dates correspond to hospital fiscal years.
- The number of residents in teaching hospitals is assumed to be constant across the five-year period.

This analysis reflects certain BBA provisions that have a substantial impact on hospital payments. A complex simulation⁴ was used to project hospital-level impacts due to the PPS update reductions,⁵ indirect medical education (IME) payment reductions,⁶ and disproportionate share (DSH) payment reductions.⁷ These changes represent the majority of the BBA payment reductions. A less complex approach was applied for the projections involving capital payments,⁸ the effects of the transfer redefinition,⁹ elimination of the outpatient formula-driven overpayment,¹⁰ and movement to an outpatient PPS.¹¹ The simulation does not include estimates of outlier changes, bad debt payment reductions, or reductions in payments to PPS-exempt subproviders, skilled nursing facilities (SNFs) and hospital-based home health agencies.

Actual values for payments and costs were included in the simulation wherever possible (for example, actual PPS standardized operating amounts were available for 1996-1999). Other simulation values were set as specified in the BBA. (For example, Medicare disproportionate share payments are progressively discounted, from 1 percent in 1998 to 5 percent in 2002.) Where no actual values were available, values were projected forward using projections from either HCFA or another source, or fixed at a constant value for the entire five-year period. For example, payments and costs were incremented by actual cost growth values from the American Hospital Association (AHA) annual survey until 1997 (the most recent data available). Each year thereafter, these values were incremented by the HCFA hospital inpatient market basket growth rate estimate for that year. The Medicare case mix index used in the analysis was fixed at the hospital-specific value estimated by HCFA for fiscal year 1999 payments (the midpoint of the five-year period).

Interpreting the Analysis Results

The impact of this analysis is best interpreted by comparing the amount that the BBA reduces Medicare payments relative to what those payments would have been if Medicare payment policies were unchanged through 2002. The results show the magnitude of the difference between the simulations' estimate of what payments in the future would have been in the absence of the BBA ("status quo") and the estimate of what the payments will be under the BBA.

It is important to remember that this analysis does not predict what total margins *will be* in 2002; but rather, it expresses the financial pressure that the Medicare reductions will place on hospitals' profitability under two payment policy scenarios. The actual margins in 2002 depend upon a number of factors in addition to Medicare, most important of which are changes in Medicaid and private sector payments, and hospitals' cost growth.

Impact of the Cost Growth Estimate

When making projections, this analysis assumed that hospital costs would grow at the projected increase in the hospital market basket. Actual costs have grown more slowly than the market basket increase estimate in recent years; consequently, others who have projected the impact of the BBA have included a cost growth assumption that is one percentage point less than the market basket increase. Clearly, the BBA will have a smaller negative effect on total margins than our analysis projects if the growth in hospital costs falls below the full market basket increase.

However, there are several reasons why it is more appropriate to assume that costs will grow at the rate of the market basket increase. First, many believe that recent trends (i.e., actual costs growing slower than the market basket) are in large measure the result of myriad "one-time" cost reduction efforts. Continuing to reduce costs in this fashion will be strongly resisted because such reductions would seriously damage the ability of teaching hospitals to perform their special missions of teaching, research, and service to the underserved. Second, some AAMC COTH member institutions report that their costs are beginning to rise sharply, in part due to rising pharmaceutical costs and a nursing shortage that is driving up labor costs. Thus, cost growth is likely to increase in the near future. Finally, it is important to remember that the recent trend of costs growing slower than the market basket is a new phenomenon. Historically, cost growth trends for hospitals have exceeded market basket estimates far more frequently than they have not. Consequently, our assumption of costs growing merely at the rate of inflation--i.e. the market basket increase--was deemed conservative.

Changes in Private Payer and Medicaid Revenues

For projection purposes, this analysis assumed that non-Medicare revenues would grow at the same rate as costs, which we projected to equal the increase in the hospital market basket. This permits our analysis to focus solely on changes in total margins that are due

to changes in Medicare reimbursement. If non-Medicare revenues grow at a rate slower than costs, the impact on total margins will be lower than what we have projected. A recent analysis indicates that private payer revenues grew slower than costs between 1992 and 1997.¹² Consequently, if this trend continues, actual total margins in 2002 may be lower than our estimates.

Teaching Payments for Medicare Managed Care Enrollees

The BBA calls for Medicare to begin making IME and DGME payments that are associated with Medicare managed care enrollees treated by teaching hospitals, effective January 1, 1998. These payments are being phased in over 5 years in 20 percent annual increments.¹³ This analysis does not include any assumptions concerning these payments because it is not possible to make meaningful estimates.

The Congressional Budget Office (CBO) estimated Medicare managed care teaching payments as part of their BBA savings analysis;¹⁴ however, there are no corresponding impact estimates on patient care payments to teaching hospitals that result from BBA reductions to Medicare managed care payment rates. Consequently, including estimates of Medicare managed care teaching payments only, without a corresponding estimate of changes in Medicare managed care patient payments, would overstate the net payments teaching hospitals receive from Medicare managed care activity. Further, even if estimates about changes in payments to teaching hospitals for Medicare managed care patients were available, it is reasonable to assume that these estimates would reflect reductions, which would offset any additional teaching payments.

In addition, no data currently exist about the impact of the Medicare managed care teaching payments at the hospital level (CBO's estimates are national level). The number of Medicare managed care enrollees in a given market who are treated in teaching hospitals is not known and exceedingly difficult to estimate. Medicare managed care penetration is highly variable across the areas in which teaching hospitals are located, and it is unlikely that these figures reflect the number of Medicare managed care enrollees treated by hospitals, let alone teaching hospitals. Thus, accurate estimates of the scope of Medicare managed care payments at the hospital level--both teaching and patient care--are virtually impossible to calculate.

End Notes

¹ Inpatient hospital market basket growth projections: 1998, 3.0%; 1999, 2.7%; 2000, 2.8%; 2001, 2.7%; 2002, 2.6%; 2003, 2.7% (source: HCFA Office of the Actuary)

² Rural hospitals, sole community provider hospitals, Maryland hospitals, and hospitals with fewer than 90 beds were excluded from the simulation. Also excluded were hospitals with fewer than 330 days reported on their cost reports. Hospitals with extreme values were excluded from any analyses involving the extreme variable.

³ The BBA impact simulation excluded COTH hospitals located in Maryland (because they are under a waiver from Medicare PPS) and Canada, as well as VA and PPS-exempt members.

⁴ This methodology was based on a BBA impact model developed by the Greater New York Hospital Association.

⁵ PPS standardized operating amounts were reduced by actual amounts through FFY 2000. Thereafter, the updates were reduced by the estimated increases in the hospital market less 1.1 percentage points in 2001; and less 1.1 percentage points in 2002 (source: section 4401 of the BBA). Diagnosis-related group (DRG) per case payments were estimated using the PPS standardized operating amount that corresponds to each hospital, the FFY 1999 estimated case-mix index, and the FFY 1999 reclassified hospital wage index. For each hospital, per case payments were then multiplied by the number of Medicare cases, as increased by HCFA projections. These projections were: 1997, 1.8%; 1998, 0.5%; 1999, 0.8%; 2000, 0.7%; 2001, 0.8%, 2002, 1.0% (source: HCFA Office of the Actuary, December, 1998). Outlier payments were estimated by multiplying projected inlier payments by the 1997 ratio of outlier payments to inlier payments. Medicare inpatient case-level payment DRG payments equal the sum of projected inlier and outlier payments.

⁶ IME payment changes were determined by multiplying the projected DRG payment by the 1997 function of the intern/resident-to-bed ratio $[(1+IRB)^{405}]$ and then by the following IME multiplier as specified in the BBA: 1.89 in 1997; 1.72 in 1998; 1.6 in 1999; 1.47 in 2000; 1.35 in 2001; and 1.35 in 2002. (Source: Section 4621 of the BBA)

⁷ The information that determines the level of DSH payments (Medicaid days and Medicare SSI days) was assumed to be constant over the period. Methodologically, DSH payments in the status quo projections were based on the ratio relationship between DSH payments and DRG payments in 1997. These amounts were then reduced by the following percentages pursuant to the BBA: 1% in 1998, 2% in 1999, 3% in 2000, 4% in 2001, 5% in 2002. (source: Section 4403 of the Balanced Budget Act of 1997)

⁸ For the status quo scenarios, inpatient capital payments for all hospitals were increased according to HCFA estimates (1998, 2.4%; 1999, 1.8%; 2000, -0.3 %; 2001, -0.5%;

2002, 4.3%. For the BBA impact, the status quo amounts were reduced by 17.8 % (source: 63 Fed. Reg. at 41121 (July 31, 1998)).

⁹ Impact of change in the definition of “transfer”: hospitals with 100 or more residents (proxy for COTH hospitals), -0.6%; hospitals with less than 100 residents (other teaching), -0.7% non-teaching hospitals, -0.7% (source: HCFA impact analysis; 63 Fed. Reg. at 25681 (May 8, 1998)).

¹⁰ Impact of changing outpatient payment formulas (eliminating the “formula-driven overpayment”): Major teaching hospitals (IRB ratios of 0.25 or higher) (proxy for COTH hospitals), -8.0%; other teaching hospitals (IRB ratio < 0.25), -8.6%; non-teaching hospitals, -9.4% (source: AAMC analysis of data in Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy at page 105, March, 1999)

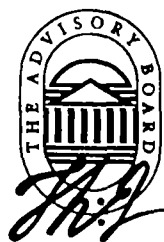
¹¹ The analysis projects the impact of the hospital outpatient PPS effective FFY 2001, which corresponds to HCFA’s estimate as to when they expect the PPS to begin. The estimated impact of the outpatient PPS incorporated into hospitals with 100 or more residents (proxy for COTH hospitals), -10.6%; hospitals with < 100 residents (other teaching), -4.4%; non-teaching hospitals, -5.1% (source: HCFA correction notice impact analysis of outpatient proposed rule; 64 Fed. Reg. at 35262 (June 30, 1999)).

¹² Presentation by Stuart Guterman, Principal Research Associate, The Urban Institute, before the Council on the Economic Impact of Health System Change (June 14, 1999).

¹³ 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and thereafter. These amounts are being “carved out” of the Medicare managed care plan capitated rates on a similar phase-in schedule.

¹⁴ “Budgetary Implications of the Balanced Budget Act of 1997,” Congressional Budget Office, December 1997.

HEALTH CARE ADVISORY BOARD
ECONOMICS BRIEF



MEDICARE PAYMENT REFORM

*Executive Briefing on Health System Financial
Performance Under the Balanced Budget Act of 1997*

HEALTH CARE ADVISORY BOARD
ECONOMICS BRIEF



MEDICARE PAYMENT REFORM

*Executive Briefing on Health System Financial
Performance Under the Balanced Budget Act of 1997*

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Members with questions about the research presented in this brief are encouraged to contact Neal Masia directly at 202-339-6504 or via E-mail at masian@advisory.com.

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SPECIAL THANKS

The Health Care Advisory Board expresses sincere appreciation to the following individuals for providing comments, assistance, data and advice during the research for this publication:

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 Mike Amaral, Analyst

MESSAGE FROM THE HEALTH CARE ADVISORY BOARD

The Balanced Budget Act of 1997 was the most significant legislation for health care finance in at least a decade. After implementation began in 1998, hospitals and health systems began reporting—almost immediately—devastating declines in financial performance, with the blame for the downturn assigned almost exclusively to the BBA. Further, though there may yet be some tinkering around the edges, hospitals are not likely to see substantial revisions to the BBA, despite the current budget surplus. This economics brief examines what we believe to be the key short-term and long-term provisions of the BBA, with an eye toward answering the following “top of mind” questions for our members:

- ☞ To what extent has the BBA contributed to our current financial performance crisis?
- ☞ Will operating margins decrease further, or have we already reached the bottom?
- ☞ Does the BBA require us to change our approach to cost reduction?
- ☞ What are the BBA’s implications for noninpatient businesses and system integration strategy?

This document will prove most useful to Chief Executives, Chief Financial Officers, and Board members grappling with the financial woes imposed—at least in part—by the BBA. For members who have not already done so, we recommend reading this brief in conjunction with our previous brief, *The Durable Core*, which examined the revenue growth prospects for major lines of business (independent of their profitability). We will address the broader issues of financial performance—in particular, commercial revenue opportunities and pricing, contracting, coding and billing, inpatient treatment costs, and so forth—in both our fall 1999 CEO meetings and in subsequent books and economics briefs into next spring. For now, we hope that this focused effort to untangle the current and future impact of the BBA will prove useful in your planning efforts.

July 1999
Washington, D.C.

ARGUMENT

Financial Performance Takes a Turn for the Worse

Preliminary cost report data indicate that the average hospital operating margin has declined from 4.5 percent to 3 percent in 1998—a one-year income drop of over 30 percent. Margin is even worse for major teaching hospitals, falling below one percent on average this year. While hospital expense growth continues at a slow but steady pace, total revenues were nearly flat last year; most observers blame the current crisis on the Balanced Budget Act of 1997.

Hospital executives expecting relief from Congress in the current context of a large budget surplus are likely to be disappointed, as other expensive health care initiatives (most notably Medicare coverage for prescription drugs) have captured the attention of policy makers.

BBA Part of a Larger Revenue Problem

Factors other than the BBA have substantially hampered revenue growth, and might have led to declining margins in 1998 even in the BBA's absence. A surprising—and thus far, unexplained—leveling of the Medicare case mix index is responsible for perhaps one third or more of the financial downturn. Tied directly to hospital reimbursement, the case mix index historically has increased by one to two percent per year, yielding a commensurate increase in revenues.

That said, the BBA has clearly been the dominant driver of the revenue problem faced by hospitals. The BBA froze Medicare inpatient payments for 1998, reduced price increases for four subsequent years and introduced a host of new rules and reimbursement systems that have already cut into hospital incomes. In addition, the BBA cut back on teaching, disproportionate share, and other ancillary payment streams while penalizing hospitals for some patient transfers to subacute settings.

Though Much of the Worst Soon Behind Us, a New Imperative to Reduce Costs

It is fair to say that every hospital in the country has suffered some revenue and income damage as a direct result of the BBA; overall, it is responsible for perhaps 60 percent of the decline in income to date. The qualified good news here is that the most draconian direct payment reductions will have been absorbed by the end of fiscal year 1999; furthermore, leaders may be able to steer their systems around some of the remaining changes. However, the realization that price updates are unlikely to return to their pre-BBA levels—and that other BBA cuts and regulations are here to stay—obligates hospital executives to refocus their attention on cost reduction.

IN BRIEF

Length of Stay No Longer the Answer Under BBA

Since the adoption of the DRG system, hospitals have found that the most reliable way to reduce costs has been to reduce length of stay. Unfortunately, three key factors combine to render length of stay reductions only a minor source of savings for the future. Most directly, new rules limiting patient transfers to home health and skilled nursing facilities essentially place a floor on patient stays by imposing financial penalties on hospitals discharging patients to such facilities too quickly. Second, new subacute prospective payment systems, as designed, make mid- to high-acuity Medicare patients much less profitable for skilled nursing and home health providers, making it difficult for hospitals to transfer patients. Third, the “easy” length of stay reductions are now behind us; length of stay was leveling off in most parts of the country even before the BBA. In light of these changes, executives must now shift their attention toward generating crucial savings from more difficult reductions in cost per-day and per-unit of service.

Underlying Shift Away From Cost-Plus Reimbursement Affects Viability of Full-Continuum Ownership Strategy

The immediate financial problem triggered by the BBA has distracted executive attention away from the more fundamental, long-term shift toward Medicare prospective payment across the continuum of care. Under the old cost-based systems, hospitals could legitimately assign some of their fixed costs to noninpatient business lines, generating additional reimbursement. Under the new rules, reimbursement will no longer be linked to a hospital's own costs, exposing hospital-based entities to the realities of market competition for noninpatient services. While benefits to the integrated delivery model certainly remain, health system leaders must consider whether ownership of the component noninpatient businesses—skilled nursing and home health businesses in particular—still makes economic sense now that they are becoming low revenue, break-even businesses.



MEDICARE PAYMENT REFORM

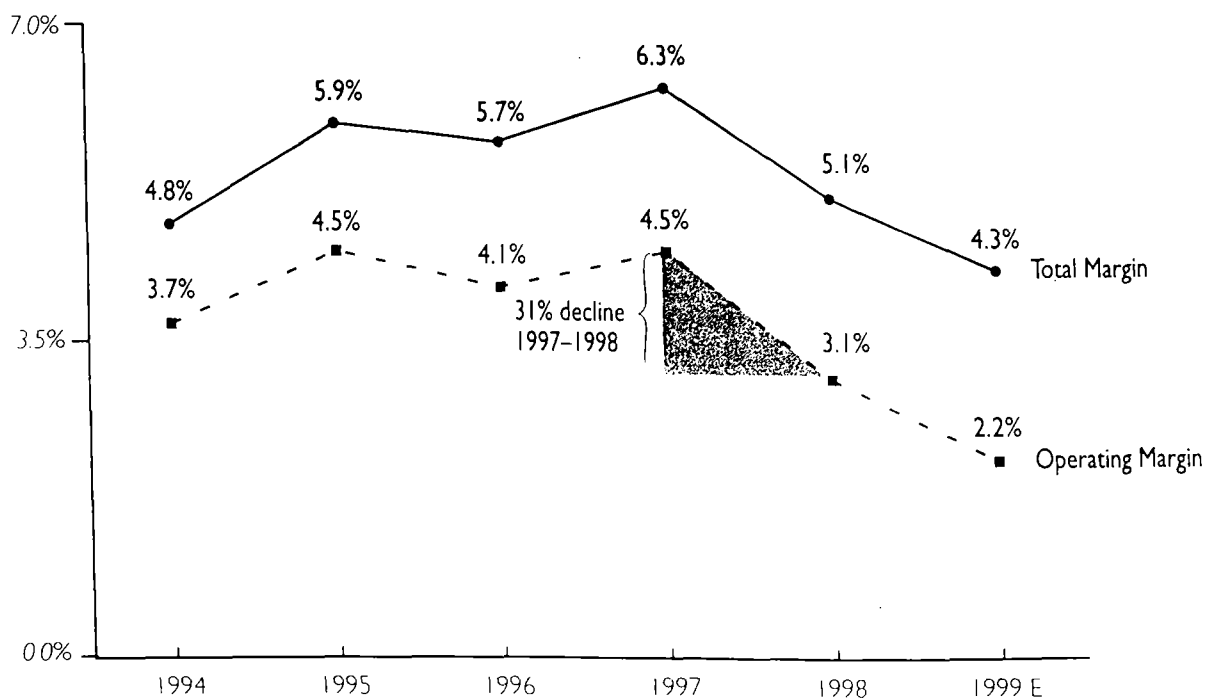
*Executive Briefing on Health System Financial
Performance Under the Balanced Budget Act of 1997*

Observation #1 Preliminary financial data confirm worst fears of hospital executives across the country; four years of solid performance suddenly reversed, with operating income dropping over 30 percent in 1998

A SUDDEN DOWNTURN

Financial Performance Off Sharply

Hospital Profit Margins, 1994-1999

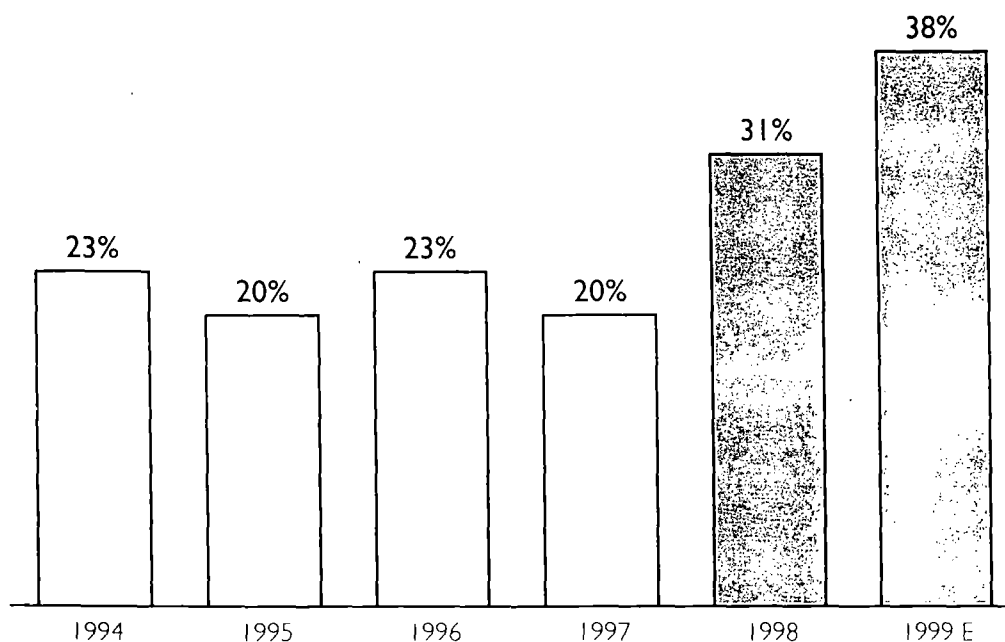


Observation #2 Disheartening short-term message for health systems that absent major changes in commercial price, occupancy rates or cost, operating margins likely to continue falling before any rebound; continued financial trends point to additional one point drop in margins for 1999, leaving nearly half of all hospitals operating in the red

IN HOSPITAL FORTUNES

Nearly Half the Industry in the Red

Percentage of Hospitals with Operating Margins Below Zero

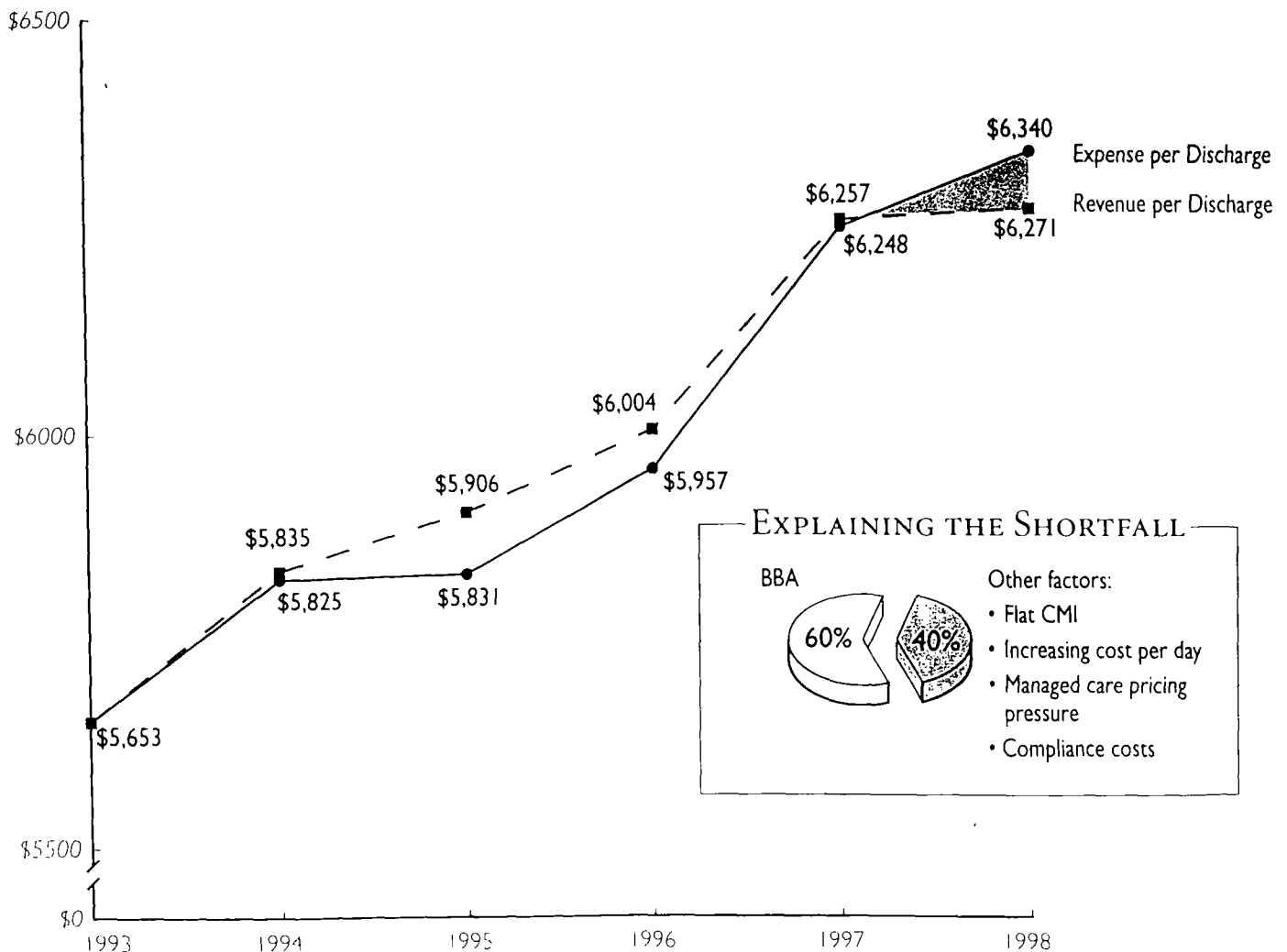


Observation #3 No surprise to most executives that margin drop the result of flat revenues overtaken by moderately growing costs; Advisory Board view that Balanced Budget Act of 1997 (BBA) significant—but only partial—driver of income decline

COSTS KEEP CLIMBING,

A Matter of Basic Economics

Net Revenue, Expense per Discharge, 1993–1998



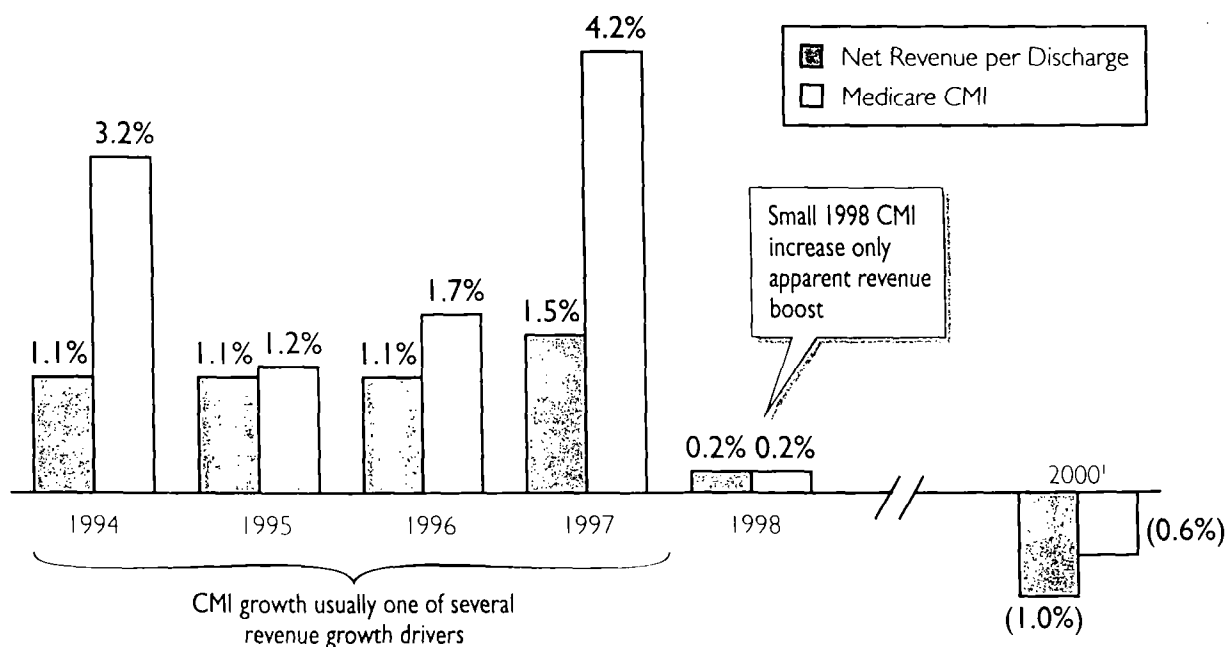
Source: Market Insights, Inc., HCAB analysis.

Observation #4 In fact, flattening Medicare case mix index a significant contributor to stagnant revenues; following four years of continued increases, contribution to rising revenues, case mix stalled in 1998 and is expected to decline in upcoming years

WHILE REVENUE STALLS

No Fuel for Revenue Growth

Percentage Annual Growth in Net Revenue per Discharge, Medicare Case Mix Index, 1994-1998



A PERPLEXING PROBLEM

"[Our CMI has gone down 19 percent in one year]...I can't understand it. Our patients certainly don't seem like they're less sick."

V.P. of Strategic Planning,
Mid-Atlantic Hospital

¹ Latest HCFA estimate; *Modern Healthcare*, May 28, 1999.

Observation #5 That said, BBA larger contributor of revenue stall and, more importantly, largest singular change to fundamental health system finances in recent history; comprised of six major reforms, BBA aims to slow down growth in Medicare expenditures by cutting reimbursement for health care services across the continuum

BALANCED BUDGET ACT

Rolling Out Changes

Major BBA Reforms	1998	1999
#1 Slowdown in Inpatient Price Increases	Medicare inpatient payment rate frozen, keeping price at 1997 level	Inpatient payment rate raised very slightly, to market basket minus 1.9 points
#2 Early Transfer Penalties		Mandatory minimum stays required to generate full payment for patients in 10 key DRGs transferred to skilled nursing, home health
#3 SNF Prospective Payment		Skilled nursing facility prospective payment system (PPS) introduced January 1, based on blend of historic and national costs
#4 Home Health Prospective Payment	Home health interim payment system (IPS) implemented	IPS updated to reflect 1995 financials
#5 Outpatient Payment Modification	Formula-driven overpayments eliminated (see appendix for details)	
#6 Teaching, DSH Cutbacks	- Indirect medical education (IME) payments reduced by 9% - Disproportionate share (DSH) payments reduced by 1%	- IME payments reduced an additional 7% - DSH payments reduced an additional 1%

Note: See Appendix for detailed information on additional changes

Observation #6 While inpatient changes already well underway, fundamental reorganization of Medicare payments for skilled nursing, home health services, outpatient care just getting started; inexorable shift toward prospective payment for most noninpatient services will be complete by 2001, fundamentally changing incentives across care continuum

OF 1997 IN BRIEF

Through 2002

2000

2001

2002

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Inpatient payment rate raised slightly, to market basket minus 1.8 points • Potential expansion of new rule to 25 or more additional DRGs • Skilled nursing PPS moves toward more fully blended payment rates; possible rate increases considered by Congress • Proposed across-the-board 15% cut in home health payments (delayed from 1999) • Proposed implementation of new outpatient prospective payment system; patient copayments frozen • IME payments reduced an additional 7.7% • DSH payments reduced an additional 1% | <ul style="list-style-type: none"> • Inpatient payment rate bumped to market basket minus 1.1 points, about the historic average rate increase • Possible expansion of new transfer rules to cover all Medicare patients in all DRGs • Skilled nursing PPS continue to move toward national rates • Continued shift away from historic costs, toward single regional pricing • Copayments remain frozen • IME payments reduced an additional 8.3%, completing net reduction of 28.5% • DSH payments reduced an additional 1% | <ul style="list-style-type: none"> • Inpatient payment rate holds steady at market basket minus 1.1 points • Payment based on national rates, independent of provider costs • Likely shift to fully prospective payment system, national payment rates • Copayments remain frozen • DSH payments reduced an additional 1%, completing 5% total reduction |
|---|---|---|

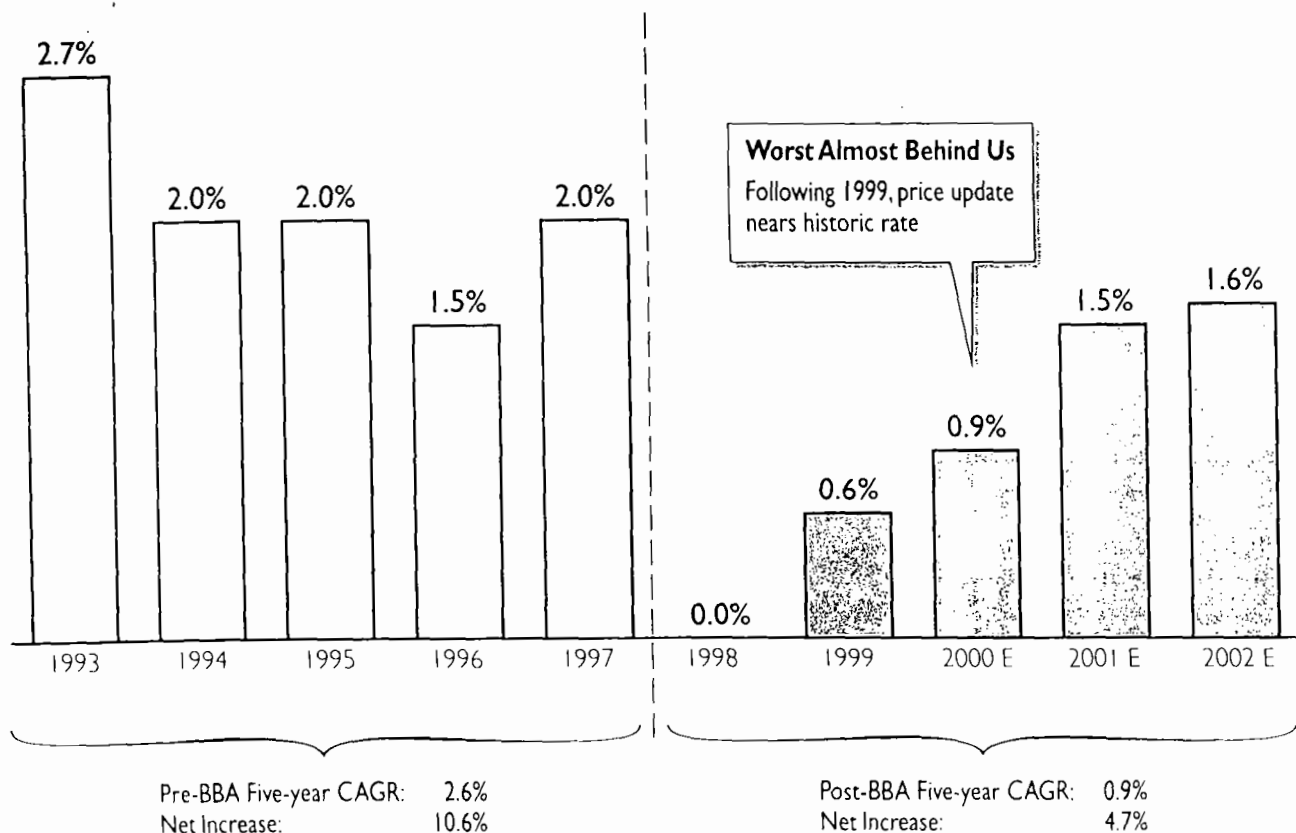
REFORM#1: SLOWDOWN IN INPATIENT PRICE INCREASES

Observation #7 Sharp slowdown in inpatient price update the most obvious—and immediately painful—aspect of BBA; 1998 rate freeze stands in vivid contrast to previous five year average increase of two percent

INPATIENT PRICE PUTS RENEWED

Medicare price increases disappointing...

PPS Inpatient Price Updates, 1993–2002

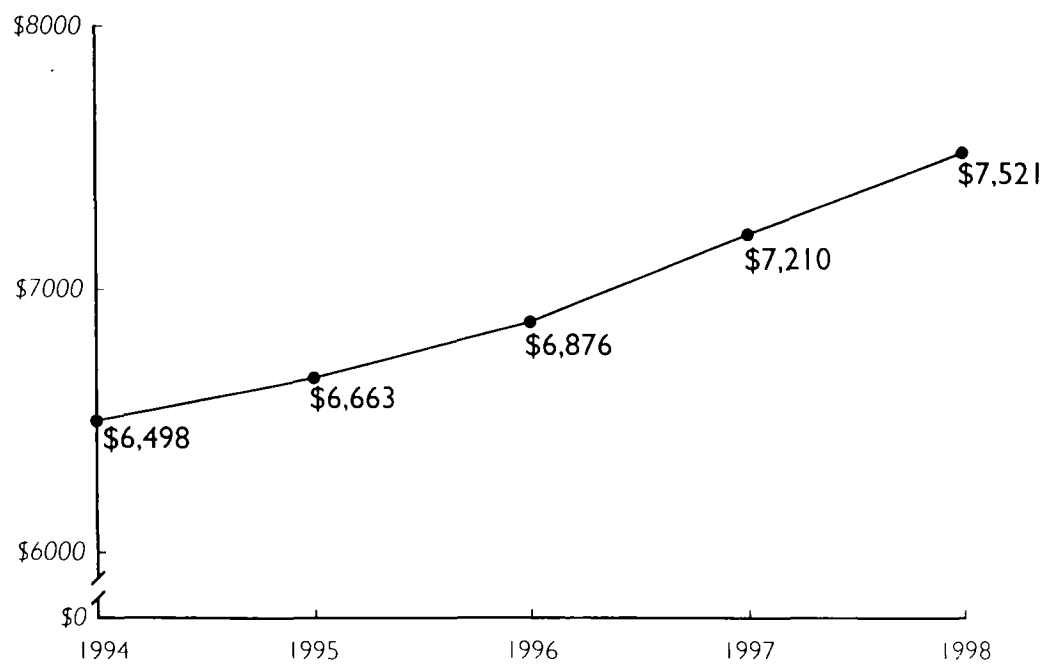


Observation #8 Renewed focus on treatment costs the clear mandate of Medicare price restrictions; while first three years of BBA the most painful, reality that updates never fully revert to pre-BBA rates creating imperative for immediate and continual attention to cost-efficient care

PRESSURE ON COSTS

...while treatment costs keep climbing

Cost per Acuity-Adjusted Discharge, U.S. Hospitals, 1994-1998



Cost Increase	3.9%	2.5%	3.2%	4.9%	4.3%
Market Basket/ Inflation Increase	2.5%	3.0%	2.7%	2.1%	2.5%

Source: Medl/AC; Market Insights Inc., HCAB analysis

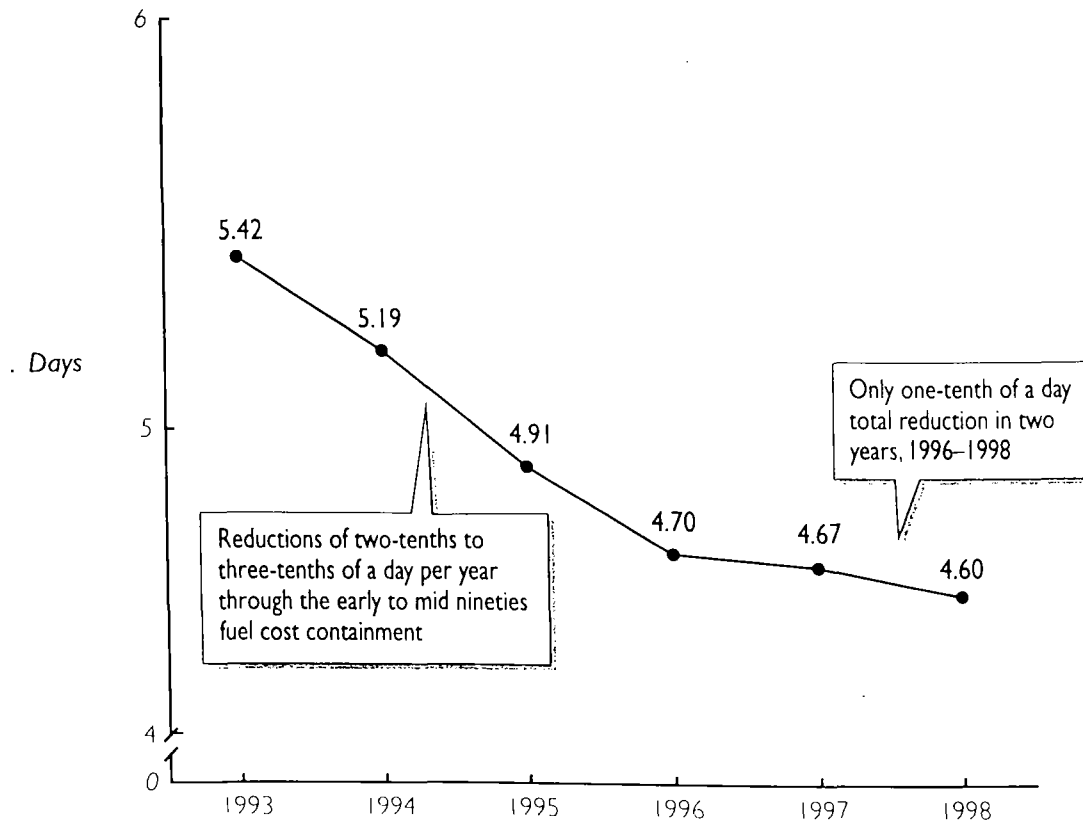
REFORM #2: EARLY TRANSFER PENALTIES

Observation #9 Cost savings mandate requiring hospitals to bypass standard DRG-based means of cost savings—cuts in length of stay—in favor of reduction of costs per day; for most hospitals, further ALOS reductions not only elusive, but now pose risk to hospital revenue

LENGTH OF STAY NO LONGER

ALOS reductions beginning to bottom out...

Average Length of Stay, U.S. Hospitals, 1993–1998



Observation #10 New transfer rules—in effect for 1999—penalize hospitals for quickly moving patients to skilled nursing, home health facilities by reducing payments for early-discharge patients in key DRGs; revenue penalty applies to any patient discharged to subacute care at least one day earlier than the national average inpatient stay

THE ANSWER UNDER BBA

...just as penalties enacted for early discharges to subacute care

Application of Transfer Rule to DRG 209, Total Knee and Hip

PENALTY IN BRIEF

- As of 1999, Medicare patients must stay in hospital for a minimum number of days to qualify for full DRG payment if they are subsequently transferred to subacute care unit
- Minimum stay for each DRG set to one day less than national average length of stay for that DRG
- Patients transferred to subacute care too early paid for on pro-rated per diem rate significantly less than full DRG payment
- Surgical DRGs paid half of full payment on day one; medical DRG payments spread more evenly
- Initial rollout of ten DRGs in 1999, likely to be expanded next year to 25 or more

LOS, Days	Average Hospital Payment, Old Rule	Average Payment, New Rule	Net Impact, New Rule	Percentage Reduction, In Payment, New Rule
1	\$9,561	\$4,781	(\$4,781)	50%
2	\$9,561	\$6,552	(\$3,009)	31%
3	\$9,561	\$7,437	(\$2,124)	22%
4	\$9,561	\$8,322	(\$1,239)	13%
<i>Minimum Stay for Full Payment: 5 Days</i>				
5	\$9,561	\$9,561	0	0%
6	\$9,561	\$9,561	0	0%
7	\$9,561	\$9,561	0	0%

Source: HCFA; HCAB analysis.

Observation #11 Though only ten DRGs covered in first year of new transfer rules, typical 300-bed hospital stands to lose over \$100,000 in revenue by maintaining previous practices, or absorb a similar sum in added costs by keeping patients longer; roll-out of new rules to all Medicare patients (expected over the next three to four years) bumps total impact to nearly \$500,000 per hospital annually

NEW TRANSFER RULES

Policy Affects Patients Across Service Lines, Acuity

Initial DRGs Affected		Minimum Length of Stay	Average Revenue Loss Each Day Below Minimum ¹
Orthopedics hit hardest so far	14 Stroke, other cerebrovascular disorders except TIA	6	\$728
	113 Amputation for circulatory system disorders	12	\$614
	209 Major joint and limb reattachment (hip, knee)	5	\$1,195
	210 Hip and femur procedures except major joint, with complications/comorbidities	7	\$664
	211 Hip and femur procedures except major joint, without complications/comorbidities	5	\$644
	236 Fractures of hip and pelvis	5	\$543
	263 Graft for skin ulcers or cellulitis, with complications/comorbidities	11	\$516
	264 Graft for skin ulcers or cellulitis, without complications/comorbidities	6	\$577
	429 Organic disturbances, mental retardation	10	\$539
	483 Tracheostomy except face, mouth and neck	39	\$1,173

¹ Calculated based on application of HCFA transfer formula to 1997 national average length of stay for all Medicare patients, national average DRG reimbursement levels. Revenue at risk might rise or minimum length of stay might fall based on 1998 and 1999 data.

AFFECT PATIENTS ACROSS THE BOARD

Potential Dollar Impact Not Insignificant

Net Dollar Impact, Typical 300-Bed Community Hospital

DRG	Total Patients	Patients Likely Affected ¹	Estimated Total Dollar Impact ²
14	160	20	\$22,000
113	25	6	\$7,500
209	160	25	\$30,000
210	60	20	\$20,000
211	12	4	\$3,000
236	20	5	\$3,000
263	12	2	\$4,000
264	5	1	\$1,000
429	30	5	\$4,000
483	25	5	\$15,000
1999 Total Impact	509	93	\$109,500
Estimated Impact of Expansion to all DRGs	5,000	350	\$450,000

¹ Based on proportion of Medicare patients transferred to subacute care, distribution of length of stay.

² Based on cost per additional day, revenue reduction per day; anticipated extra days per stay.

Source: HCAB analysis; glossary includes assumptions.

REFORM #3: SNF PROSPECTIVE PAYMENT

Observation #12 For skilled-nursing facilities, volume threat from early transfer penalties pales in comparison to potential losses from transition of SNF reimbursement to prospective payment system; mid- to high-acuity patients, profitable under cost-plus reimbursement, now a serious financial burden to both hospital-owned and publicly-held nursing homes, sending formerly robust operators into a financial tailspin

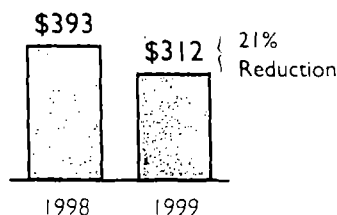
LOW PER DIEM RATES

Public companies battered by changes...

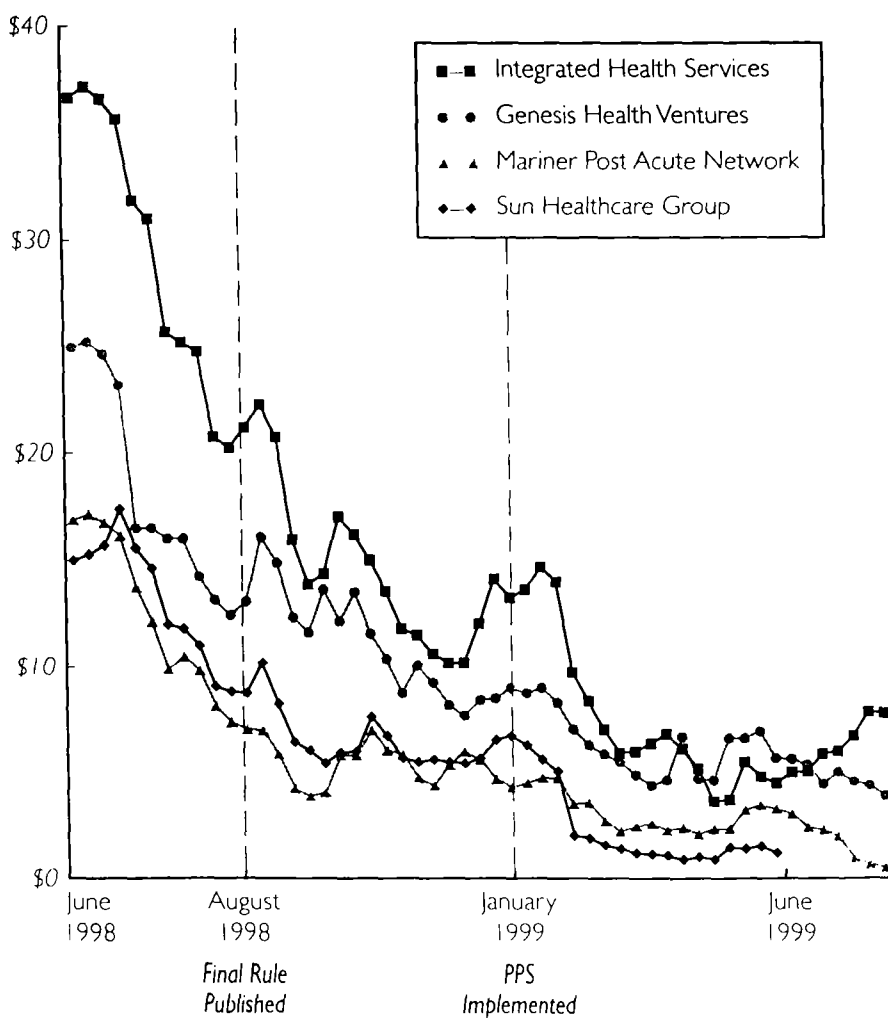
NEW RULE IN BRIEF

- All SNF patients classified into one of 44 Resource Utilization Groups (RUGS)
- Each RUG has a comprehensive per diem payment covering SNFs provisions of all necessary nonphysician services
- 1999 payment rate a blend of facility-specific historic costs and a national rate, eventually moving toward fully national rate
- SNFs must also bill for all Part B services on behalf of the providers of service, even if the patient's stay is not covered by Medicare
- New fixed-payment system a radical departure from previous cost-plus reimbursement system, dramatically reducing average daily payments to nursing homes

Average Medicare Payment per Day, Genesis Health Ventures



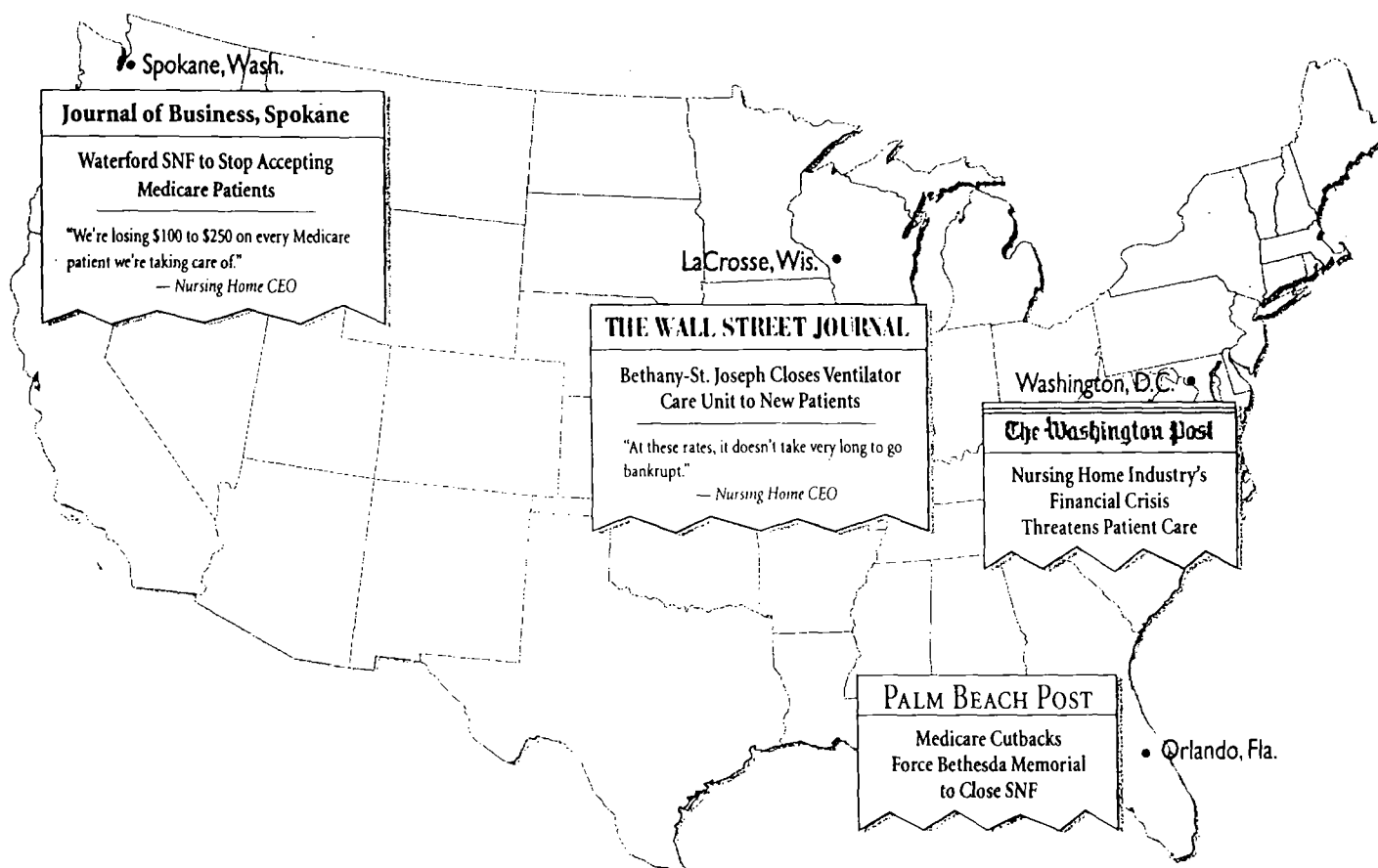
Stock Price, Four Major Nursing Facility Corporations



Observation #13 Prospective SNF payment system indirectly harmful to bottom line even for hospitals not directly involved in skilled nursing business; hospital efforts to transfer costly mid- to high-acuity patients meeting resistance from subacute institutions, increasing inpatient stays and costs with no provision for additional revenues to offset such losses

HURT SNFs, HOSPITALS

...while hospitals scramble to place (unprofitable) patients



THE HALF-EMPTY APPROACH

"[SNF Operators] are being forced to play a much more intellectual game...unlike in the past, when occupancy was a nursing home operator's key concern, now you might be better off half full...you could be full and go broke."

CEO, Northwest SNF

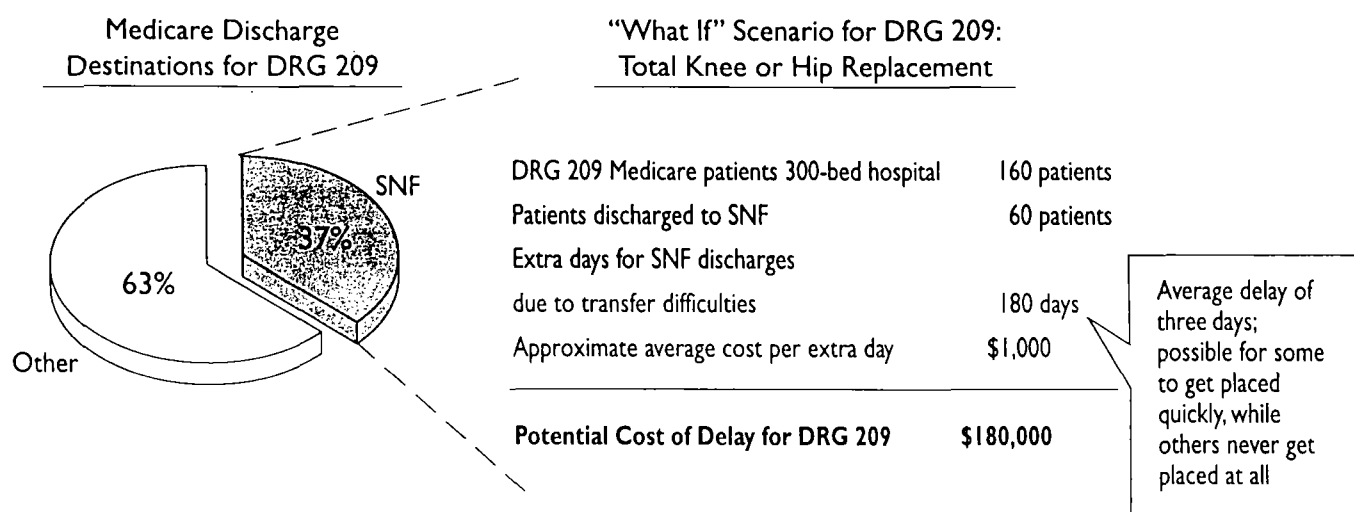
Note: Headlines reflect story content, but not original headline titles in all cases.

Source: *The Wall Street Journal* 26 May 1999; *The Washington Post* 19 June 1999; *Palm Beach Post* 19 May 1999; *Journal of Business-Spokane* 22 April 1999.

Observation #14 Potential cost of widespread patient transfer delays substantial even for individual DRGs; for example, typical hospital might absorb nearly \$200,000 in extra costs for total knee and hip patients alone

HOLDING ON TO SNF TRANSFERS

Potentially Expensive for One DRG



RUNNING OUT OF OPTIONS

"Our primary job has been to move patients *out* of the hospital...but alot of our possibilities for placement are being eliminated...with Medicare patients staying in the hospital longer, [we expect] costs to rise by \$1 million this year."

Administrator
Gundersen Lutheran Medical Center

Observation #15 Net result of new transfer rules, subacute prospective payment system could be an increase in average length of stay across all Medicare patients on order of half a day or more; net decrease in income for typical 300-bed hospital could well exceed \$2 million

A COSTLY PROPOSITION FOR HOSPITALS

Total Across All Patients Could Be Much Worse

"What If" Scenario for All SNF Discharge Patients for 300-Bed Community Hospital

Service Line	Medicare Patients	SNF Discharges	Extra Days	Total Cost ¹
Cardiovascular	1,390	120	360	\$360,000
Orthopedics	480	160	480	\$480,000
Pulmonary	750	125	375	\$375,000
Neurology	420	80	240	\$240,000
All Other	2,000	260	780	\$780,000
Total	5,040	745	2235	\$2,235,000

¹ Assumes average cost per day of \$1,000

REFORM #4: HOME HEALTH PROSPECTIVE PAYMENT

- Observation #16 Transition to prospective payment imposing equal financial strain on home health industry; home health costs for Medicare patients projected to exceed new payment limitations under BBA for nearly 90 percent of hospital-based agencies, further exacerbating already dismal financial performance

BBA RENDERS HOME HEALTH AGENCIES

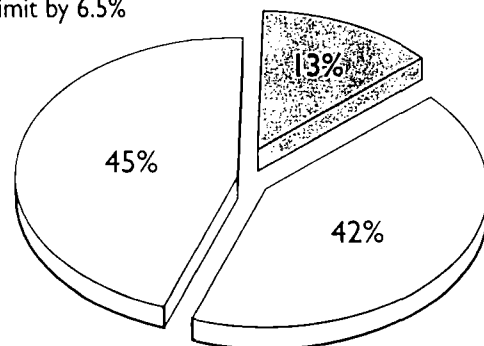
Not a Very Appealing Prospect

NEW RULE IN BRIEF

- New limits imposed on both a per-visit basis and per-beneficiary basis; agencies are paid the lesser of their own actual costs, the per-visit limit, or the per-beneficiary limit
- Per-beneficiary limit applies across home health providers; i.e., the limit is a global maximum for each enrollee
- Agencies enrolling beneficiaries must absorb any costs or necessary services beyond per-visit limit or per-beneficiary limit
- Limit initially depends on each agencies' historic costs combined with a national rate; eventually, payments will be fully based on national rate

Proportion of Hospital-Based Home Health Agencies Below and Above Cost Limits, 1999

Medicare reimbursement restricted to per-beneficiary limit; average agency costs exceed reimbursement limit by 6.5%



Medicare reimbursement at or above cost

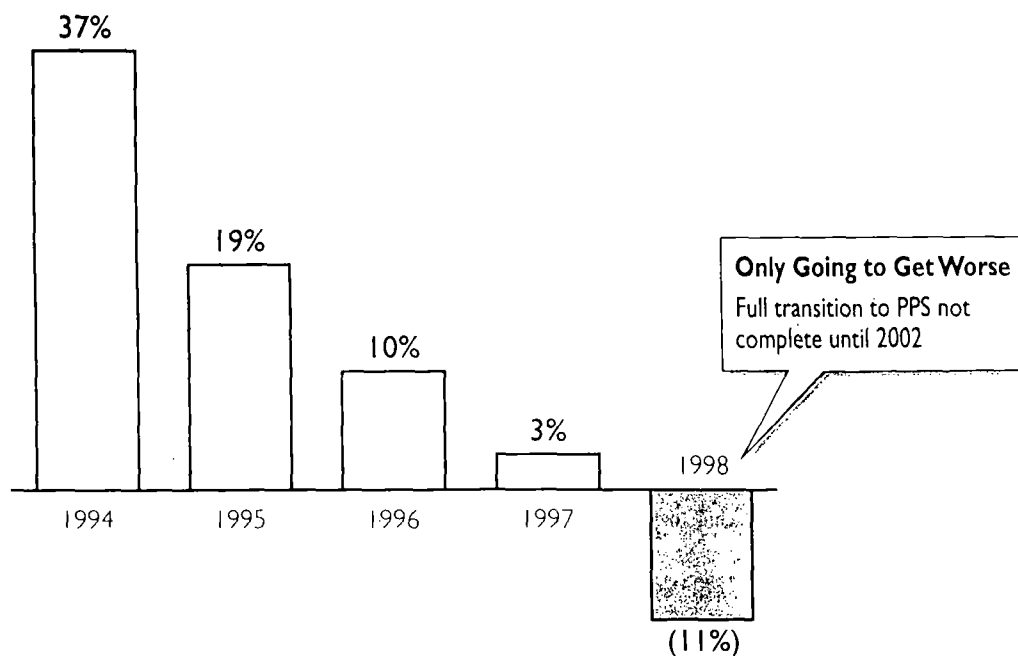
Medicare reimbursement restricted to per-visit limit; average agency costs exceed reimbursement limit by 4.5%

- ☐ Profitable Under Current Reimbursement, Costs
- ☐ Unprofitable Under Current Reimbursement, Costs

DEFINITIONALLY UNPROFITABLE

Revenue at Hospital-Based Agencies Already Falling Fast

Average Revenue Growth, Hospital-Based Home Health Agencies, 1994-1998



GETTING OUT QUICK

"Once we understood the implications of the new payment system, we unloaded our home health operations as fast as we could."

Spokesman, Large Regional Health System

Source: Market Insights, Inc., HCAP analysis.

REFORM #5: OUTPATIENT PAYMENT MODIFICATION

Observation #17 Outpatient prospective payment system, slated for introduction next year, a much less pressing concern for hospitals; while new system will change relative profitability of certain procedures, Advisory Board view that Medicare too small a component of total outpatient reimbursement to make or break overall performance

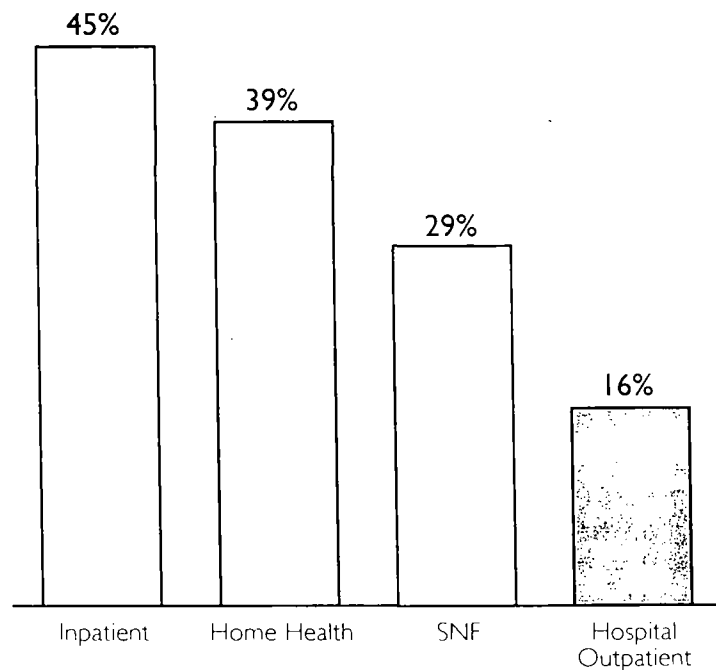
OUTPATIENT CARE REMAINS

Medicare Payments Less Critical for Outpatient Care

Medicare Proportion of All Payment, by Business Line

NEW RULES IN BRIEF

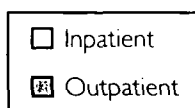
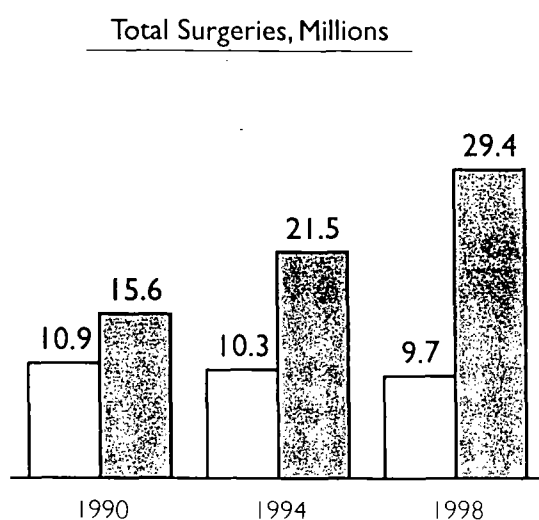
- Formula-driven overpayment eliminated
- Prospective payment, initially slated for introduction this year, delayed until at least mid-2000
- New system will likely be based on ambulatory patient classification system in use by several state Medicaid agencies; system pays providers for bundled services rather than the current mixture of a-la-carte, cost-based payments
- Beneficiary copayments will be frozen at 1999 levels, gradually deflating to 20 percent of visit costs (rather than current rate of 20 percent of charges); hospitals will have option of eliminating copayments entirely, and advertising on that basis
- Final rule yet to be announced



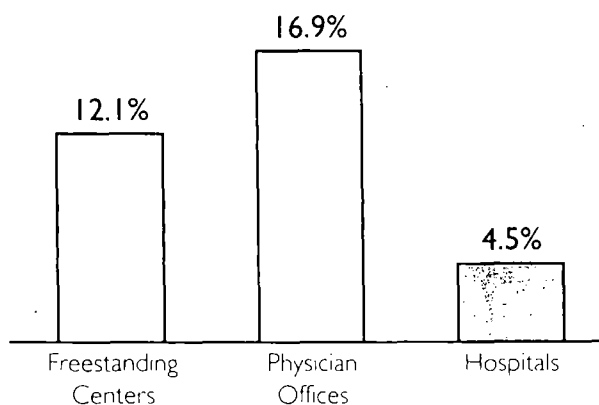
Observation #18 In fact, hospitals well advised to develop strong presence in outpatient facilities market, keeping pace with freestanding providers that have built market share at hospitals' expense; any short-term Medicare price problems certain to be overwhelmed by long-term commercial market growth

A STRONG OPPORTUNITY

Phenomenal Outpatient Surgery Growth (Largely at Hospitals' Expense)



Compound Annual Growth Rate,
Outpatient Surgeries, 1990-1998



Source: SMG Marketing Group.

REFORM #6: TEACHING, DSH CUTBACKS

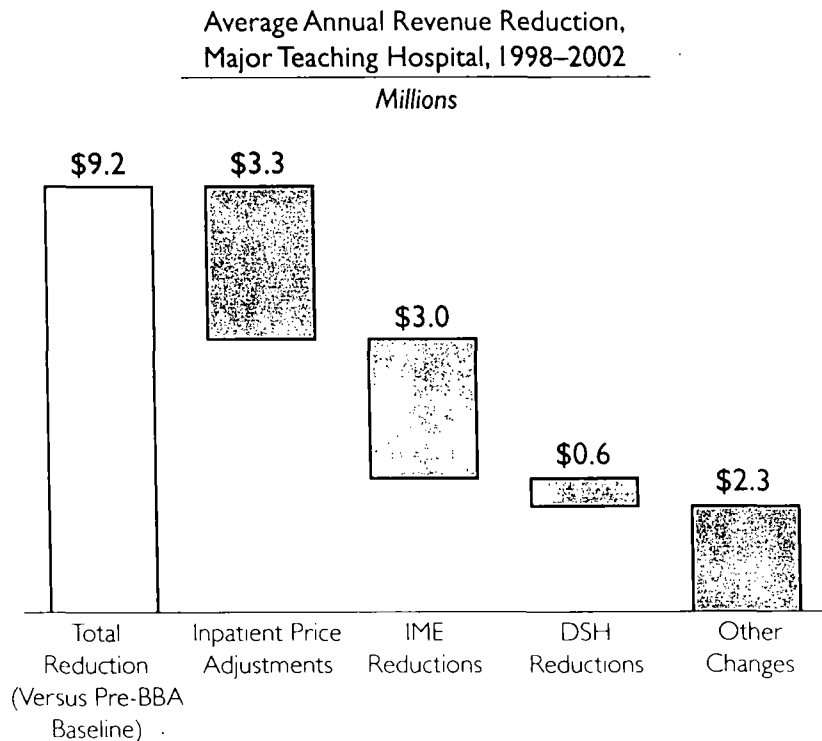
Observation #19 Major teaching hospitals hardest hit by BBA changes; in addition to absorbing standard changes in Medicare payments, academics face substantial cuts to indirect medical education payments, moderate reductions in disproportionate share payments

A DIFFICULT ROAD

Fighting on Several Fronts

NEW RULES IN BRIEF

- Indirect medical education (IME) payments to teaching hospitals, based on a complex formula and added to each DRG payment on a percentage basis, reduced each year through 2001
- Net reduction of 28 percent over full implementation period
- Disproportionate share (DSH) payments, based on each hospital's proportion of indigent care (approximated by their share of Medicaid patients) reduced as well; almost all major teaching hospitals are also major DSH hospitals
- DSH payments reduced by one percent each year through 2002

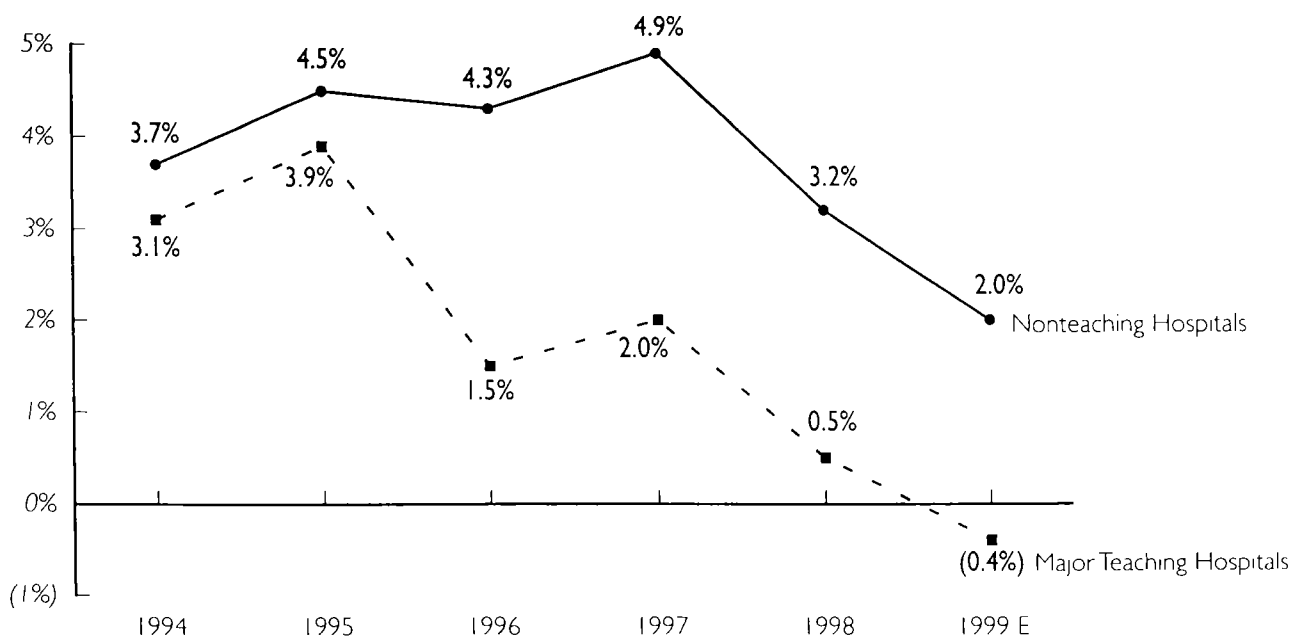


Source: Association of American Medical Colleges; HCAB analysis, assumes total revenues of \$300 million per year.

FOR MAJOR TEACHING HOSPITALS

Sliding Toward Crisis

Major Teaching and Nonteaching Hospital Operating Margins, 1994–1999



Major Teaching Hospitals
with Operating Margins
Less Than 0%

30% 15% 38% 23% 45% 52%

¹ n = 61, major teaching hospital indicated by membership in Council of Teaching Hospitals

REVISITING STRATEGY IN LIGHT OF BBA

- Observation #20** Real danger that current performance crisis obscures fundamental abandonment of cost-based reimbursement under BBA; underlying adoption of "one-price" policy for provision of all noninpatient services calls into question hospital rationale for ownership of nonacute services

SUCCEEDING ON THE

Summarizing the Strategic

BROADER IMPLICATIONS OF THE BBA

- Length of stay reductions much more difficult and unlikely as new transfer rules, subacute PPS will keep patients in the hospital longer
- Prior to BBA, hospitals could allocate costs to home health, SNF, rehab, and ambulatory surgery to boost reimbursement; under the new rules, reimbursement becomes fully independent of costs and ownership status, seriously disadvantaging high-cost hospital providers
- Given new payment mechanisms, most hospitals could easily lose more money on SNF and home health operations than on physician practices, managed care plans

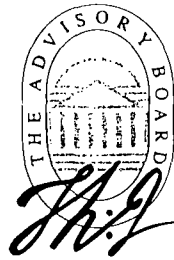
Business Line	Pre-BBA Features
Hospital Inpatient	• Regular reimbursement increases of about one percent less than inflation rate • Costs reduced through length of stay reductions, partly generated by quick transfers to skilled nursing, home health • Some fixed costs covered by spreading onto noninpatient income statements, generating additional Medicare reimbursement
Hospital Outpatient	• Each service, test, surgery reimbursed by Medicare on cost-plus basis • Medicare patients pay 20 percent of hospital charges as co-payment, regardless of ultimate reimbursement level as percentage of charges
Home Health	• Reimbursement based on historic and current costs, including some inpatient hospital costs • Highly profitable, strong revenue growth • Few limitations on per-beneficiary services
Skilled Nursing	• Reimbursement based on costs, services provided • Highly profitable, strong revenue growth • Many hospitals converted unused beds and wings into skilled nursing facilities to provide step-down care for mid-acuity patients

Observation #21 High cost structure inherent in hospital ownership no longer generates the increased reimbursement available with cost-plus pricing; limitation of Medicare's inexorable move to episodic reimbursement by increasing number of payers, strengthens imperative for systems to evaluate formerly guaranteed profit centers on their own economic merits

MERITS, OR NOT AT ALL

Imperatives, Before and After the BBA

Post-BBA Features	Strategic Implications
• Reimbursement penalty for transferring patients too soon to SNF, home health, or risk some reimbursement • Fewer incentives for SNF, home health institutions to accept high-acuity patients, forcing hospitals to absorb cost of treating languishing patients through extended stays • Fixed costs no longer reimbursable expenses for noninpatient settings	• Stronger imperative than ever to manage costs effectively under slow reimbursement growth, but length of stay no longer the answer as early transfers often reduce payments under new rules and transfers for longer-stay, high-acuity patients more difficult to secure • Critical for hospitals to streamline transfer process and focus cost reduction efforts on unit cost, not length of stay
• New outpatient prospective payment system slated for 2000, bundling payments for discrete visits into one rate • Rates calibrated to a four percent reduction across the board compared to previous year rates • Patient copayment rate frozen to previous year level once PPS implemented, eventually reduced to 20 percent of costs; hospitals permitted to drop copayments entirely and publicize their decision	• Outpatient care major growth area beyond 2000, important revenue and income opportunity for most hospitals and health systems • Necessary to improve efficiency and streamline care delivery across entire visit or procedure, just as was required when inpatient payment shifted to DRG system in 1984 • Goal to promote procedures and visits that are easily coordinated, less resource intensive
• Reimbursement increasingly based on national average costs, putting high-cost hospitals at a disadvantage; inpatient fixed costs no longer transferable • Unprofitable to break-even operation, revenues declining; most hospitals exceed maximum allowable cost for services • Strict limits on per-beneficiary services, spending caps • Current payments on an interim system; not clear when or in what form full PPS will arrive	• No longer a profitable revenue source for hospitals and health systems • Hospital ownership no longer provides advantaged reimbursement, but in most cases still increases costs • New beneficiary limits require large increase in patient base to maintain profitability
• Prospective payment introduced January 1, 1999 with 44 categories of per diem rates based on predicted intensity of services • Hospital-based facilities experience revenue reductions of up to 20 percent • High acuity patients no longer profitable, as too many services required to justify low per diem rates; accepting such patients now seriously hampers profitability	• Difficult for any SNF to maintain profitability in new payment environment • New transfer rules reduce hospital demand for placing some low-end patients, while hospitals look to place newly unprofitable high-end patients to cut costs • System ownership still makes sense for ensuring smooth patient transfers out of the hospital, but not based on inherent revenues or profitability



APPENDIX

Glossary of Terms

ASSUMPTIONS FOR “TYPICAL” HOSPITAL

In several cases the text refers to a “typical” 300-bed hospital. Unless noted otherwise, we assume a stand-alone hospital with 300 beds in service, 12,000 discharges per year, and \$100 million in revenue of which 35 percent comes from outpatient services. A “typical” teaching hospital is modeled to have 500 beds, 20,000 discharges, and \$300 million in revenue of which 30 percent comes from outpatient services.

COST PER CMI-ADJUSTED DAY, DISCHARGE

Cost per day or cost per discharge are often adjusted for case mix (CMI, see below) to account for performance independent of acuity. The cost per day (or discharge) is divided by the case mix index at each hospital to make valid comparisons across hospitals and over time; all things equal, a hospital treating sicker patients would expect to have higher costs, but after dividing by its (relatively high) case mix index it should have costs comparable to other hospitals.

MAJOR TEACHING HOSPITAL

We consider “major teaching hospitals” to include hospitals that are members of the Council of Teaching Hospitals (COTH).

MARKET BASKET

Medicare prices are linked to the input costs paid by hospitals. Input costs include wages, supply costs and other services purchased by hospitals; HCFA tracks the prices of the basket of items purchased by hospitals across the country, and determines the annual increase to those prices. The annual increase is referred to as the market basket price increase. The PPS price update for 1999 is set in law to market basket minus 1.9 percent. Hospitals are expected to reduce costs enough to make up for the difference between the increase in their input costs and the growth in reimbursement.

MEDICARE CASE MIX INDEX

Each Medicare patient is classified into one diagnosis-related group (DRG) that is determined by the diagnoses and procedures constituting the hospital stay. Each DRG is assigned a case “weight”, indexed to one, reflecting the resource intensity or cost associated with treating that particular type of patient across the country in the previous year. The more expensive it is to treat a patient, the higher the weight; for example, DRG 106, an open heart surgery DRG, had a weight of 5.5564 in 1997 while DRG 89, for simple pneumonia, had a 1997 weight of 1.1156. Each hospital receives a payment for each patient that depends on 1) hospital-specific items including the local wage index, teaching status and several other factors, and 2) that patient’s DRG and its associated weight. In the example above, a DRG 106 patient would generate about five times the revenue of a DRG 89 patient in a given hospital. The Medicare Case Mix Index (CMI) for an individual hospital is simply the average case weight for all Medicare patients in that hospital.

OPERATING PROFIT MARGIN

Net income from operations divided by gross revenues from operations.

TOTAL PROFIT MARGIN

Total net income (including investment income) divided by total gross revenues.

ADDITIONAL DETAILS

BAD DEBT WRITE-OFFS

Beneficiaries generally bear some financial responsibility for their inpatient and outpatient hospital bills. Patients covered by a Medigap plan, or by Medicaid, get coverage for their portion of the costs, but patients without supplemental policies often fail to pay their bills. Bad debt payments from Medicare reimburse hospitals for a portion of beneficiaries' unpaid deductibles and coinsurance after the hospital has made a good faith effort to collect the fees from the beneficiaries directly. The BBA gradually reduces the reimbursement rate from 100 percent to 55 percent of costs, a 45 percent reduction over five years.

DISPROPORTIONATE SHARE (DSH) PAYMENTS

Hospitals that treat a disproportionately high number of indigent patients receive additional payments from HCFA. The payment amount depends on the proportion of Medicaid and SSI patients treated, which are used as an approximation for the total amount of indigent care provided. Though over 2,000 hospitals receive some DSH funding, well over half of all payments are concentrated into about 250 large urban hospitals, many of which are also major teaching hospitals. DSH payments are to be reduced by five percent over the term of the BBA.

INDIRECT MEDICAL EDUCATION (IME) PAYMENTS

HCFA supplements payments to teaching hospitals in order to subsidize the indirect costs associated with their medical education programs. The payments are added onto the PPS DRG payments through a complex formula depending primarily on the intern and resident to bed ratio. The IME payments range from very small (for hospitals with one or two residency programs) to about 20 to 25 percent of the total DRG payment (for large AMCs). Changes to the formula will reduce IME payments to hospitals by about 28 percent through 2001.

HOME HEALTH INTERIM PAYMENT SYSTEM (IPS)

Home health agencies began the transition to fully prospective payment (to be complete by 2001 or later) by moving first to an interim payment system (IPS) that combines features of the cost-plus and prospective systems. On the interim system, new limits have been placed on reimbursement per visit and per beneficiary, but there remains a connection to a hospital's own historic costs during the transition. The connection is slowly phased out over the course of implementation, although there have been some delays as payments have been reduced more sharply than originally anticipated by HCFA.

OF BBA PROVISIONS

FORMULA-DRIVEN OVERPAYMENTS (FDO)

Ambulatory surgery services are paid based on a blend of hospitals costs (42 percent of the rate) and freestanding ambulatory surgery center rates (58 percent of the rate). The change affects the calculation of the 58 percent of payments based on the freestanding rate. Under the old system, that 58 percent was applied to 80 percent of the ASC rate. The 80 percent reduction was meant to account for the patient copayment, which is set at 20 percent of hospital charges. However, the formula resulted in overpayments to hospitals because actual copayments usually far exceed 20 percent of actual costs, which are supposed to be the basis of payments. Under the new system, the 58 percent is applied to the ASC rate minus the actual beneficiary copayment instead of being applied to 80 percent of the ASC rate. The best explanation of this fairly complex calculation is through an example:

Ambulatory Payments Before and After FDO Elimination

	Before FDO Elimination	
Hypothetical hospital outpatient surgery charge, total	\$2,000	\$2,000 After FDO Elimination
Patient coinsurance (20% off hospital charges)	\$400	\$400
Hypothetical Medicare rate for freestanding ASCs	\$600	\$600
Hypothetical hospital costs	\$1,000	\$1,000
42% of Medicare payment to hospital based on hospital's costs minus co-payment	\$252	\$252
	[42% of \$1000 (hospital costs) minus \$400 (the co-payment)]	[42% of \$1000 (hospital costs) minus \$400 (the co-payment)]
58% of Medicare payment to hospital based on ASC rate	\$278	\$116
	[58% of 80% of \$600 (the ASC rate)]	[58% of \$600 (the ASC rate) minus \$400 (the co-payment)]
Total payments to hospital (co-payment plus hospital cost portion plus ASC portion)	\$930	\$768
		Net Reduction: 17%



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Greater New York Hospital Association

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Kenneth E. Raske, President

September
Thirteen
1999

Christopher C. Jennings
Deputy Assistant to the President for Health Policy Development
216 Old Executive Office Building
17th St. and Pennsylvania Avenue, N.W.
Washington, DC 20502

Dear Chris:

Thank you for the opportunity to provide you and your colleagues with additional data regarding the impact of the Balanced Budget Act of 1997 (BBA) on the nation's teaching hospitals, in general, and on our member hospitals, in particular. I know we have had numerous conversations about the financial condition of our member hospitals. I hope the additional data we are providing will be dispositive about the need for a freeze in the indirect medical education (IME) adjustment at the FY 1999 level of approximately 65% of each hospital's ratio of interns and residents to beds (IRB). First I'd like to review our analysis of the fiscal impact of the BBA, and then I shall discuss our members' limitations with respect to making the cost reductions that would be required to maintain financial viability, and, thus, their urgent need for relief.

As you know, we modeled the impact of the BBA on hospital Medicare and total margins assuming no changes in non-Medicare revenue or in the hospitals' cost structures. The purpose of this exercise was to assess the level of cost reduction that hospitals would have to achieve to maintain financial viability. First, with respect to the revenue reduction alone, owing to the cuts in the IME and disproportionate share hospital (DSH) adjustments, major teaching hospitals took a harder hit from the BBA than other hospitals. Our model shows that they lost 14.0% of their baseline Medicare revenue compared with 12.2% for non-teaching hospitals, and, more importantly, that the BBA actually reduced payments from the 1996 level for major teaching hospitals — *unadjusted for inflation* — rather than merely slowing the growth of payments, as it did for other hospitals.

With respect to the Medicare inpatient margin, we found that the BBA forced Medicare revenue significantly below cost for all hospitals, *including* major teaching hospitals. We believe that this finding has been obscured by the margins computed by the Medicare Payment Advisory Commission (MedPAC), which failed to accurately match payments and costs by including DSH revenue but no associated DSH costs. DSH payments are provided to facilitate access by Medicare beneficiaries to hospitals that serve large indigent and uninsured patient populations. Thus, the correct Medicare inpatient margin calculation should either exclude DSH payments from the revenue calculation or include an allocation of uncompensated care in the cost calculation. Our analysis excluded DSH payments because uncompensated care costs are not currently reported on the Medicare cost report. Attachment A shows the margin calculations with no associated DSH costs, both including and excluding DSH revenue. Including DSH revenue, as MedPAC does, implicitly reallocates DSH payments to standard operating payments, thus effectively eliminating the DSH adjustment, which was not Congressional intent.

Regardless of whether DSH is treated as a Medicare payment or a non-Medicare payment in the Medicare margin calculation, the total margin is the same. Thus, Attachment A shows that with no

changes in non-Medicare revenue or in the hospitals' cost structures, the BBA would force the total margin into a negative position for major teaching hospitals as opposed to other hospitals. The only way the hospitals could avoid this outcome would be to increase revenue from other sources, to decrease expenses, or both. Increasing revenue from other sources is not a viable option, first because many teaching hospitals derive most of their revenue from regulated payments, leaving little flexibility for cost-shifting, and, second, because hospitals have very little bargaining power in the current market environment. Therefore, in order to maintain financial viability, the BBA is effectively asking major teaching hospitals to cut their budgets, while other hospitals merely have to tolerate a reduction in their profitability. This begs the question of whether that requirement is reasonable.

Here, we must switch our focus from a national analysis to a local analysis, since national data about current cost trends are not yet available. To evaluate the feasibility of making cost reductions in the 4% range, first we compared our members' current efficiency with their national counterparts. Attachment B provides state-level comparative data from The Center for Healthcare Industry Performance Studies. These data show that when adjusted for differences in case-mix and regional wage levels, New York hospitals' median cost, price, surplus, and staffing per inpatient are among the lowest in the United States, as are its median cost, price, and surplus per outpatient visit. Furthermore, the financial condition of New York's hospitals is almost the worst in the nation, as measured by profitability, liquidity, capital structure, and overall financial flexibility.

Second, to confirm that our members have little to no ability to reduce their budgets further, we surveyed their first-quarter 1999 financial statements. The results of our analysis are found in Attachment C. The vast majority of our members are teaching hospitals. Furthermore, the 50 hospitals that responded to our survey represent a broad cross-section of our membership with respect to size, location, case mix, and payer mix. In aggregate, from the 1998 first quarter to the 1999 first quarter, operating revenue grew by 2.7% and operating expenses grew by 4.3%. Thus, the hospitals were unable to cut expenses or even hold expense growth to the revenue growth rate. Therefore, aggregate operating income fell by \$56 million from positive \$17 million to negative \$38 million, and the operating margin decreased by 1.6 percentage points from 0.51% to -1.09%. Because of a reduction in non-operating income, aggregate net income fell by \$78 million from positive \$75 million to negative \$2 million. Furthermore, this trend was evident for most of our members, with 74% experiencing a decrease in their operating margin, and 78% experiencing a decrease in their total margin.

All told, our member hospitals are already quite efficient compared with their national counterparts, but are also in deep financial distress, in contrast with their national counterparts. The recent worsening of their financial condition was caused by the BBA, which cut Medicare payments to teaching hospitals too much, too soon. Medicare inpatient payments are now significantly below cost when measured correctly, that is, by allocating DSH payments to uncompensated care, which is their intended purpose. Thus, it is appropriate for the Administration to support some short-term relief by freezing the IME adjustment at its FY 1999 level. There is absolutely no doubt that failing to do so will cause immediate service and access problems in the metropolitan New York area.

Thank you for your consideration of these materials. I look forward to talking with you soon about this matter.

My best,

Sincerely,

Kenneth E. Raske
President

Cc: Dennis Rivera
Attachments

Letters

Teaching hospitals' Medicare margins wrong

I've been troubled for some time that Medicare margins for teaching hospitals are overstated, because disproportionate-share hospital (DSH) revenues are factored in without an offset for uncompensated-care costs and because teaching hospitals receive two-thirds of all DSH payments.

When DSH revenues ostensibly paid for Medicare beneficiary costs that were higher because of a hospital's high indigent patient load, no one challenged the Medicare Payment Advisory Commission's margin analysis. Now, however, MedPAC has explicitly recognized DSH payments as Medicare's contribution to uncompensated-care costs. It has revised the DSH adjustment to serve the broader purpose of protecting access to care for Medicare beneficiaries and low-income patients by assisting the hospitals they use. According to a MedPAC report, these hospitals have not only large uncompensated-care burdens but difficulty in attracting privately insured patients.

MedPAC recommended basing the

adjustment on inpatient and outpatient costs associated with these patients, patients in other indigent-care programs and uninsured and underinsured patients as represented by uncompensated care.

Because MedPAC changed its characterization of DSH payments, the commission should change the way it computes Medicare margins. The need for change is urgent, because the current method is obscuring the damage the Balanced Budget Act of 1997 has done to the nation's teaching hospitals. In fact, some policymakers have said that the positive inpatient operating PPS margins for teaching hospitals reported by MedPAC under the budget law show that the law is not contributing to the industry's financial troubles.

Because uncompensated-care costs are not included on the Medicare cost report, an equally valid way to match Medicare payments and costs is to remove the DSH payments from Medicare revenues for the margin analysis. That way, the impact of the budget law on

Medicare margins for teaching hospitals is revealed to be much worse than otherwise thought.

An analysis by the Greater New York Hospital Association shows that if post-budget law payment policy had been in effect in 1996, the Medicare inpatient operating PPS margins for teaching hospitals would have been -3.9%, and the total Medicare acute-care margin would have been a distressing -8.6%.

Productivity improvements are unlikely to mitigate this margin; preliminary 1998 and 1999 audited financial statements from GNYHA member hospitals have shown costs are increasing. That is why teaching hospitals have turned to Congress and the Clinton administration to provide budget relief.



Raske

*Kenneth Raske
President*

*Greater New York Hospital Association
New York*

Comparison of the Effect of the BBA on Medicare Margins Including and Excluding DSH Revenue

Margins	Including DSH Revenue				Excluding DSH Revenue			
	1996	1999	2000	2002	1996	1999	2000	2002
Total Medicare Inpatient (a)								
All Hospitals	12.0%	2.4%	0.7%	-1.3%	7.3%	-2.9%	-4.7%	-6.7%
Major teaching	18.7%	9.2%	6.9%	4.7%	11.7%	1.3%	-1.2%	-3.5%
Other teaching	11.0%	1.2%	-0.5%	-2.5%	6.5%	-3.9%	-5.6%	-7.7%
Total teaching	14.2%	4.5%	2.6%	0.5%	8.6%	-1.8%	-3.8%	-6.0%
Non-teaching	9.3%	-0.3%	-1.6%	-3.5%	5.7%	-4.3%	-5.7%	-7.5%
Total Medicare Acute Care (b)								
All Hospitals	8.9%	-1.0%	-2.7%	-4.7%	4.8%	-5.6%	-7.4%	-9.4%
Major teaching	15.0%	5.3%	2.9%	0.5%	8.6%	-1.9%	-4.5%	-7.1%
Other teaching	8.4%	-1.6%	-3.2%	-5.1%	4.4%	-6.1%	-7.7%	-9.6%
Total teaching	11.1%	1.3%	-0.7%	-2.8%	6.1%	-4.4%	-8.4%	-8.6%
Non-teaching	6.2%	-3.7%	-5.0%	-6.9%	3.1%	-7.1%	-8.5%	-10.3%
Total Hospital (c)								
All Hospitals	5.8%	2.9%	2.4%	1.9%	5.8%	2.9%	2.4%	1.9%
Major teaching	3.0%	0.3%	-0.3%	-0.9%	3.0%	0.3%	-0.3%	-0.9%
Other teaching	6.9%	3.9%	3.4%	2.9%	6.9%	3.9%	3.4%	2.9%
Total teaching	5.1%	2.2%	1.7%	1.1%	5.1%	2.2%	1.7%	1.1%
Non-teaching	6.8%	3.8%	3.4%	2.9%	6.8%	3.8%	3.4%	2.9%

(a) Includes PPS, direct GME, and inpatient TEFRA.

(b) Includes all inpatient and outpatient.

(c) Represents the total margin, which is the net change in unrestricted net assets.

Source: Greater New York Hospital Association Center for Applied Health Economics.

THE 1998-99 ALMANAC

OF HOSPITAL FINANCIAL & OPERATING INDICATORS

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Net Price per Discharge (Adjusted for Wage Index & Case Mix)

	Median Values					1997 Percentile Values			
	1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration									
High	5,288	5,385	5,231	5,237	5,275	3,833	4,451	6,275	7,390
Medium	4,727	4,771	4,969	4,807	5,049	3,671	4,360	6,057	7,074
Low	5,171	5,144	5,088	5,229	5,141	3,933	4,275	6,110	6,980
States									
Alabama	5,552	5,435	4,806	5,360	5,706	4,040	4,719	6,240	6,492
Alaska	6,056	5,900	6,104	6,142	6,208	4,383	4,780	6,728	6,991
Arizona	5,458	5,349	5,693	6,320	N/A	N/A	N/A	N/A	N/A
Arkansas	4,811	5,408	5,424	5,176	5,187	4,166	4,523	5,433	6,930
California	4,717	4,625	4,633	4,830	5,249	3,350	4,092	6,274	7,133
Colorado	5,170	5,682	5,752	5,160	5,169	4,443	4,766	5,833	6,158
Connecticut	5,234	5,016	5,219	4,940	4,901	4,174	4,416	5,717	6,322
Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	7,245	6,891	6,133	5,614	N/A	N/A	N/A	N/A	N/A
Florida	5,406	5,670	5,271	5,028	5,510	4,715	5,116	5,868	6,717
Georgia	5,244	5,585	5,456	5,692	5,756	4,397	4,971	6,512	6,782
Hawaii	6,441	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Idaho	4,581	5,008	5,018	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	5,653	5,783	5,679	5,626	5,567	4,481	4,909	6,252	7,331
Indiana	5,227	5,414	5,460	5,668	5,844	4,024	5,073	6,329	6,639
Iowa	5,303	5,369	5,209	5,498	5,506	4,619	5,094	6,174	7,953
Kansas	4,928	5,089	5,634	5,408	6,393	4,375	4,966	7,327	7,685
Kentucky	4,846	4,805	4,906	4,858	5,529	3,284	4,348	5,842	6,520
Louisiana	5,770	5,767	6,178	6,167	5,925	4,523	5,370	6,288	6,972
Maine	4,710	4,951	5,384	5,623	5,589	4,539	5,041	6,291	7,936
Maryland	4,774	4,909	4,586	4,806	4,907	4,586	4,643	5,221	6,221
Massachusetts	4,270	3,868	3,798	3,443	3,611	2,767	3,344	4,554	6,392
Michigan	4,529	4,675	4,667	4,740	4,488	3,854	4,002	5,242	5,702
Minnesota	4,595	4,951	5,022	5,036	5,103	4,515	4,710	5,549	5,726
Mississippi	5,897	5,487	6,685	6,536	N/A	N/A	N/A	N/A	N/A
Missouri	5,342	5,603	5,741	5,539	6,202	4,442	5,281	6,670	7,456
Montana	5,584	4,233	5,558	5,359	5,202	4,340	4,715	6,216	6,363
Nebraska	5,421	5,497	5,536	5,371	5,921	4,634	5,211	6,504	7,633
Nevada	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
New Hampshire	4,735	4,897	5,249	5,685	5,042	3,915	4,381	5,509	5,686
New Jersey	4,743	4,652	4,785	4,964	4,810	4,030	4,493	5,411	6,347
New Mexico	5,675	5,441	5,123	5,784	5,364	4,773	5,573	7,006	7,539
New York	4,389	4,252	4,478	4,243	4,426	3,606	4,014	5,095	6,522
North Carolina	5,171	5,495	5,455	5,548	5,544	4,238	4,806	6,674	7,136
North Dakota	5,569	5,881	5,557	6,076	5,731	5,221	5,607	6,744	7,257
Ohio	5,036	5,064	5,026	5,115	5,422	4,669	4,992	6,340	6,904
Oklahoma	4,807	4,957	4,969	5,878	5,721	5,170	5,523	6,457	7,270
Oregon	4,299	4,722	4,711	4,292	4,439	3,682	3,808	4,637	5,629
Pennsylvania	4,508	4,426	4,453	4,587	4,236	3,509	3,843	4,972	6,422
Rhode Island	3,976	3,822	4,046	4,100	N/A	N/A	N/A	N/A	N/A
South Carolina	5,994	6,308	6,573	5,926	5,715	4,917	5,360	7,117	7,181
South Dakota	6,164	N/A	6,459	6,234	N/A	N/A	N/A	N/A	N/A
Tennessee	5,390	5,895	5,149	6,121	5,148	4,053	4,696	6,525	6,685
Texas	5,148	5,565	5,508	5,307	5,490	4,532	4,973	6,468	8,055
Utah	4,669	N/A	5,455	N/A	N/A	N/A	N/A	N/A	N/A
Vermont	5,005	4,887	5,079	N/A	N/A	N/A	N/A	N/A	N/A
Virginia	5,644	5,465	5,280	5,401	5,468	4,940	5,014	6,132	7,270
Washington	4,687	4,822	4,705	4,419	4,395	3,677	4,019	5,354	5,932
West Virginia	5,180	5,282	5,083	5,243	4,922	4,101	4,699	5,297	6,945
Wisconsin	5,168	5,533	5,541	5,414	5,434	4,765	5,205	5,663	6,280
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Intensity of Service Indicators

Cost per Discharge (Adjusted for Wage Index & Case Mix)

		Median Values					1997 Percentile Values			
		1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration										
	High	5,356	5,339	5,335	5,232	5,133	3,874	4,477	6,373	7,667
	Medium	4,817	4,866	5,021	4,913	5,036	3,738	4,390	6,153	7,391
	Low	5,146	5,144	5,060	5,110	5,007	3,827	4,438	6,065	7,117
States										
	Alabama	5,422	5,658	4,750	5,318	5,538	3,897	4,580	6,276	6,477
	Alaska	6,655	5,927	8,783	6,258	6,955	5,169	6,129	7,258	7,448
	Arizona	5,692	5,128	5,879	5,735	N/A	N/A	N/A	N/A	N/A
	Arkansas	4,513	4,966	5,295	4,980	4,864	3,893	4,413	5,219	6,853
	California	4,796	4,601	4,634	4,849	5,057	3,628	4,345	6,354	8,722
	Colorado	5,278	5,686	5,733	5,077	4,873	4,180	4,342	5,641	6,184
	Connecticut	5,312	5,213	5,227	5,096	4,969	4,085	4,392	5,911	6,302
	Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	District of Columbia	7,324	6,809	6,640	5,732	N/A	N/A	N/A	N/A	N/A
	Florida	5,316	5,521	5,212	5,177	5,512	4,665	5,057	6,060	7,550
	Georgia	5,241	5,317	5,168	5,260	5,965	4,255	4,563	6,272	6,547
	Hawaii	6,424	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Idaho	4,543	4,764	4,931	N/A	N/A	N/A	N/A	N/A	N/A
	Illinois	5,642	5,752	5,608	5,742	5,629	4,268	4,827	6,268	7,206
	Indiana	5,129	5,247	5,366	5,376	5,900	3,974	4,841	6,162	6,673
	Iowa	5,138	5,179	5,320	5,225	5,608	4,727	5,052	6,010	8,677
	Kansas	4,828	5,187	5,474	5,145	6,189	4,191	4,747	7,148	7,620
	Kentucky	5,020	4,724	5,125	5,123	5,287	3,697	4,250	5,597	6,077
	Louisiana	5,953	5,454	5,675	5,945	5,639	5,342	5,457	6,049	6,779
	Maine	4,734	4,899	5,376	5,829	5,579	4,666	4,766	6,084	7,743
	Maryland	4,792	4,751	4,570	4,674	4,732	4,371	4,475	5,028	6,165
	Massachusetts	4,287	4,051	3,881	3,572	3,729	2,866	3,389	4,827	7,473
	Michigan	4,584	4,596	4,601	4,661	4,445	3,685	4,027	5,126	5,570
	Minnesota	4,507	4,762	4,789	4,829	4,955	4,314	4,620	5,483	5,655
	Mississippi	5,682	5,425	6,235	6,080	N/A	N/A	N/A	N/A	N/A
	Missouri	5,266	5,474	5,833	5,621	6,440	4,327	5,681	6,797	7,413
	Montana	5,622	4,314	5,214	5,124	5,023	4,095	4,680	5,849	6,239
	Nebraska	6,027	5,412	5,358	5,272	5,678	4,648	5,113	6,225	7,362
	Nevada	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	New Hampshire	4,790	4,700	5,326	5,560	4,970	3,744	4,195	5,381	5,772
	New Jersey	4,756	4,742	4,848	4,993	4,904	4,132	4,583	5,648	7,021
	New Mexico	5,594	5,280	4,788	5,770	5,956	4,635	5,050	6,825	7,174
	New York	4,544	4,492	4,649	4,432	4,609	3,712	3,993	5,298	6,780
	North Carolina	5,219	5,537	5,100	5,099	5,364	4,541	4,704	6,456	7,072
	North Dakota	5,570	6,154	5,428	6,126	5,597	5,002	5,210	6,650	6,904
	Ohio	4,896	4,993	4,928	5,096	5,261	4,387	4,729	6,015	7,157
	Oklahoma	4,887	4,948	4,944	5,800	5,425	4,928	5,213	6,343	7,440
	Oregon	4,468	4,544	4,713	4,254	4,263	3,529	3,659	4,704	5,426
	Pennsylvania	4,499	4,492	4,433	4,651	4,252	3,388	3,777	5,203	6,554
	Rhode Island	4,283	4,263	4,192	4,297	N/A	N/A	N/A	N/A	N/A
	South Carolina	5,664	6,204	6,176	5,820	5,660	4,574	5,024	6,862	7,051
	South Dakota	6,084	N/A	6,197	6,257	N/A	N/A	N/A	N/A	N/A
	Tennessee	5,703	5,710	4,983	5,658	4,515	3,634	4,411	6,030	6,631
	Texas	4,964	5,763	5,606	5,119	5,424	4,448	4,891	6,964	8,097
	Utah	5,170	N/A	5,447	N/A	N/A	N/A	N/A	N/A	N/A
	Vermont	5,007	4,818	4,930	N/A	N/A	N/A	N/A	N/A	N/A
	Virginia	5,491	5,264	5,086	5,252	5,178	4,236	4,586	5,742	7,154
	Washington	4,725	4,646	4,467	4,357	4,366	3,687	3,962	4,956	6,211
	West Virginia	4,754	5,261	4,755	5,233	4,839	3,885	4,355	5,236	6,825
	Wisconsin	4,952	5,442	5,336	5,436	5,303	4,658	4,836	5,629	6,382
	Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Profitability Indicators

Profit per Discharge

		Median Values					1997 Percentile Values			
		1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration										
	High	-34.21	-1.66	14.74	-33.62	-54.86	-1,618.47	-477.37	227.88	461.85
	Medium	-103.20	-60.50	-36.27	-29.23	-55.92	-873.13	-314.89	214.31	593.63
	Low	-23.07	-18.85	-8.19	-13.42	10.32	-623.25	-179.70	245.00	443.39
States										
	Alabama	-28.96	-56.71	-93.33	39.58	14.35	-196.69	-35.79	109.10	335.68
	Alaska	-343.33	-173.94	-203.03	-180.45	-380.22	-1,627.17	-846.15	-36.32	85.59
	Arizona	256.75	155.42	143.61	221.94	N/A	N/A	N/A	N/A	N/A
	Arkansas	51.69	126.70	152.18	187.57	124.11	-13.00	64.12	319.21	471.05
	California	-75.91	-17.04	-80.02	-129.36	-402.48	-3,907.85	-1,539.22	133.03	432.02
	Colorado	209.23	50.29	90.02	239.48	234.09	-128.24	145.14	318.67	351.54
	Connecticut	-74.65	-121.44	-59.25	-29.43	-64.66	-453.97	-391.11	61.89	280.46
	Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	District of Columbia	-208.72	65.41	66.68	-1,371.89	N/A	N/A	N/A	N/A	N/A
	Florida	53.51	62.03	106.95	90.55	74.43	-619.30	-170.26	301.27	463.88
	Georgia	103.99	127.54	189.37	185.56	68.81	-256.06	-60.45	706.30	851.66
	Hawaii	-213.93	-237.89	-210.38	N/A	N/A	N/A	N/A	N/A	N/A
	Idaho	-52.18	65.96	73.81	N/A	N/A	N/A	N/A	N/A	N/A
	Illinois	14.23	52.14	104.36	52.26	68.45	-578.90	-191.54	257.56	447.33
	Indiana	139.64	122.76	158.90	206.32	116.10	-478.32	-90.43	324.19	547.50
	Iowa	-18.50	-2.05	-11.19	56.49	3.80	-424.56	-156.07	151.66	337.18
	Kansas	23.43	91.92	145.39	77.11	187.08	-50.98	36.19	271.64	659.84
	Kentucky	-26.10	0.28	57.32	190.21	164.73	1.95	82.01	241.52	285.44
	Louisiana	201.51	241.78	228.96	225.60	168.36	-249.07	-33.35	394.66	449.51
	Maine	-23.18	45.35	52.59	8.59	179.06	-150.42	-39.14	260.76	446.65
	Maryland	56.44	111.49	70.00	138.18	129.59	-131.93	56.50	278.64	376.84
	Massachusetts	-78.47	-84.48	-123.96	-125.60	-139.56	-1,080.21	-256.55	-52.48	14.85
	Michigan	32.10	30.88	117.11	125.29	157.20	-192.77	-71.84	320.61	432.55
	Minnesota	-14.01	37.50	67.88	41.23	47.41	-327.37	-35.97	165.36	309.06
	Mississippi	72.53	-2.92	0.44	58.20	N/A	N/A	N/A	N/A	N/A
	Missouri	-2.14	16.25	75.08	85.54	22.59	-1,001.48	-556.37	266.68	370.56
	Montana	120.76	50.69	126.02	286.61	263.42	-143.92	-124.71	408.51	458.22
	Nebraska	-16.23	70.38	126.55	105.76	143.94	-150.48	-3.87	226.74	269.26
	Nevada	76.38	133.11	532.05	N/A	N/A	N/A	N/A	N/A	N/A
	New Hampshire	-62.82	105.66	27.45	45.46	181.44	-174.53	34.86	184.44	192.53
	New Jersey	-26.43	-77.30	-130.80	-158.08	-116.40	-1,540.15	-1,014.18	51.92	112.50
	New Mexico	-94.24	170.80	82.22	336.12	244.51	-49.75	35.50	444.59	513.77
	New York	-188.80	-149.93	-181.45	-104.63	-143.82	-725.49	-473.21	-45.03	149.69
	North Carolina	82.93	87.58	180.23	226.96	220.45	-500.90	33.73	424.60	570.34
	North Dakota	3.62	-68.77	116.64	-49.23	132.94	-135.94	-32.97	217.18	589.18
	Ohio	19.17	29.70	64.43	38.78	71.12	-447.01	-191.04	315.26	532.73
	Oklahoma	56.66	10.26	-11.81	66.93	-16.29	-333.88	-89.10	265.23	338.49
	Oregon	24.18	52.58	77.23	79.44	122.86	-388.31	-70.71	302.50	483.86
	Pennsylvania	-61.06	-67.15	-61.45	-82.87	-23.21	-404.05	-130.07	74.52	165.61
	Rhode Island	-191.32	-218.22	-172.58	-174.85	N/A	N/A	N/A	N/A	N/A
	South Carolina	-25.84	90.38	282.38	138.54	246.94	70.77	128.35	411.62	442.72
	South Dakota	41.48	-201.04	100.92	-81.81	N/A	N/A	N/A	N/A	N/A
	Tennessee	-37.44	70.51	157.05	238.96	373.66	-270.28	136.78	599.42	747.31
	Texas	133.11	8.72	-46.54	45.49	105.35	-2,016.86	-593.53	315.70	429.33
	Utah	-115.57	N/A	44.85	N/A	N/A	N/A	N/A	N/A	N/A
	Vermont	-44.38	130.58	-21.58	31.38	N/A	N/A	N/A	N/A	N/A
	Virginia	115.01	171.88	265.94	218.39	358.07	34.80	134.57	464.36	721.36
	Washington	-21.93	77.52	14.47	-2.31	-41.86	-446.00	-279.84	246.72	482.13
	West Virginia	38.95	-1.24	43.17	72.65	62.66	-259.14	-88.11	196.46	561.58
	Wisconsin	79.94	99.70	149.60	140.67	121.87	-132.85	34.88	284.80	417.81
	Wyoming	58.04	214.58	-102.34	238.32	N/A	N/A	N/A	N/A	N/A

Intensity of Service Indicators

Cost per Visit (Adjusted for Wage Index)

	Median Values					1997 Percentile Values			
	1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration									
High	216.39	222.72	233.29	236.10	240.27	121.10	166.20	304.64	408.01
Medium	212.45	230.33	229.10	239.69	253.12	141.65	205.78	369.68	475.95
Low	200.66	212.36	210.30	208.22	220.99	109.47	160.60	295.25	418.94
States									
Alabama	368.57	368.93	400.51	356.24	320.35	130.69	201.12	430.29	477.79
Alaska	152.06	180.53	182.66	151.23	127.48	112.19	121.10	218.00	328.48
Arizona	171.70	249.23	269.21	257.28	N/A	N/A	N/A	N/A	N/A
Arkansas	317.76	356.28	385.60	479.52	402.86	331.00	391.48	434.08	534.67
California	170.31	180.03	189.61	186.02	177.56	109.61	140.65	251.50	324.32
Colorado	178.85	248.63	276.47	186.72	200.53	144.82	159.82	242.68	268.91
Connecticut	220.17	201.66	188.57	178.96	224.06	137.33	195.52	322.35	356.12
Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	195.69	357.76	291.99	245.52	N/A	N/A	N/A	N/A	N/A
Florida	263.28	286.46	285.96	290.01	308.95	221.47	258.44	367.94	416.64
Georgia	313.86	281.02	285.08	358.76	343.68	245.56	280.38	439.09	493.55
Hawaii	211.63	172.24	154.46	N/A	N/A	N/A	N/A	N/A	N/A
Idaho	236.47	200.15	253.06	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	213.58	226.17	236.80	235.49	253.95	156.45	194.54	345.18	409.43
Indiana	187.38	201.31	221.61	203.57	241.95	123.38	169.88	371.04	393.65
Iowa	181.72	199.66	220.68	217.45	245.72	126.78	181.42	337.14	449.98
Kansas	173.14	186.49	215.50	260.57	263.30	134.33	221.42	421.80	497.08
Kentucky	251.12	303.66	309.89	266.26	272.75	190.36	242.56	395.97	435.81
Louisiana	340.25	380.24	380.69	350.04	321.94	135.77	257.34	421.35	473.62
Maine	142.22	151.04	179.35	189.85	219.05	182.33	210.39	256.21	344.89
Maryland	197.56	222.25	193.84	290.52	252.33	106.02	161.61	309.14	348.57
Massachusetts	225.79	203.06	214.17	225.34	257.86	144.26	202.44	357.99	441.40
Michigan	220.16	214.03	209.39	197.04	210.90	133.74	159.82	245.83	300.72
Minnesota	232.51	297.28	268.92	254.39	254.35	190.23	206.48	384.18	459.67
Mississippi	428.17	278.80	424.00	371.70	N/A	N/A	N/A	N/A	N/A
Missouri	336.00	307.66	332.36	322.53	316.66	151.22	202.54	412.25	502.75
Montana	241.38	198.45	235.47	255.62	279.13	222.27	257.18	295.24	312.25
Nebraska	245.20	195.39	248.70	324.54	290.81	181.74	249.33	375.68	532.22
Nevada	203.63	252.68	231.09	N/A	N/A	N/A	N/A	N/A	N/A
New Hampshire	217.60	206.88	238.07	208.93	266.77	152.32	173.99	290.96	330.75
New Jersey	145.18	142.58	156.46	175.01	232.25	97.61	154.87	258.92	301.09
New Mexico	238.20	305.61	250.89	354.71	327.42	222.46	253.46	392.68	408.00
New York	155.94	167.17	169.34	183.58	170.10	118.60	145.87	235.90	387.71
North Carolina	263.70	279.88	294.86	327.83	332.89	192.90	227.45	446.16	508.91
North Dakota	367.62	337.62	310.22	448.68	503.78	381.95	415.15	660.02	767.41
Ohio	216.51	234.11	241.78	243.49	259.16	177.45	224.83	362.09	394.92
Oklahoma	367.26	357.85	359.13	371.88	340.88	304.34	324.23	528.34	584.84
Oregon	220.25	201.84	191.43	248.57	214.89	100.96	116.58	294.56	314.14
Pennsylvania	170.74	170.73	185.64	187.47	196.17	127.04	167.67	241.84	277.68
Rhode Island	236.68	291.24	285.47	349.44	N/A	N/A	N/A	N/A	N/A
South Carolina	245.84	275.25	281.31	304.15	286.62	160.17	220.34	340.75	371.86
South Dakota	281.51	307.06	247.88	185.81	N/A	N/A	N/A	N/A	N/A
Tennessee	286.14	273.83	298.45	276.28	294.60	212.91	245.53	442.26	546.44
Texas	293.79	306.92	290.88	294.52	291.74	189.79	246.97	377.51	396.79
Utah	174.06	N/A	133.34	N/A	N/A	N/A	N/A	N/A	N/A
Vermont	194.50	185.63	160.87	227.97	N/A	N/A	N/A	N/A	N/A
Virginia	233.33	242.72	249.12	263.83	259.52	189.82	207.68	325.87	366.75
Washington	223.24	227.49	241.17	244.29	252.54	142.05	192.13	316.21	355.49
West Virginia	219.41	222.54	207.80	195.22	183.87	135.96	158.02	264.89	286.00
Wisconsin	245.00	213.72	222.76	237.93	266.27	175.84	225.43	324.33	425.62
Wyoming	228.61	331.34	225.88	268.75	N/A	N/A	N/A	N/A	N/A

Net Price per Visit (Adjusted for Wage Index)

	Median Values					1997 Percentile Values			
	1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration									
High	207.65	216.18	228.02	231.39	228.77	118.02	163.82	306.97	396.50
Medium	209.69	231.67	226.04	231.25	262.66	133.15	206.49	365.31	468.95
Low	194.80	210.00	200.44	203.63	215.32	108.08	170.54	304.88	417.72
States									
Alabama	370.48	351.20	409.85	356.45	332.43	131.00	210.87	431.32	483.79
Alaska	140.45	165.02	185.58	151.95	124.73	88.38	102.05	201.12	327.11
Arizona	176.02	266.61	275.33	238.89	N/A	N/A	N/A	N/A	N/A
Arkansas	316.52	362.18	384.33	495.16	414.33	335.30	397.16	462.95	608.78
California	159.22	186.00	176.57	184.29	167.36	103.84	121.61	220.15	272.80
Colorado	194.02	232.04	284.22	190.55	211.47	153.45	166.08	237.68	269.97
Connecticut	237.99	195.24	181.81	179.24	235.05	138.70	198.58	321.51	352.54
Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	161.94	311.02	311.75	240.53	N/A	N/A	N/A	N/A	N/A
Florida	261.86	288.00	285.48	296.79	297.08	223.77	241.61	369.06	402.38
Georgia	307.89	266.18	296.45	382.35	367.58	240.47	274.80	437.28	509.31
Hawaii	216.49	171.96	152.29	N/A	N/A	N/A	N/A	N/A	N/A
Idaho	243.25	201.59	253.28	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	210.64	226.47	237.13	233.21	252.33	153.46	177.16	353.37	414.82
Indiana	194.41	192.99	231.88	206.77	247.57	110.88	176.20	349.69	411.97
Iowa	184.61	191.31	222.31	230.62	247.08	124.48	174.71	343.45	447.85
Kansas	176.04	195.38	222.02	276.03	269.82	137.94	227.98	435.74	520.41
Kentucky	247.37	302.67	302.60	271.45	267.58	200.62	247.68	416.35	443.96
Louisiana	348.24	389.32	384.40	364.31	320.13	119.60	272.43	428.53	471.62
Maine	143.70	151.84	184.17	182.19	232.43	181.29	202.15	258.62	351.49
Maryland	208.53	222.37	200.50	302.41	267.96	115.89	159.47	316.32	363.08
Massachusetts	215.85	197.16	192.34	219.25	255.82	144.39	201.64	347.89	431.84
Michigan	220.64	215.30	210.90	204.31	209.04	136.42	166.07	244.70	310.20
Minnesota	229.88	299.72	302.93	253.09	268.70	193.93	217.33	384.76	471.03
Mississippi	451.33	282.28	433.87	376.33	N/A	N/A	N/A	N/A	N/A
Missouri	346.84	308.78	334.94	331.66	318.57	130.00	208.18	400.11	452.61
Montana	231.03	195.48	257.03	280.79	293.39	221.38	253.97	308.01	330.81
Nebraska	213.94	188.67	247.05	290.89	295.57	192.78	262.68	345.54	548.33
Nevada	202.35	256.45	257.39	N/A	N/A	N/A	N/A	N/A	N/A
New Hampshire	220.48	206.48	236.45	202.30	251.65	155.06	179.53	302.65	342.93
New Jersey	145.81	138.70	151.30	183.03	227.20	92.03	156.05	256.73	287.80
New Mexico	258.94	340.09	266.97	388.17	356.29	234.63	280.28	407.55	408.88
New York	149.62	163.02	165.27	180.14	177.89	112.11	133.98	228.69	340.74
North Carolina	259.87	296.25	303.37	340.59	335.52	178.02	230.30	466.98	558.74
North Dakota	375.88	336.54	305.77	437.01	520.73	283.58	412.93	720.08	836.24
Ohio	222.43	237.15	246.78	243.08	271.53	181.47	227.18	344.41	397.28
Oklahoma	375.56	374.07	356.49	368.22	378.38	286.38	308.30	560.46	604.84
Oregon	214.13	214.78	195.60	251.80	193.84	102.77	122.49	304.77	322.24
Pennsylvania	169.03	175.24	188.09	181.66	194.29	128.33	172.84	238.66	274.26
Rhode Island	230.34	271.20	277.37	333.78	N/A	N/A	N/A	N/A	N/A
South Carolina	259.97	271.92	282.89	293.79	301.41	174.33	234.70	348.55	388.86
South Dakota	261.78	300.39	254.23	162.14	N/A	N/A	N/A	N/A	N/A
Tennessee	285.65	288.96	322.48	281.96	306.23	221.32	238.82	498.72	628.10
Texas	297.15	294.69	288.30	285.55	284.18	171.07	241.57	362.19	399.26
Utah	177.83	N/A	126.48	N/A	N/A	N/A	N/A	N/A	N/A
Vermont	191.27	184.97	165.58	222.00	N/A	N/A	N/A	N/A	N/A
Virginia	234.83	250.59	262.68	280.07	282.37	211.16	228.14	343.74	379.87
Washington	224.49	228.36	239.61	239.33	233.02	136.67	181.57	292.10	380.13
West Virginia	225.39	217.55	206.82	200.73	189.86	139.80	155.22	259.75	290.04
Wisconsin	244.57	212.33	229.78	230.32	271.13	188.74	226.00	332.63	441.32
Wyoming	194.97	322.20	209.11	247.93	N/A	N/A	N/A	N/A	N/A

Profitability Indicators

Profit per Visit

		Median Values					1997 Percentile Values			
		1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration										
	High	-1.29	0.80	0.76	-1.26	-1.25	-44.64	-15.90	10.30	22.58
	Medium	-2.74	-2.05	-1.28	-1.17	-2.02	-22.71	-9.95	9.28	20.76
	Low	-0.74	-0.31	-0.41	-0.83	0.17	-22.19	-6.83	6.60	16.23
States										
	Alabama	-2.03	-1.13	-6.09	1.63	0.94	-5.99	-0.28	6.55	10.69
	Alaska	-3.13	-6.95	-4.84	-6.75	-17.83	-37.83	-27.41	-0.43	2.76
	Arizona	6.61	10.64	7.52	9.61	N/A	N/A	N/A	N/A	N/A
	Arkansas	2.96	7.14	5.94	12.31	9.77	-0.07	5.30	21.78	52.90
	California	-2.63	0.36	-2.77	-3.64	-8.07	-86.98	-39.19	1.56	10.01
	Colorado	5.77	1.96	5.96	9.60	9.13	-2.82	4.54	11.55	11.71
	Connecticut	-2.83	-4.39	-3.91	-1.16	0.98	-10.19	-4.29	5.86	9.59
	Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	District of Columbia	-4.05	1.43	6.73	-45.86	N/A	N/A	N/A	N/A	N/A
	Florida	2.13	2.82	3.30	5.13	3.50	-30.41	-9.00	10.15	13.74
	Georgia	3.17	6.56	10.81	8.87	2.40	-17.47	-9.03	25.18	35.97
	Hawaii	-2.42	-2.38	-2.44	N/A	N/A	N/A	N/A	N/A	N/A
	Idaho	-0.11	3.59	2.48	N/A	N/A	N/A	N/A	N/A	N/A
	Illinois	0.40	2.20	2.68	2.42	1.88	-19.84	-5.63	11.56	26.31
	Indiana	4.36	5.15	7.19	7.37	3.12	-26.25	-4.28	11.69	26.42
	Iowa	-0.84	-0.93	-0.37	-1.19	-0.97	-15.60	-4.49	9.08	17.09
	Kansas	2.83	3.39	13.52	4.09	5.35	-0.70	1.11	19.47	21.99
	Kentucky	-1.45	-0.04	4.98	8.92	8.52	-4.02	3.84	15.64	23.68
	Louisiana	10.69	11.87	11.01	11.56	5.31	-18.46	-2.13	7.09	15.42
	Maine	-1.04	1.27	2.29	0.17	2.29	-5.33	-2.40	9.37	12.16
	Maryland	2.47	5.27	3.51	7.83	3.56	-6.01	-2.19	12.47	15.64
	Massachusetts	-2.10	-2.63	-5.46	-4.77	-9.40	-39.68	-13.47	-1.72	2.40
	Michigan	1.34	1.28	3.79	3.66	4.00	-9.33	-4.91	10.41	17.12
	Minnesota	0.03	1.51	3.84	4.12	6.49	-15.65	-1.17	10.13	19.71
	Mississippi	3.85	1.91	-0.40	7.56	N/A	N/A	N/A	N/A	N/A
	Missouri	0.37	1.57	3.12	6.02	0.68	-37.67	-15.05	11.74	20.95
	Montana	5.95	-4.86	10.27	15.50	4.42	-8.11	-6.63	18.66	21.09
	Nebraska	-0.40	3.05	6.55	6.81	8.01	-19.14	-0.01	12.99	16.76
	Nevada	3.13	7.06	18.47	N/A	N/A	N/A	N/A	N/A	N/A
	New Hampshire	-1.54	2.99	2.30	1.61	7.19	-6.08	2.16	12.43	15.46
	New Jersey	-0.03	-1.61	-2.93	-4.35	-3.18	-44.77	-16.63	1.92	2.61
	New Mexico	-5.23	11.71	3.56	18.95	11.49	-5.66	-0.42	22.36	25.73
	New York	-5.82	-5.41	-6.65	-3.76	-4.81	-17.70	-10.55	-1.71	3.81
	North Carolina	4.23	6.51	14.20	11.74	14.97	-15.46	1.89	27.44	32.06
	North Dakota	2.31	-1.94	5.01	-5.32	10.63	-42.52	-7.01	33.07	50.98
	Ohio	0.95	1.38	3.36	2.83	3.88	-18.18	-5.30	11.75	20.70
	Oklahoma	4.70	0.88	3.93	1.10	-0.98	-12.26	-7.33	19.21	28.04
	Oregon	1.65	2.54	4.27	5.39	5.42	-13.18	-1.33	13.14	20.19
	Pennsylvania	-1.97	-2.47	-1.32	-3.08	-0.34	-11.87	-4.21	3.62	8.78
	Rhode Island	-8.17	-22.32	-3.78	-17.36	N/A	N/A	N/A	N/A	N/A
	South Carolina	0.20	2.86	14.34	9.51	9.28	2.44	4.65	14.55	26.73
	South Dakota	0.71	-7.49	4.06	-1.40	N/A	N/A	N/A	N/A	N/A
	Tennessee	-1.49	2.02	7.07	10.24	18.84	-9.68	4.49	43.07	66.03
	Texas	8.37	1.95	0.23	1.00	5.55	-90.29	-23.93	16.03	17.93
	Utah	-5.46	N/A	1.07	N/A	N/A	N/A	N/A	N/A	N/A
	Vermont	-1.44	-0.09	-1.10	1.39	N/A	N/A	N/A	N/A	N/A
	Virginia	5.26	6.11	10.24	7.45	14.76	1.23	5.63	23.69	36.79
	Washington	-0.35	2.47	2.14	0.49	-0.48	-23.96	-9.10	15.45	24.54
	West Virginia	1.69	-0.06	1.43	1.80	2.57	-14.56	-5.01	7.34	16.56
	Wisconsin	3.23	3.62	5.15	5.22	6.64	-3.46	1.56	15.16	22.06
	Wyoming	-4.07	-10.36	0.95	15.44	N/A	N/A	N/A	N/A	N/A

Efficiency Indicators

FTEs per Occupied Bed

		Median Values					1997 Percentile Values			
		1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration										
	High	5.37	5.56	5.69	5.66	5.96	4.60	5.33	7.27	8.25
	Medium	4.71	4.95	5.21	5.33	5.60	3.98	4.75	6.53	7.44
	Low	4.76	4.82	5.03	5.10	5.22	3.97	4.43	6.22	7.13
States										
	Alabama	4.77	5.22	5.05	5.31	5.31	4.24	4.55	6.09	6.13
	Alaska	6.19	6.40	7.18	6.71	8.16	6.57	7.45	9.22	10.87
	Arizona	6.15	5.45	5.59	5.87	N/A	N/A	N/A	N/A	N/A
	Arkansas	4.62	4.35	4.51	4.75	5.39	3.95	4.40	5.94	6.42
	California	5.73	5.78	6.17	5.84	6.72	4.59	5.49	7.90	10.05
	Colorado	6.27	6.52	5.78	6.25	6.50	5.57	5.85	7.77	8.18
	Connecticut	4.74	5.00	5.30	5.86	5.42	4.89	5.22	6.08	6.84
	Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Distict of Columbia	5.33	5.65	6.11	5.58	N/A	N/A	N/A	N/A	N/A
	Florida	4.67	4.98	5.01	5.14	5.45	4.70	4.93	6.03	7.09
	Georgia	5.24	5.39	5.26	5.44	5.73	4.57	5.46	6.25	7.45
	Hawaii	4.98	4.79	5.13	N/A	N/A	N/A	N/A	N/A	N/A
	Idaho	5.59	5.44	6.35	N/A	N/A	N/A	N/A	N/A	N/A
	Illinois	5.05	5.12	5.53	5.77	5.90	4.50	5.02	7.02	7.69
	Indiana	5.45	5.48	5.82	5.77	6.54	5.29	5.83	7.08	7.38
	Iowa	5.09	5.00	5.55	6.43	6.19	4.16	5.23	7.38	9.99
	Kansas	5.48	5.18	5.53	6.47	5.98	5.25	5.46	6.59	7.55
	Kentucky	4.41	4.33	4.49	4.80	4.54	3.65	4.19	5.34	5.78
	Louisiana	5.30	5.41	5.62	5.91	6.80	4.21	6.27	7.22	8.29
	Maine	5.27	5.94	5.45	6.08	5.94	4.49	5.40	6.60	6.93
	Maryland	4.37	4.65	4.83	4.87	5.38	4.78	5.17	5.76	6.17
	Massachusetts	4.01	4.42	4.56	4.36	4.82	3.29	3.59	6.10	7.00
	Michigan	4.95	5.22	5.08	5.74	5.73	4.38	5.12	6.28	8.40
	Minnesota	5.70	5.64	5.68	5.70	6.43	4.48	5.53	8.20	10.63
	Mississippi	4.80	4.67	4.61	5.45	N/A	N/A	N/A	N/A	N/A
	Missouri	5.08	5.54	5.90	5.55	5.78	4.15	4.56	6.72	7.88
	Montana	5.93	5.78	5.71	5.91	7.02	4.10	5.44	8.96	12.19
	Nebraska	6.13	5.75	5.81	6.18	6.26	4.00	5.44	7.73	8.80
	Nevada	5.79	5.63	4.80	N/A	N/A	N/A	N/A	N/A	N/A
	New Hampshire	5.44	4.92	6.18	6.08	6.06	4.79	5.57	6.53	7.26
	New Jersey	4.38	4.48	4.72	4.85	4.84	4.00	4.54	5.17	5.85
	New Mexico	5.41	5.59	5.52	5.68	5.62	4.28	4.93	6.24	6.75
	New York	3.92	4.21	4.23	4.43	4.27	3.49	3.85	5.82	7.73
	North Carolina	4.63	4.67	4.69	4.68	4.83	3.85	4.42	5.55	7.29
	North Dakota	5.12	5.14	5.04	5.81	5.96	3.99	4.37	8.96	11.05
	Ohio	5.05	5.26	5.45	5.48	5.64	4.75	5.22	6.64	7.29
	Oklahoma	5.18	5.06	5.23	6.00	5.26	4.61	4.98	5.76	6.87
	Oregon	6.05	6.36	6.17	6.32	6.60	5.29	5.53	7.48	8.59
	Pennsylvania	4.38	4.50	4.68	4.82	4.74	3.78	4.20	5.57	8.40
	Rhode Island	4.33	4.95	5.04	5.22	N/A	N/A	N/A	N/A	N/A
	South Carolina	4.62	4.36	4.66	4.75	4.98	4.49	4.83	5.35	6.07
	South Dakota	5.82	6.04	6.03	6.30	N/A	N/A	N/A	N/A	N/A
	Tennessee	5.25	4.95	5.15	5.37	5.07	4.30	4.87	5.58	6.71
	Texas	5.01	5.29	5.36	5.33	5.68	4.73	5.25	6.62	9.53
	Utah	7.03	N/A	6.93	N/A	N/A	N/A	N/A	N/A	N/A
	Vermont	5.01	4.61	5.05	5.83	N/A	N/A	N/A	N/A	N/A
	Virginia	4.85	4.91	5.27	5.01	5.51	4.37	4.78	5.99	6.79
	Washington	5.95	6.18	5.90	6.08	6.17	4.99	5.47	7.13	8.76
	West Virginia	4.47	4.40	4.56	4.71	5.19	4.00	4.37	5.82	6.65
	Wisconsin	5.03	5.17	5.39	5.69	5.75	4.71	5.07	6.48	7.24
	Wyoming	6.21	6.28	N/A	6.69	N/A	N/A	N/A	N/A	N/A

Financial Flexibility Index

Definition

The Financial Flexibility Index is a composite of seven financial ratios that measure a firm's ability to control funds flow. It is intended to give a measure of the overall financial health of a firm. Caution should be exercised in the use of this measure because, at the present time, all seven dimensions are weighted equally. Some aspects, such as profitability, would clearly justify greater weight.

Trends

The Financial Flexibility Index median tracks closely with the general trend in profitability. Profitability has a pervasive effect upon almost any dimension of financial performance. This year's increase in the Financial Flexibility Index is attributable to the improvement in Total Margins and the increases in Replacement Viability.

Strong regional differences in the Financial Flexibility Index exist. The Northeast region has the lowest values, largely due to lower profits coupled with higher leverage.

Rural hospitals have a relatively strong Financial Flexibility Index that results primarily from low levels of debt.

A strong relationship between bond rating categories and Financial Flexibility Index values can be seen.

Performance Implications

High-performance hospitals have much higher Financial Flexibility Index values than do low-performance hospitals. This is to be expected, since high-performance hospitals have better relative performance in each of the individual areas that comprise the Financial Flexibility Index.

Forecast

Financial Flexibility Index values are expected to increase slightly during the next five years. Reduced reliance upon debt financing, coupled with increasing liquidity, will provide the source for modest improvement in Financial Flexibility. Values for the Financial Flexibility Index should reach 4.0 within five years.

Other Financial Ratios

Financial Flexibility Index

		Median Values					1997 Percentile Values			
		1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration										
	High	1.453	1.265	2.229	2.173	2.838	-2.546	0.154	6.734	9.717
	Medium	0.744	0.716	1.681	2.400	2.951	-2.586	0.064	6.159	9.817
	Low	2.395	2.052	2.697	2.155	3.311	-2.709	-0.091	7.198	11.255
States										
	Alabama	3.590	3.488	4.619	4.277	3.618	-0.166	0.688	6.124	7.587
	Alaska	1.702	1.240	1.782	2.205	3.132	-5.091	-0.313	11.664	20.323
	Arizona	1.336	1.199	0.609	3.965	5.813	-3.579	1.513	10.289	12.299
	Arkansas	1.017	2.716	3.707	4.244	5.188	3.445	4.892	6.046	9.416
	California	1.812	1.455	2.201	2.653	2.583	-3.218	-1.153	6.447	8.945
	Colorado	3.776	3.372	5.735	5.735	7.594	3.319	5.127	11.022	14.561
	Connecticut	0.323	-0.424	1.023	3.431	4.876	-2.460	1.670	6.693	9.127
	Delaware	3.685	3.535	4.376	N/A	N/A	N/A	N/A	N/A	N/A
	District of Columbia	-0.883	-1.782	-1.068	-1.585	N/A	N/A	N/A	N/A	N/A
	Florida	3.175	2.337	2.597	2.220	3.142	-1.476	0.248	7.127	9.675
	Georgia	2.068	5.785	6.199	7.354	6.266	0.110	2.371	9.902	11.727
	Hawaii	2.763	1.170	0.709	-4.885	-18.857	-35.069	-26.601	-8.638	0.312
	Idaho	4.559	3.648	5.056	5.653	1.690	-2.482	-1.071	4.896	6.301
	Illinois	1.844	1.808	2.642	2.166	3.752	-0.416	0.982	7.648	10.718
	Indiana	3.130	2.614	3.498	3.733	3.822	-4.771	0.539	9.121	13.252
	Iowa	1.606	3.239	2.511	4.336	5.450	-0.557	1.750	8.472	9.855
	Kansas	3.301	2.443	2.106	2.107	4.380	0.248	0.831	7.223	13.896
	Kentucky	1.209	1.699	2.935	3.126	8.071	2.213	5.256	9.142	12.274
	Louisiana	3.006	3.091	3.350	4.138	4.125	0.427	1.643	7.106	9.409
	Maine	0.630	1.113	2.349	1.785	3.902	-0.914	1.588	7.001	11.876
	Maryland	2.172	2.337	1.829	2.898	1.856	-3.943	-0.924	5.050	6.974
	Massachusetts	-0.072	-0.412	0.097	1.043	2.233	-2.153	0.970	4.882	10.798
	Michigan	0.644	1.155	2.390	1.509	2.885	-2.706	-1.031	6.754	10.253
	Minnesota	0.743	2.853	2.699	2.601	4.055	-1.758	-0.451	6.621	8.782
	Mississippi	3.452	0.215	2.990	5.387	2.310	-0.196	0.521	4.948	7.193
	Missouri	2.874	1.769	3.646	3.068	3.374	-2.419	-0.756	11.756	15.693
	Montana	3.446	3.082	4.749	6.777	4.803	-4.197	0.145	9.921	11.185
	Nebraska	2.708	4.036	4.173	4.063	4.113	-3.938	1.225	7.295	14.736
	Nevada	0.443	0.687	2.407	1.688	1.552	-4.497	-2.731	6.947	9.218
	New Hampshire	0.381	3.775	4.576	5.287	6.080	3.523	4.720	7.170	8.622
	New Jersey	1.081	0.915	1.209	0.011	0.805	-3.756	-1.438	3.692	6.851
	New Mexico	1.400	3.342	2.230	6.873	11.233	5.498	7.293	15.557	18.043
	New York	-2.340	-2.201	-1.751	-0.721	-1.891	-5.097	-3.667	1.889	4.799
	North Carolina	3.619	3.808	4.704	6.085	6.394	1.800	3.203	10.713	12.481
	North Dakota	1.430	2.335	1.323	1.398	1.427	-2.964	-0.409	5.012	9.322
	Ohio	1.469	1.815	2.556	3.253	4.570	-1.596	1.696	8.137	14.398
	Oklahoma	0.018	-0.324	-0.302	0.026	0.196	-9.707	-4.926	4.332	9.937
	Oregon	2.354	3.616	2.868	1.887	4.499	-1.633	0.183	9.467	13.820
	Pennsylvania	0.817	0.845	1.531	1.331	2.316	-1.045	0.314	5.544	10.029
	Rhode Island	-1.203	-1.303	-0.027	1.165	1.555	-1.000	0.586	2.217	3.580
	South Carolina	6.668	5.420	6.940	8.892	7.180	-3.506	5.231	12.992	15.903
	South Dakota	1.133	0.791	2.010	1.930	N/A	N/A	N/A	N/A	N/A
	Tennessee	0.542	2.256	3.217	3.257	4.737	0.464	2.197	8.060	18.481
	Texas	2.308	2.814	3.487	3.076	2.655	-0.364	1.862	5.678	9.238
	Utah	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vermont	2.606	1.775	1.625	2.806	5.331	2.708	3.745	5.696	9.214
	Virginia	3.779	2.772	4.202	5.598	6.634	1.394	4.401	9.505	11.189
	Washington	1.867	2.125	3.358	2.396	2.445	-1.157	0.342	6.283	9.379
	West Virginia	-0.615	-0.606	-0.320	0.031	2.597	-5.388	-3.140	6.449	9.616
	Wisconsin	1.509	2.121	2.868	3.641	4.556	0.135	1.275	7.632	9.689
	Wyoming	-1.517	0.945	-1.852	0.663	N/A	N/A	N/A	N/A	N/A

Profitability Ratios

Total Margin

		Median Values					1997 Percentile Values			
		1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration										
	High	3.1	4.0	4.6	3.9	5.1	-1.3	2.0	8.8	13.6
	Medium	2.9	2.6	3.8	3.5	4.4	-1.2	2.1	7.8	11.0
	Low	3.7	3.6	4.2	3.9	5.2	-1.7	2.3	9.0	12.6
States										
	Alabama	4.6	4.1	4.8	6.1	6.4	3.6	4.1	8.7	9.8
	Alaska	0.3	0.8	4.0	3.5	4.7	-15.0	-6.3	10.6	11.9
	Arizona	4.7	3.9	3.9	6.8	5.4	-7.8	-1.3	14.8	17.1
	Arkansas	3.1	6.6	5.9	7.0	9.3	3.7	4.5	10.5	14.5
	California	3.1	4.0	4.5	3.3	4.3	-4.7	1.0	8.3	14.2
	Colorado	5.1	5.1	6.7	6.1	6.1	2.5	3.5	10.2	13.9
	Connecticut	2.0	1.0	2.8	3.6	4.2	-0.6	2.4	7.1	11.6
	Delaware	2.9	4.9	5.6	N/A	N/A	N/A	N/A	N/A	N/A
	District of Columbia	1.3	1.0	-0.8	1.3	N/A	N/A	N/A	N/A	N/A
	Florida	3.9	3.9	5.1	-2.0	6.0	2.5	3.9	8.8	10.9
	Georgia	4.8	6.8	7.0	8.0	8.4	1.7	3.4	9.4	12.7
	Hawaii	2.1	2.6	2.4	-1.3	-31.6	-89.6	-73.4	-5.4	0.7
	Idaho	5.0	5.1	5.5	8.8	5.5	1.8	3.2	8.0	9.1
	Illinois	4.7	5.0	5.4	5.2	5.8	1.1	3.3	9.2	13.9
	Indiana	5.8	4.8	5.8	6.7	6.2	-0.6	3.6	11.6	16.1
	Iowa	4.1	5.9	5.4	6.0	6.5	2.5	5.2	8.5	11.3
	Kansas	3.0	3.2	3.7	4.1	5.0	2.5	3.6	9.1	11.7
	Kentucky	3.6	3.7	7.4	4.2	7.1	5.2	5.5	9.9	10.3
	Louisiana	6.2	7.9	7.7	7.1	7.0	-1.1	4.3	9.9	10.7
	Maine	2.2	2.3	3.8	4.5	7.1	1.8	3.8	8.7	11.8
	Maryland	3.4	3.5	4.6	4.9	5.0	-0.9	1.8	8.2	12.1
	Massachusetts	1.7	1.3	2.4	3.5	5.0	0.3	2.6	6.4	8.8
	Michigan	3.3	3.3	4.1	3.9	4.9	-2.2	2.5	8.4	12.4
	Minnesota	3.1	4.4	5.6	4.8	5.9	0.2	2.4	8.8	12.3
	Mississippi	4.8	3.6	4.9	8.3	5.6	-0.2	4.2	9.1	12.5
	Missouri	4.1	4.1	6.0	5.3	4.5	-1.6	-0.3	9.5	12.2
	Montana	6.3	4.7	6.5	7.5	10.3	-2.0	3.0	10.8	12.1
	Nebraska	4.2	5.4	5.5	6.0	5.2	-5.1	2.0	9.0	12.3
	Nevada	5.1	5.0	4.8	5.9	4.5	-2.9	-1.9	8.5	12.4
	New Hampshire	3.0	6.0	6.0	6.6	6.7	2.9	5.9	9.6	11.0
	New Jersey	3.9	2.7	3.5	2.2	3.0	-3.2	-0.4	4.9	8.0
	New Mexico	4.6	5.7	4.3	7.4	8.9	6.6	7.4	10.0	12.6
	New York	0.9	1.3	1.9	2.4	2.2	-5.1	0.5	3.9	7.4
	North Carolina	4.9	4.8	6.5	8.3	7.9	3.7	4.9	12.1	15.7
	North Dakota	3.5	3.7	4.3	2.7	3.4	-4.2	-1.3	7.4	9.1
	Ohio	3.8	4.0	5.7	5.2	7.8	0.6	3.1	11.3	14.8
	Oklahoma	2.1	2.4	2.5	2.4	2.7	-11.2	-2.1	5.1	6.7
	Oregon	4.9	5.1	5.0	5.8	4.9	-1.3	1.2	10.4	13.1
	Pennsylvania	2.6	2.8	3.6	2.9	4.7	-0.6	2.8	7.0	9.9
	Rhode Island	1.1	0.3	2.2	2.2	3.2	0.7	2.1	4.7	5.8
	South Carolina	8.2	7.3	9.9	13.1	10.7	-5.9	1.3	12.4	14.0
	South Dakota	6.1	5.6	6.1	6.6	11.6	9.1	10.7	13.0	15.5
	Tennessee	3.8	4.4	5.6	5.8	9.3	2.1	5.1	12.0	17.5
	Texas	6.2	4.7	5.1	5.8	6.7	-1.2	3.1	9.3	11.6
	Utah	2.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vermont	4.0	3.5	3.8	3.1	6.9	4.4	4.9	7.9	11.2
	Virginia	4.9	4.8	8.4	8.2	7.6	1.5	4.1	11.8	12.9
	Washington	4.6	4.6	6.2	6.1	6.0	1.3	2.8	9.9	11.6
	West Virginia	3.3	2.6	3.8	3.4	5.8	-11.3	-0.6	9.8	13.2
	Wisconsin	4.3	5.7	6.7	6.9	7.9	3.2	5.3	9.7	11.8
	Wyoming	0.5	3.3	3.0	3.4	6.8	-1.3	3.8	7.5	8.3

Liquidity Ratios

Current Ratio

	Median Values					1997 Percentile Values			
	1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration									
High	1.83	1.81	1.83	1.67	1.86	0.99	1.25	2.59	3.61
Medium	1.68	1.63	1.83	1.63	1.66	1.00	1.27	2.23	3.04
Low	1.78	1.78	1.74	1.76	1.79	0.92	1.37	2.42	3.31
States									
Alabama	2.31	2.77	2.61	2.07	2.78	1.73	1.93	3.05	4.52
Alaska	2.40	2.27	2.45	2.83	3.17	1.53	2.19	3.79	5.59
Arizona	1.99	1.91	2.44	2.40	2.69	1.98	2.19	3.86	4.48
Arkansas	2.78	2.76	3.23	2.70	3.77	1.61	2.34	4.47	5.06
California	1.72	1.71	1.80	1.61	1.67	0.88	1.15	2.43	3.55
Colorado	2.01	1.91	1.79	1.86	1.70	1.01	1.45	1.79	1.96
Connecticut	1.79	1.68	1.62	1.71	1.68	1.04	1.27	1.97	2.71
Delaware	1.90	1.92	1.96	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	1.91	1.67	1.58	1.59	N/A	N/A	N/A	N/A	N/A
Florida	2.03	2.04	1.95	1.81	1.76	0.97	1.33	2.25	2.98
Georgia	2.08	2.47	2.61	2.23	2.50	1.78	2.02	2.79	4.54
Hawaii	1.07	1.01	1.01	0.91	0.99	0.43	0.66	2.63	3.70
Idaho	2.35	3.03	2.16	2.27	2.72	1.59	2.01	3.64	3.95
Illinois	2.18	2.28	2.25	2.27	2.37	1.38	2.04	3.13	3.98
Indiana	1.96	1.99	2.10	2.21	2.61	1.11	1.79	3.12	3.68
Iowa	2.14	2.11	2.05	2.13	2.33	1.45	1.63	2.70	3.31
Kansas	2.79	2.47	2.44	2.43	2.25	1.62	1.80	2.82	3.50
Kentucky	2.18	2.27	2.45	2.21	2.43	1.57	1.85	3.16	3.58
Louisiana	2.35	2.54	2.26	2.06	2.59	1.36	1.65	2.96	3.75
Maine	1.55	1.55	1.47	1.54	1.45	0.92	1.00	1.98	2.68
Maryland	1.77	1.76	1.91	2.20	1.76	1.14	1.54	2.28	3.45
Massachusetts	1.36	1.34	1.30	1.37	1.42	0.86	1.20	1.76	2.57
Michigan	1.63	1.78	1.71	1.63	1.68	0.75	1.20	2.12	2.83
Minnesota	2.00	1.99	1.97	2.03	2.05	1.35	1.63	2.75	3.35
Mississippi	2.90	3.79	3.72	3.04	2.64	2.21	2.27	3.00	3.38
Missouri	2.25	2.13	2.15	2.17	2.30	1.32	1.52	2.81	3.65
Montana	2.36	2.41	2.71	2.44	2.31	1.82	2.13	2.99	3.49
Nebraska	2.32	2.48	2.59	2.55	2.35	1.34	1.83	3.62	4.99
Nevada	2.36	2.25	2.81	2.73	3.06	1.37	1.76	3.65	3.86
New Hampshire	1.91	2.15	2.31	2.19	1.76	1.33	1.37	2.48	3.02
New Jersey	1.63	1.58	1.68	1.66	1.88	1.02	1.33	2.36	2.93
New Mexico	1.85	2.24	2.20	2.71	2.81	1.74	2.02	3.13	3.35
New York	1.25	1.29	1.25	1.41	1.40	0.98	1.14	1.73	2.05
North Carolina	2.52	2.47	2.42	2.05	2.06	1.37	1.63	2.68	3.57
North Dakota	2.41	2.65	2.49	2.44	2.27	1.16	1.86	2.86	3.27
Ohio	1.98	1.98	1.86	1.75	2.13	1.27	1.50	2.76	3.96
Oklahoma	2.68	2.68	2.38	2.40	2.40	1.08	1.63	3.17	4.43
Oregon	2.10	1.35	2.06	2.00	1.94	1.13	1.35	2.81	3.12
Pennsylvania	1.73	1.69	1.76	1.87	1.64	0.94	1.29	2.09	2.71
Rhode Island	1.46	1.29	1.49	1.64	1.78	1.40	1.46	1.95	2.29
South Carolina	2.76	2.89	3.24	2.88	2.44	1.46	1.82	4.22	6.64
South Dakota	2.24	2.03	2.00	1.88	2.22	1.25	1.76	2.40	2.41
Tennessee	2.18	2.36	2.06	2.48	2.64	1.27	1.60	3.98	4.79
Texas	2.29	2.20	2.23	2.04	1.92	1.46	1.72	3.49	4.42
Utah	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vermont	1.70	1.88	1.69	1.71	1.93	1.12	1.64	2.04	3.05
Virginia	2.30	2.22	2.41	2.35	2.50	1.00	1.55	3.35	4.14
Washington	1.85	1.92	1.81	1.93	2.01	1.36	1.51	2.57	3.78
West Virginia	1.88	1.88	1.90	1.97	1.96	1.17	1.56	2.47	3.34
Wisconsin	2.04	2.09	2.22	2.21	2.44	1.68	1.98	2.84	3.68
Wyoming	1.99	2.95	2.55	3.12	2.02	1.74	1.89	2.89	4.35

Capital Structure Ratios

Equity Financing Ratio

	Median Values					1997 Percentile Values			
	1993	1994	1995	1996	1997	10th	25th	75th	90th
Managed Care Penetration									
High	46.0	47.6	49.8	47.6	57.1	7.6	39.3	68.7	82.6
Medium	43.6	44.4	46.6	47.7	53.6	19.8	38.4	66.0	75.4
Low	48.0	47.2	49.4	51.3	52.2	23.9	40.1	64.7	76.1
States									
Alabama	53.0	48.5	53.2	52.0	61.6	47.0	52.6	74.3	83.9
Alaska	77.9	79.3	74.4	77.8	86.1	64.0	66.4	92.4	94.8
Arizona	32.9	31.6	39.5	45.8	50.5	39.4	42.1	73.9	86.2
Arkansas	57.9	60.1	63.7	66.2	70.6	60.1	67.2	86.7	89.5
California	48.1	48.3	49.4	44.1	56.7	-7.3	26.6	70.3	91.7
Colorado	59.8	60.0	58.9	68.8	70.1	53.2	63.2	75.2	81.7
Connecticut	64.6	56.3	55.2	55.9	57.7	38.6	44.4	70.8	77.5
Delaware	53.1	52.8	54.0	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	41.7	32.9	36.2	30.3	N/A	N/A	N/A	N/A	N/A
Florida	30.8	36.0	39.7	42.8	44.1	17.5	30.7	49.9	61.7
Georgia	55.8	62.0	65.6	59.3	59.9	44.1	50.9	74.3	78.8
Hawaii	51.9	48.2	51.6	47.2	41.3	-1.2	28.4	63.1	76.5
Idaho	65.1	64.2	65.7	66.2	64.6	38.9	48.8	74.8	83.2
Illinois	57.0	57.4	56.9	59.7	60.8	38.2	48.5	74.6	82.8
Indiana	57.4	57.8	62.1	62.8	62.1	42.3	54.1	70.5	81.0
Iowa	61.9	65.9	60.7	63.1	67.3	47.2	52.9	84.2	92.1
Kansas	77.7	75.0	75.9	72.1	65.4	50.2	58.0	82.2	89.6
Kentucky	51.7	51.4	54.5	55.9	64.8	45.3	51.7	80.4	84.7
Louisiana	56.0	58.0	62.3	61.0	59.5	41.7	47.0	69.9	75.1
Maine	49.4	51.4	55.5	55.0	60.2	28.8	49.2	66.3	75.1
Maryland	42.4	41.7	45.5	48.7	49.1	23.8	41.7	59.8	69.1
Massachusetts	35.6	37.2	39.8	37.3	45.9	27.2	38.0	61.6	67.3
Michigan	48.2	48.7	50.0	50.7	53.5	23.3	41.3	66.8	74.9
Minnesota	58.3	58.4	60.3	60.9	61.4	38.1	48.5	76.9	85.9
Mississippi	61.0	57.8	59.8	67.5	63.7	34.2	45.6	81.3	88.3
Missouri	60.0	62.2	63.1	62.2	73.2	32.1	54.6	81.8	90.8
Montana	51.6	62.9	66.0	64.1	69.9	45.3	51.0	72.8	76.2
Nebraska	75.4	74.1	74.6	75.0	74.4	48.9	65.4	83.9	93.2
Nevada	62.8	52.9	55.6	56.4	58.6	33.6	42.1	73.6	76.0
New Hampshire	56.0	52.7	56.8	62.1	61.1	48.8	55.7	68.1	69.3
New Jersey	40.7	40.0	44.2	44.1	45.1	18.7	33.9	55.5	67.6
New Mexico	59.9	69.1	66.5	76.0	79.2	47.2	58.9	87.2	90.0
New York	31.9	32.8	34.1	41.3	44.0	12.7	25.0	56.3	71.7
North Carolina	60.0	60.1	63.7	63.3	63.8	52.1	57.0	73.4	84.8
North Dakota	69.1	73.1	70.1	70.9	61.2	38.4	44.9	78.6	87.2
Ohio	55.8	56.9	57.0	58.5	62.3	32.6	52.5	74.3	84.0
Oklahoma	68.4	69.5	67.9	60.8	61.1	22.5	44.9	77.3	88.0
Oregon	64.5	66.0	64.3	70.0	72.4	40.6	58.1	76.9	86.6
Pennsylvania	48.1	48.2	48.2	52.1	53.9	18.0	40.2	64.0	76.2
Rhode Island	52.0	52.2	56.3	60.5	59.2	43.1	48.1	69.8	81.4
South Carolina	62.2	61.9	61.2	58.8	56.8	16.2	38.4	70.6	78.2
South Dakota	66.2	63.2	60.4	50.4	59.5	53.1	54.1	67.2	72.3
Tennessee	55.2	58.2	60.3	64.6	63.1	49.5	58.7	77.8	84.3
Texas	54.0	54.7	57.1	55.9	60.6	35.6	46.2	67.4	74.7
Utah	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vermont	62.3	60.8	60.2	58.2	61.9	54.4	55.9	68.8	69.4
Virginia	57.6	57.4	60.3	59.9	53.5	25.1	45.0	70.9	74.6
Washington	48.3	49.2	50.0	56.3	59.9	38.1	46.0	69.1	80.6
West Virginia	53.7	54.1	55.9	59.2	63.2	31.2	50.3	75.7	90.5
Wisconsin	51.9	52.7	56.1	58.2	60.6	48.2	57.2	73.3	75.7
Wyoming	60.6	65.6	71.7	74.9	67.3	58.5	61.4	72.6	74.3

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- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

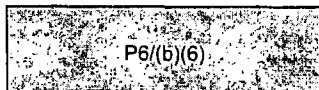
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[0017]

Sept. 7, 1999

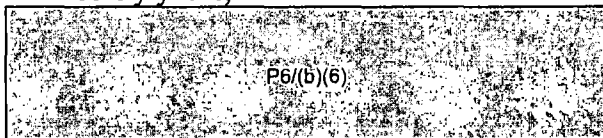
Chris Jennings
216 Old Executive Office Building
White House, Washington D. C. 20502

Dear Chris Jennings,

I am writing to ask you to use your influence to get the Balanced Budget Act of 1997 repealed. It has hurt the small rural hospitals very much since so many of their patients are on Medicare. If the hospitals are forced to close, it will not only hurt the elderly but the young and middle aged as well as they will all have to drive many, many miles for hospital care or even to see a doctor. Doctors will not practice in a small town that does not have a hospital. Many of these people will not have the resources, time or be able to drive the long distances for medical care. It will also have a grave economical impact on these small communities. I believe that the people who live in rural communities are entitled to the same quality of medical care as those who live in urban communities.

I am also asking you to see if you can get Medicare to change its position on reimbursing the doctors only about \$18.00 for a pessary when a good pessary costs around \$40.00. If they will not do this, they should let the patients pay the difference between the cheap pessary and the good one, like they do on eyeglass frames. Or they could at least let the doctor write a prescription for the good pessary and let the patient pay for it. The cheap pessaries get hard in less than a year so that they rub, hurt when you walk and make you bleed. I have worn a Milex Pessary which costs around \$40.00 for over four years. It is still comfortable but is beginning to tear a little. I need a new one but the doctors will not pay the difference, and they should not have to. I would buy one but I cannot get one without a prescription and Medicare says the doctors can get into trouble if they give prescriptions. In the long run it would be cheaper for Medicare to buy the more expensive pessary as they last so much longer and it sure would be better for the women who have to wear them. If Medicare can afford to pay for Viagra for men, I think that they should pay a lot less for good pessaries for women.

Sincerely yours,



Tax Credits for Uninsured Workers

Prepared by
Lynn Etheredge

Abstract: The recently passed legislation that allocates \$792 billion of projected surpluses to tax cuts did not contain major initiatives to assist the 43 million persons without health insurance. This paper outlines an incremental reform proposal—based on federal tax credits—that could be included in revised versions of that legislation and would assure basic benefit coverage for 33 million adults in working families who do not have employer-sponsored benefits. The proposal uses federal tax credits as core financing to provide these individuals with competitive choices in a well-functioning individual insurance market. It incorporates elements from the Arney-Stark tax credit proposal, the Breaux-Thomas "premium support" design for Medicare beneficiaries, and the new state-federal CHIP programs. The paper provides a rationale for a basic benefit package that would cost about \$1,400 per individual, with financing shared among federal tax credits (\$780 per person), individual premiums (\$525 per person), and state tax credits (\$95 per person). States would have major policy-setting and implementation roles. Individuals with employer-sponsored coverage would have assurance that these basic benefits would be available if they lost their employer coverage. Federal costs for assisting 33 million adults in working families would be about \$22 billion in 2000.

Federal budget surpluses and prosperity now create a unique opportunity for assisting the 43 million uninsured. Without agreement on a proposal for extending health insurance coverage, however, the projected surpluses may be spent for tax cuts and other purposes. It would be regrettable to miss this opportunity.

Three leading reform ideas—tax credits, consumer choice, and federalism—have proven useful foundations for recent bipartisan health initiatives. The purpose of this paper is to discuss how these elements can also be used for a legislative initiative to

assure basic health benefits for the 33 million adults in working families who do not have access to employer-sponsored coverage.¹

The key provisions of the proposal are the following:

- The federal government would establish a legislative policy framework and finance tax credits for basic benefits.
- State governments would have lead policy-setting and implementation roles, using the CHIP model for federal-state cooperation.
- Eligible individuals would be able to choose among competing health plans.

There is growing support for *federal tax credits* as a way to resolve tax code inequities and assist the uninsured. Recently, Reps. Dick Arney (R-Tex.) and Pete Stark (D-Calif.), who often espouse different policies, jointly advocated the use of tax credits to assure health insurance coverage for all Americans.² Among the growing numbers of other proposals advocating tax credits (or deductions) are the one sponsored by Reps. Jim McDermott (D-Wash.) and James E. Rogan (R-Calif.) and those sponsored by Reps. Nancy Johnson (R-Conn.), John Shadegg (R-Ariz.), and Sen. Barbara Boxer (D-Calif.). Interest groups now supportive of tax-financed proposals include the American Hospital Association, the Blue Cross and Blue Shield Association, the Health Insurance Association of America, and the American Society of Internal Medicine/American College of Physicians. A major factor in this support of tax code reforms is the question of equity: workers without employer coverage do not participate in the \$125 billion of tax subsidies (1998) for workers with employer benefits.³ Federal tax assistance has recently been enacted to allow self-employed individuals, on a phased-in basis, to deduct their full premium expenses from taxable federal income.

Consumer choice among competing health plans is also proving an attractive political formula. The federal government has long provided an organized system of choices for its workers (the Federal Employees Health Benefits [FEHB] program), as have most state governments and many large employers. In the Balanced Budget Act of 1997, federal decision-makers expanded the opportunities for Medicare's 38 million enrollees to choose from among traditional fee-for-service Medicare benefits and private health plans. The recent Bipartisan Commission on the Future of Medicare proposed new policies for improving this market. Many state Medicaid programs have also been reformed to enroll more beneficiaries in managed care plans. Various ideas for health marts and purchasing alliances are being discussed to offer more choices and economies for small employers and their workers.

Federalism is also proving a successful formula for bipartisan legislation. The state-federal CHIP program targets uninsured children in low-income working families, provides state options with respect to benefits and implementation, and allocates federal funds based on numbers of eligible persons, a standard benefit policy, and geographic cost adjustments. Increasingly, the political challenges for comprehensive reform legislation seem to grow in light of the health system's size, complexity, acrimonious relations, and comprehensive reform costs. Several scholars of national health care reform have suggested that, after five failures to enact comprehensive health reform in this century, a "federalist option" may now be the best course to deal with the political impasse.⁴ States now vary widely in their share of the uninsured problem (from less than 5% of the under-65 population uninsured in some states to nearly 25% uninsured in other states), health insurance

markets and regulation, in state programs (Medicaid, CHIP, state assistance), political philosophies, and other characteristics.

Table 1
Recent Health Initiatives

Tax Credits/Deductions

Enacted: Self-employed premium deductions
Proposals: Arney-Stark, McDermott-Rogan, Johnson, Shadegg, Boxer

Consumer Choice

Enacted: Medicare+Choice, state Medicaid reforms
Proposals: Breaux-Thomas, health marts

Federalism

Enacted: CHIP, HIPAA

The following sections develop an outline for a proposal, discuss major national legislative policy questions, and propose their resolution. The first section deals with tax credits; the second deals with state policies and insurance markets. The paper does not aim for a comprehensive redesign of the national health system, but for an enactable, workable compromise that will assure basic benefits for 33 million individuals without employer coverage. Advocates for comprehensive reform will find that many items from their agendas would remain.

TAX CREDITS

In designing federal tax credits for coverage of uninsured workers, the first issues that need to be considered deal with the amount of the tax credit and how the federal government, workers, and state governments will share premium costs. At least three major critiques of tax credit-based proposals also need to be addressed.

Tax Credit Amount

If there is going to be a federal tax credit, how large should it be? Current proposals reflect a range of options: (a) basic benefits; (b) average benefits; or (c) comprehensive benefits.

There are a number of reasons for preferring a basic benefits plan for an incremental proposal. Federal costs escalate with higher tax credits. Higher tax credits also increase risks of unravelling employer coverage, if workers can receive benefits better than those available from employer-sponsored policies. There are also equity issues if some workers pay taxes to finance benefits for uninsured workers that are greater than those they receive.

For illustrative purposes, Medicare's benefits—adjusted to include maternal and child health benefits and preventive services for an under-65 population—are a useful prototype for a basic health insurance package. Medicare's benefits are well below the norms of employer-sponsored benefits. They are only a "10th percentile" plan, due to high deductibles, lack of catastrophic or stop-loss protection, and absence of prescription drug coverage. This is, however, probably about the right benefit level to avoid unravelling employer coverage or generating complaints from insured workers. At the same time, Medicare offers a good health insurance package, one that has been well-accepted over 30 years, and it is a very popular benefit. It also seems questionable whether public policymakers would enact a tax credit for workers that provides more generous benefits than are now available for Medicare beneficiaries. The estimated premium for a basic benefit modelled on the Medicare program would be about \$1,400 per adult in 2000.⁵

Worker Premium

How much of a \$1,400 premium should be paid by enrollees, and how much should be financed by a tax credit? One way to think about this question is that Medicare enrollees now pay \$525.60 (\$43.80 per month) for a comparable benefit package. If retirees, many living on Social Security checks and without work income, are expected to pay this amount, it would seem reasonable to expect as much from full-time workers. On this basis, the government premium support would be \$875 per person, and individuals would pay about \$525 for basic benefits, depending on the actual cost of the plan they select.

State Tax Credit Share

If a government tax credit is set at \$875, how much of this amount should be paid by state governments? States' tax policies mirror the same inequities for workers without employer health benefits as federal tax policies, and states can afford to contribute. With tax credits financing coverage for 33 million workers, the states' eligible residents will benefit; state and local governments will save on Medicaid disproportionate share hospital (DSH) payments for the uninsured; and the states' employers should realize premium savings (from less cost-shifting). Since a number of administrative functions would fall to state governments, it is also prudent that some state funds should be at risk for their actions.

In 1998, an estimated \$13.6 billion of the total \$124.8 billion government tax expenditures for employer health benefits came from state governments, about an 11% state share.⁶ Using this ratio, government tax credit expenses would be shared \$780 per person (federal) and \$95 per person (state).

The federal and state tax credit costs would be reduced by lower Medicare and Medicaid DSH payments for the uninsured. A rough estimate of federal savings would be \$3.5 billion in 2000; they would offset federal tax credits of \$25.7 billion, for a net federal cost of \$22.2 billion.^{7, 8}

Table 2
Tax Credits

Benefits:	Basic
Amount:	\$1,400 /adult premium
Premium shares:	Federal \$780/person Individual \$525/person State \$95/person
Effectiveness:	Federal/state subsidies Workplace sign-up, payroll contributions Automatic enrollment Safety-net benefits
Efficiency:	Flat credit per adult Allocated to states for payment to insurers
Geographic flexibility:	"Premium support" adjustments

Issues

Three issues are often raised about the use of tax credits to expand health insurance coverage: effectiveness, efficiency, and geographic flexibility.

Effectiveness

Since tax credits support voluntary purchase of insurance, but are not mandates, one of the key questions is whether eligible workers will use them to buy insurance coverage. Obviously, good benefits and lower premiums make it more likely that an individual will sign up. The proposed benefits—Medicare-based—

would be widely recognized as valuable, and individuals would be receiving a benefit of \$875. Even for a worker with \$10,000 of wages (full-time work at \$5 per hour), the \$525 annual premium would be only about 5% of income. Enrollees would also benefit from provider price discounts available through health plans. Given that the new market would have 33 million people, there would likely be significant advertising and marketing to encourage eligible persons to enroll.

Eligible workers would find purchasing health insurance more affordable than they do currently. As well, there are two methods for encouraging voluntary enrollment that are now used in the FEHB program and Medicare that would also be helpful; their use is proposed for this incremental initiative.

Workplace sign-up and payroll contributions—Employer-based insurance (including the FEHB program) typically allows workers to sign up at their work place and to have their premium contributions automatically deducted from paychecks. This is convenient, facilitates enrollment, and sharply reduces administrative costs. Medicare hospital insurance (Part A) contributions—as well as Social Security, unemployment insurance, and the income tax system—also use payroll withholding.⁹ Employers should not object to offer this service, as it makes health insurance coverage available for their workers.¹⁰ Arrangements could be made for firms to submit premiums to a clearinghouse if submission to individual plans was too burdensome.

Automatic enrollment—A second measure to increase voluntary coverage, effective for the Medicare program, would be to establish an automatic enrollment system for eligible individuals. Employers that did not offer health insurance (and unemployment insurance offices) would be required to with-

hold the worker's premiums and submit that amount as premiums for health insurance coverage to a worker-specified plan (or to a state-designated health plan, absent a worker selection) unless the worker explicitly declined coverage. Workers would have to decline in writing, after reading a statement that explains the tax credits and the benefits of basic health insurance. In the Medicare supplementary medical insurance program (Part B), such automatic enrollment and deductions from Social Security checks have produced over 95% sign-up rates.¹¹

An administrative arrangement that features workplace sign-up, payroll contributions, and automatic enrollment would also sharply reduce both government and individual costs. In today's individual insurance market, insurers' administrative charges—including medical underwriting, collection costs, and other load factors—expressed as a percentage add-on to benefits, range from 18% to 20% for HMO and Blue Cross/Blue Shield individual policies to 78% for individual commercial insurance policies. These are markups for typical insurance benefits; for basic benefits, the administrative charges would be an even larger mark-up percentage. Estimates for the proposed arrangement are for administrative costs of 7.5%.

What should happen if an individual who is eligible for a tax credit decides not to use it to purchase private coverage? He or she could receive no benefits, but that would not be consistent with across-the-board progress on insurance for all workers. In this proposal, tax credits that individuals do not use for private insurance would be used by state governments to finance whatever "safety-net" coverage could be purchased on their behalf for the \$875 federal-state tax credits.¹² With workplace sign-up and premium payments, automatic enrollment—and this safety-net provision—all 33

million eligible individuals would be assured of at least some coverage.

Administrative efficiency

A second issue in the use of tax credits is how to administer them efficiently. Three specific concerns that can arise are (a) it is complicated (and expensive) to calculate income-related tax credits for 33 million eligible persons and to issue individual vouchers or rebates; (b) a number of the individuals eligible for a tax credit would not be filing tax returns; and (c) since income tax returns are filed after the year in which the income is earned, it is difficult to match income-related tax credits with current incomes. These concerns can be addressed through the following measures:

- The proposed tax credits would be a flat credit per adult. To be eligible, an individual would need to certify that he or she met work requirements and was not eligible for employer-sponsored health benefits but would not have to file an income tax return. This would vastly simplify administration and make it easy to use the employer-based sign-up and contribution system described above. There would be no need to calculate new tax credits from tax returns for 33 million individuals or to adjust tax credits for changing incomes. It seems difficult to justify such administrative complexity and expense for a tax credit which is such a limited amount—and when many high-income workers receive far more generous tax benefits that are not income-related. In 1998, federal health insurance tax benefits for families with incomes over \$100,000 averaged \$2,357 and totalled \$26.2 billion.¹³
- To provide a much simpler and less expensive way to administer tax benefits than using millions of checks or

vouchers, the Arney-Stark tax credit proposal suggests that tax credits be payable to insurance companies or other entities rather than to individual taxpayers. The proposal developed here adopts this approach and would allocate the federal tax credits to state governments. States would then pay private insurance companies (or another entity) the combined federal-state tax credits due for the individuals they enrolled, and the balance would be available for tax credit financing of the state-sponsored plan (if there was one) or for the minimal benefits payable for individuals who did not sign up for health insurance.¹⁴

Geographic flexibility

A third issue that arises with using tax credits to purchase health insurance is that health insurance premiums can vary a great deal among geographic regions. A nationally uniform tax credit would buy more benefits in some areas than in others and would not assure basic benefits that are comparable for all eligible persons. Should the federal tax credit be a "defined contribution" or support a "defined benefit"?

The recent plan supported by Sen. John Breaux (D-La.) and Rep. Bill Thomas (R-Calif.), based on work of the Bipartisan Commission on the Future of Medicare, proposed a creative way to deal with this issue for Medicare's beneficiaries. Using a "premium support" concept, the Medicare program would calculate a national average premium for a defined benefit (a modified Medicare benefit package) and then adjust this amount for geographic cost variations. The federal government would pay this adjusted premium contribution on behalf of enrollees who signed up for private health plans in each area.¹⁵ Using the premium support concept, the national average tax

credit per person (\$780) could also be adjusted for geographic cost variations. To simplify the federal administrative role, the tax credits for each state's residents (allocated to states for payment to health plans) would be adjusted for state cost differences. Since health insurance premiums would vary within a state in ways that are influenced by a state's health policies (discussed in the next section), states would be responsible for adjusting the tax credit amounts payable to health plans within a state.

STATES AND INSURANCE MARKETS

The foregoing discussion dealt with tax credits and their administration. What else does a legislative policy framework need to include for a tax credit initiative to work well?

Two other major tasks for legislative policy-making are to assure that benefit plans are available for eligible persons in all areas and assure that eligible individuals can purchase these plans. Assurance that eligible individuals can purchase plans involves (a) setting market rules (guaranteed issue, no pre-existing condition exclusions) and (b) adjusting tax credits, using the same factors insurers will be allowed to use to adjust premiums in this market. These tasks fall within the broad scope of state health insurance market regulation and programs on which recent legislation built the federal-state CHIP program and HIPAA legislation. For this tax credit proposal to work, federal and state governments will also need to work together. Beneficiaries should be able to expect that they will be able to purchase basic benefits for the tax credits. And if federal decision makers are going to allocate some \$22 billion annually of taxpayer funds to extend coverage for workers and their families, they need to assure that the funds accomplish this objective.

Availability of the basic insurance benefits for eligible persons should not be a widespread problem. The size of the new market, with over \$46 billion of premiums (\$1,400 x 33 million eligibles), should be attractive to insurance brokers and insurance companies. They would be able to offer the basic benefit plan, with the \$875 tax credit sweetener, to all eligible persons without medical underwriting.¹⁶ Nevertheless, the Medicare+Choice experience illustrates that legislative policy needs a contingency plan if some areas do not have basic health insurance available. While Medicare health plan enrollment has continued to grow, more than 800,000 individuals will be dropped from coverage because it was not profitable enough to serve the counties in which they lived.

If there are no rules or tax credit adjustments in this new insurance market, eligible persons could find that they are denied health plan coverage, are subject to pre-existing condition exclusions, or that health plan premiums are priced unaffordably, even with the government tax credit. The current variation in state individual insurance markets illustrates the need to address this issue. As of 1998, for example, 11 states had community rating requirements for the individual coverage market, and an additional 8 states had rate band limits. Thirteen states had guaranteed issue for the individual coverage market, and 31 states limited pre-existing condition exclusions.¹⁷

In the bipartisan HIPAA legislation, national standards (state-administered) have already been established for guaranteed issuance of insurance and pre-existing condition exclusions in the group health insurance market. These HIPAA provisions should simply be extended to this new tax-credit eligible group.¹⁸ The HIPAA extension would benefit the 33 million individuals eligible for tax credits directly. Quite importantly, it would also benefit the more

than 160 million workers and family members with employer group coverage (now covered by HIPAA) by assuring that—if they did lose employer-based coverage in the future—they would be able to purchase basic health insurance, with the same portability protections, in this new market.¹⁹ For dealing with the remaining issues, such as insurance availability in all areas and health insurance premium variations, the CHIP legislation offers a recently enacted model.

The CHIP Model

In the CHIP program's model for federal-state relations, the federal legislative framework specifies an objective (e.g., coverage of a defined population group), key policy parameters (e.g., financing), and state model standards that would accomplish that objective (e.g., a "benchmark" benefits package). States have options to propose equivalent arrangements that they prefer or that would work better in their state.

Benefits and premiums

As discussed in the previous section, the federal government would determine its payment to states based on a "benchmark" plan, the numbers of persons eligible, and geographic cost adjustments. As a model standard for within-state adjustments, the federal tax code could require that all private health insurance products, as a condition for participating in this new market and receiving tax credits, offer the benchmark health benefits for all eligible persons in their service areas (on a guaranteed-issue basis, without pre-existing condition exclusions,) and set premiums using community rating methods for this group. These are the same kind of requirements that large payers, e.g., the FEHB program, CalPERs, and Medicare+Choice, usually establish in structuring individual choice markets for their enrollees.^{20, 21}

While these legislative provisions would be a model state standard, states could propose—as in CHIP—actuarially equivalent approaches for health benefits and premium adjustment factors. For example, a state might specify a basic benefit package for eligible adults that is actuarially equivalent to the model benefit package but which better integrated with its CHIP benefits for low-income children. Or a state might elect a strategy of allowing premiums to be adjusted for age and sex and between large urban areas and rural areas—and propose that the tax credits it pays be adjusted by the same factors. Some states (e.g., California and Florida) have fostered health alliances or purchasing cooperatives and may want to use them. States that help to pay for COBRA coverage (e.g., Massachusetts) might design ways to combine tax credits with state assistance. States may also supplement basic benefits or safety-net benefits from their own funds. There are many creative ideas that could be tried by leadership states.

Availability

The other legislative objective—access to insurance if it is not available from the private market—could be accomplished through a model provision that states sponsor a health plan for areas where the health insurance market was not adequately serving the eligible populations in terms of costs or quality of care.

Should the model state standard for this objective be that states cover the eligible individuals through separate state-sponsored programs or through their Medicaid programs? Medicaid is available nationwide and offers broad benefits; welfare reform legislation provided new Medicaid options for covering working populations (Section 1931). Nevertheless, there are a number of other factors to be considered.

Most importantly, Medicaid has a means-tested "welfare program" reputation among politicians, health plans, and providers—and among the tax-credit beneficiaries. Among other concerns are that Medicaid's benefits are more generous than the basic benefits that could be financed by tax credits, and it has many regulatory and procedural requirements that would hamper flexible administration of a tax-credit financed program.²² This proposal is thus that the legislative model for states be to assure health insurance coverage, where market performance is not satisfactory, through a state-contracted plan rather than through enrolling workers in Medicaid programs.

Table 3
State Insurance Markets

Objectives:	Health plan available in all areas Eligibles able to purchase using tax credits and self-paid premiums
Basic rules:	Extend HIPAA group standards Guarantee issue No pre-existing condition exclusions
State regulation:	CHIP model (legislative standard, state flexibility) Community rating (or actuarial equivalent) State assures availability if market fails
Federal role:	HIPAA model (federal regulation if state declines)

As with the insurance plan standards, states could develop equivalent arrangements for assuring availability of insurance products. States governments, working with insurance companies, may be able to assure availability of good insurance products, in a competitive insurance market, for all locales and eligible individuals. States may also find better ways to integrate tax credits and CHIP for families that qualify for both benefits. Some states have already inte-

grated Medicaid and state-funded programs to assist working families (e.g., MassHealth and Wisconsin's BadgerCare), and other states have state-funded assistance programs for low-income adults (e.g., MinnesotaCare, Oregon's Family Health Insurance Assistance Program, and Washington's Basic Health Plan); they may wish to build on those foundations.

Other Insurance Coverage

Another set of state health policy concerns relates to the potential of tax credits for workers without employer-sponsored coverage to reduce insurance coverage in the small group market. This could be a problem if there were large new tax credits. But the potential effects of a \$875 tax credit for financing basic benefits are likely to be modest. Most workers would see themselves as worse off if they lost employer group benefits and employer-paid premiums.²³ The basic health plan is designed to have a limited benefit package (10th percentile, no prescription drugs) and individual premium share (over 30%), that would make it an unattractive alternative to most employer group health insurance. Insurance brokers and insurance companies would be able to offer better benefits for the small group market. Problems could also arise if states allowed wide premium variations in their small employer market (resulting in more high-cost firms that might have a cost advantage in dropping coverage). Regulatory tools are already in use in most states, however, to reduce premium variations in the small group market; in 1998, forty-six states had rating bands or community-rating that limited premium variations in their small group market.²⁴ Nevertheless, this is one of the issues each state would need to consider in developing implementation proposals for the tax-credit program.²⁵

State Participation

This tax credit proposal, with its flexible state policy and implementation roles, should prove very attractive to state governments. But what should legislative policy provide if a state did not participate or, more likely, proposed to do so selectively? Traditionally, these are uncommon occurrences, but a complete legislative policy should address them.²⁶ The recent HIPAA statute for federal-state health insurance regulation includes provisions that address this issue. Under HIPAA, if a state declines to take on a specific responsibility, the federal government takes it on. This approach would assure that the federal tax credits for the 33 million eligible adults would be available nationwide so that all of them would have health insurance coverage.

Table 4
Proposal's Benefits

Opportunity:	Projected budget surpluses Bipartisan support for tax credits, consumer choice, federalism
Beneficiaries:	33 million adults in working families eligible for tax credits Workers with employer-based coverage, if they lose those benefits
Employers:	No employer mandates Coverage for all full-time workers
Insurance brokers/ companies:	\$46 billion new market
States:	Lead state role, flexibility Fewer uninsured Limited state costs
Hospital/ physicians:	Reduced bad debt/charity care
Federal government:	No large federal bureaucracy or new taxes Affordable (\$22 billion in 2000)

CONCLUSION

Federal budget surpluses, prosperity, and bipartisan support for key reform strategies create a unique opportunity for a major incremental proposal to assist the uninsured. Building on broadly supported ideas for tax credits, federalism, and consumer choice, the legislative policy proposed in this paper would assure basic benefits for 33 million adults in working families without employer coverage and correct serious tax code inequities. Given the size of the \$792 billion tax cuts now being considered (over ten years), the proposal's \$22 billion annual cost (in 2000) would be affordable. New taxes, employer mandates, or a large federal bureaucracy are not required. The proposal is intended to be attractive to 33 million eligible persons, 160 million individuals who could lose employer-sponsored benefits, state governments, insurance brokers and insurance companies, hospitals and physicians, and employers. Major technical issues concerning tax credits (effectiveness, administrative efficiency, geographic adjustment), health insurance standards, and health insurance availability can be resolved using recently enacted legislative models and bipartisan proposals. We should not miss this opportunity.

Support for this paper was provided by a grant from the Robert Wood Johnson Foundation to the Health Insurance Reform Project at George Washington University. The author thanks Stanley Jones, Judith Moore, and Sandra Foote for comments on this paper and also thanks participants in an HIRP-*Health Affairs*-sponsored meeting of December 11, 1998, and an HIRP-sponsored meeting on April 6, 1999, to discuss tax credits for the uninsured, insurance market reforms, and state roles.

ENDNOTES

1. The 33 million number refers to adults in working families in which (a) at least one adult is a full-time employee (at least three days per week) or a worker receiving unemployment insurance (UI) benefits and (b) no family member is eligible for employer-sponsored health insurance. Fewer than one-quarter of these individuals are now estimated to purchase individual coverage policies. A rationale for targeting working families, estimates for eligible population, benefit and administrative costs, and discussions of related reform issues can be found in Lynn Etheredge, Stanley Jones "Affordable Health Benefits for Workers without Employer Coverage," Research Agenda Brief, Health Insurance Reform Project, George Washington University, February 1998; available at <http://www.hirp.gwu.edu>.
2. Dick Armey and Pete Stark, "Medical Coverage for All: The Ultimate Congressional Odd Couple Weighs In," *Washington Post*, June 18, 1999.
3. John Sheils and Paul Hogan, "Cost Of Tax-Exempt Health Benefits in 1998," *Health Affairs*, March/April 1999, 176-181.
4. Theodore Marmor, Jerry Mashaw, and Jonathan Oberlander, *National Health Reform: Where Do We Go From Here? in Health Policy, Federalism, and the American States*, Robert Rich and William White (eds.) (Washington, D.C.: Urban Institute Press, 1996).
5. These estimates are based on extrapolating 1998 estimates of \$1,382 per adult. They assume an efficient administrative load factor (7.5%). For comparison, national average HMO benefits for 1998 would be about \$2,037 per adult in the individual coverage market, with estimates using a typical 18.5% load factor for that market.
6. Sheils and Hogan, "Cost of Tax-Exempt Health Benefits."
7. In 2000, Medicaid DSH payments are estimated to be \$11.8 billion (CBO) and Medicare DSH payments \$4.5 billion (projected from MedPac data). DSH savings would require revised payment calculations.
8. If the 16 million children in these families were eligible for a federal tax credit of \$490, the added federal costs would be \$7.8 billion. Estimated premium costs would be \$880 per child. Using the matching shares for adult coverage, these premiums would be split \$490 (federal), \$330 (individual), \$60 (state). State CHIP programs, since their eligibility

can extend to 200 percent of poverty, may cover many of these children.

9. The cost estimates for this proposal assume such economies.

10. Providing sign-up information and premium remissions is proposed as an employer requirement, but employers could be allowed to take a small administrative charge as a tax credit. Individuals could also sign up for plans with health insurance brokers and with health insurance plans directly and inform employers of the plan to which their premium contribution should be remitted.

11. Enrollment also could be encouraged by a provision that (a) offered a "one-time" regular sign-up period when an individual first became eligible and (b) imposed a late-enrollment surcharge. The Medicare SMI program now applies a premium surcharge for late enrollment.

12. Legislative policy guidance should be provided for a state model benefit, with state options to offer actuarial equivalent coverage, but was not developed for this paper. States can supplement either (or both) of the basic benefits and safety-net benefits from their own funds. This state flexibility can be used to calibrate a balance of benefit generosity, individual premiums, and voluntary sign-up rates.

13. Sheils and Hogan, "Cost of Tax-Exempt Health Benefits."

14. Initial federal payments would be based on estimated numbers of eligibles with adjustments based on actual numbers of eligibles (audited).

15. A similar concept is also applied in the CHIP legislation which allots funds to states based on number of uninsured children and a geographic cost factor.

16. With the \$875 tax credit, health insurance brokers and companies could also encourage eligible individuals who already purchase health insurance to improve their benefits.

17. Susan Laudicina, Jacqueline Yerby, and Katherine Pardo, *State Legislative Health Care and Insurance Issues*, Blue Cross and Blues Shield Association, December 1998.

18. See Karl Polzer "HIPAA as a Regulatory Model" National Health Policy Forum, Issue Brief #735, George Washington University, April 1999. In general, HIPAA requires that an insurer take all members of a group who apply without new waiting periods or bans on pre-existing conditions.

19. The automatic coverage for basic benefits should be particularly useful in dealing with transitional, short-term problems in health insurance. About 50% of the uninsured are without coverage for six months or less, e.g., because of unemployment (See Robert Bennefield, "Who Loses Coverage and for How Long?" *Current Population Reports*, U.S. Bureau of Census, May 1996, 70-54). Although COBRA now allows insured workers to continue coverage when they leave their jobs, they need to pay the full premiums for the employer-offered benefits, and most elect not to incur this level of out-of-pocket expense.

20. Insurers could offer supplemental benefits and coverage, e.g., coverage of children, Medigap-type options.

21. A critique of community-rating for the individual coverage market is that there would be many losers among insured experience-rated individuals whose premiums would rise. In this instance, however, the new tax credit of \$875 per person would offset any premium increases for persons who faced a rate increase. As well, the market for individuals eligible for tax credits would be distinct from the individual coverage market for other individuals; averaging of high-cost nonworking populations with the working population into one community rate would not be required by this standard.

22. This general discussion should be qualified for some Medicaid programs and subpopulations. TennCare uses a Medicaid waiver; Medicaid is being reformed in other states, e.g., to include outreach, eligibility expansions, and private insurance buy-ins and to enroll the CHIP population. For some sub-populations that move from welfare to work (e.g., those eligible for TANF) or that have Medicaid eligibility that changes month-to-month with earnings variations, a Medicaid-integrated option may also make sense.

23. Economic theory and studies suggest that workers, on average and over the long term, pay employer premium contributions through a reduction in their wages, so that they would be better off to forego employer-paid premiums if they could get a bigger tax break. But it is also clear that workers generally do not see the matter this way; a \$5,000 family health insurance policy, with \$4,000 employer contribution, so a worker need only pay \$1,000 for a \$5,000 benefit is a different option than having to pay a \$5,000 premium for the same benefits out of one's own pocket. It is also difficult for an employer to "gross up" wages for all workers, who differ in single/family, age/sex, health status, availability of spousal coverage, income and tax brackets,

and other ways in amounts that would compensate them equivalently for their loss of employer contributions and cover the premiums they would be charged in the nongroup health insurance market. Workers would owe income (15% or more) and Social Security taxes (7.65%), and employers would owe higher Social Security taxes (7.65%) on premium contributions that are converted to workers' wages.

24. Laudicina, Yerby, and Pardo, *State Legislative Health Care*. Thirty-six of 38 states using rate bands had adopted NAIC model standards for the small group market.

25. As an incentive against employers dropping childrens' coverage, many state CHIP plans impose a six-month waiting period for eligibility after loss of employer coverage. A similar waiting period could be applied for tax credit eligibility of workers who lose employer coverage.

26. Arizona did not participate in Medicaid for a number of years, and HCFA will need to administer some HIPAA requirements in California, Missouri, and Rhode Island.