

NEW BUDGET IDEAS / NEW INITIATIVES FOR FY 2001

1. **MEDICARE REFORM**
 - Nature of the drug benefit
 - BBA extenders
 - Medicare competition
 - Board
2. **MEDICARE**
 - Fraud
 - Prevention
 - QMB / SLMB
 - Cancer clinical trials
3. **LONG TERM CARE**
 - Tax credit
 - Caregivers initiative
4. **NEAR ELDERLY**
 - Medicare buy-in
 - COBRA
5. **MEDICAID / CHIP / COVERAGE**
 - Legal Immigrants
 - Transitional Medicaid
 - Parents of CHIP and Medicaid Kids
 - 1115
 - Small Business Incentives
 - Tax Credit 125 percent
6. **KIDS**
 - Presumptive eligibility entity expansion
 - Lugar amendment / school lunch
 - Adjunctive eligibility
 - Enrollment bonus
7. **QUALITY**
 - Patients Bill of Rights
 - Privacy
 - Genetic discrimination
 - Outcomes oriented research

8. PUBLIC HEALTH / UNDERSERVED POPULATIONS (TENTATIVE)

- Asthma
- Lead poisoning prevention
- Medicaid and dental services
- Prescription drugs and the internet
- Bioterrorism
- Breast / prostate cancer environmental health lab
- Kids GME
- Mental health
- Race and Health
- Biomedical research
- Increased protections for human subjects in clinical trials
- Gene patenting



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NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Press Conference

**"What the American Public Thinks About Safety Net
Hospitals & Health Systems"**

Results of a national poll conducted by
Lake, Snell, Perry & Associates for the National Association of
Public Hospitals & Health Systems

National Press Club
September 14, 1999 - 1:00 PM EDT



UPDATE

PUBLIC OPINION

Bolstering The Safety Net

A top priority for health care reform.

BY LARRY S. GAGE AND MARSHA REGENSTEIN

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THE YEAR 1999 MARKS the fiftieth anniversary of America's first great debate over national health reform. In the wake of World War II, President Harry Truman appointed a National Health Assembly to assess whether a British-style health system would be suitable for the United States. That body endorsed the idea in 1949.¹ The assembly's primary lasting impact was to provoke Sen. Bob Taft (R-OH) into coining the term *socialized medicine*, while leading the successful congressional battle to defeat Truman's plan. But the door was opened to spend the next half-century debating health reform.

Although much of the recent debate has focused on expanding insurance coverage, earlier cycles also emphasized improving access to care by building up an institutional health care safety net. In the late 1950s and early 1960s these efforts included the Hill-Burton hospital construction program and Great Society initiatives such as community, rural, and migrant health centers and the National Health Service Corps (NHSC).

As these movements began to bear fruit in the 1960s, attention shifted back to the issues of entitlement and coverage, culminating in the enactment of Medicare and Medicaid. The potent combination of vast new sources of patient care revenues and new providers eager to collect them led to a perhaps inevitable cycle in which the primary focus was on neither access nor coverage, but on cost.

In the early 1980s the Medicare prospec-

tive payment system (PPS) was enacted, and Medicaid cost controls were also implemented, permitting states to adopt new PPS methodologies for hospitals.² The few expansions enacted during the 1980s largely consisted of modest improvements to Medicaid eligibility for children and pregnant women. However, a good deal of attention was focused on bolstering the institutional safety net via Medicare and Medicaid disproportionate-share hospital (DSH) payments and cost-based reimbursement for federally qualified health centers (FQHCs).³

In 1993-1994 the health care reform cycle returned with a vengeance to issues of coverage. Those efforts failed spectacularly, but as the 2000 elections approach, political support may again be building for reforms aimed at the under- and uninsured. Today nearly forty-four million people lack health insurance, a number that is expected to continue to grow for the foreseeable future.⁴

Health care reform proposals are already starting to emerge, from across the ideological spectrum, to address this national embarrassment. These range from tax incentives to "health marts" to Medicare buy-in proposals for the near-elderly.⁵ Most observers, however, expect future coverage reforms to be incremental at best. Based upon our failure thus far to sign up millions of people who are already eligible for Medicaid, the State Children's Health Insurance Program (CHIP), and other public coverage, any such health care

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reform efforts must be augmented by support for institutional safety-net providers.

Safety-Net Crisis

America's institutional health care safety net includes a diverse range of providers, centered on community health centers, public health departments, and those public and private nonprofit hospitals that share a safety-net mission. Because our experience as president and research director, respectively, of the National Association of Public Hospitals and Health Systems (NAPH) is primarily with hospitals and hospital-based systems, our research and our discussion is focused on those institutions. However, we believe that our concerns and recommendations apply equally to all safety-net providers.

The common mission of these providers can be illustrated by a brief look at the current NAPH membership. NAPH consists of more than 100 of America's urban safety-net hospitals and health systems. These providers are uniquely reliant on governmental financing to support the care of Medicare, Medicaid, and uninsured patients. They also provide huge volumes of ambulatory services as well as costly tertiary services to their entire communities, not just to the poor and elderly. These services include a wide variety of around-the-clock services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis-response units for both natural and manmade disasters. Most NAPH members also serve as major teaching hospitals.

Another characteristic that defines NAPH member hospitals is their provision of high volumes of charity care, including how they finance that care. NAPH members, on average, provided 26 percent of their inpatient services and 41 percent of their outpatient and emergency services to "self-pay" (typically uninsured) patients in 1997. In 1997 NAPH members on average received just 21 percent of their net operating revenues from Medicare and 14 percent from commercial insurance and managed care plans. With another 30 percent in Medicaid patient care revenues, that

left 35 percent of costs to be covered by alternative sources.

The primary sources of financing for uncompensated care in NAPH member hospitals are the Medicaid and Medicare DSH programs. In 1997 Medicaid DSH payments covered 24 percent of the costs incurred in treating the uninsured and underinsured; Medicare DSH payments covered another 8 percent for all NAPH members nationally. State and local subsidies made up most of the difference, accounting for 52 percent of total payments for uncompensated care. Such subsidies accounted for 16 percent of net revenues for NAPH members in 1997.

Safety-net health systems also face increased competitive pressures, including competition for privately insured patients and for selected Medicaid patients. In obstetrics, for example, NAPH members have seen a dramatic reduction in the number of deliveries, as private providers have increasingly sought to compete for Medicaid patients expecting uncomplicated deliveries. In particular, between 1990 and 1997 the number of births has declined by more than 36 percent (or nearly 1,800) at the average NAPH member hospital.

In addition to eliminating cost shifting, managed care and competition have affected providers in ways that will influence their provision of uncompensated care. States have used managed care to contain Medicaid costs and, in some instances, have attempted to expand coverage to the uninsured with some of the savings. However, many such states have been forced to cap or reduce such expanded eligibility. This has further increased pressure on safety-net providers.

Such declines have severely constrained the ability of many safety-net hospitals to shift the uncompensated costs of serving the uninsured (for whom no such "competition" exists). These pressures have been made worse by recently enacted caps on or reductions in current sources of institutional support, such as DSH and FQHC funding, culminating in the many cost-cutting provisions of the Balanced Budget Act (BBA) of 1997.⁶ According to one analysis, the BBA adversely af-

fecting all hospitals.⁷ The impact of many of its provisions on public hospitals, FQHCs, and other safety-net providers was further exacerbated by welfare and immigration reforms and by reductions in support at the state and local levels. This has led to increased concern over whether safety-net providers can remain viable and withstand the rigors of future reimbursement cuts and an increasingly competitive health care marketplace.⁸

Public Support

In the face of these pressures, NAPH commissioned a household telephone survey in May 1999 to assess Americans' concerns about (among other things) the viability of safety-net providers. Because the NAPH membership is drawn primarily from metropolitan areas, this survey was limited to residents of those areas, who represent 79.6 percent of U.S. households. In all, 1,000 persons over age eighteen participated in the survey, with a response rate of 42.6 percent.⁹

Respondents were overwhelmingly supportive of the notion that every American should have access to physician and hospital services. Ninety-nine percent of respondents said that it was important for each and every person to have access to care; 95 percent of respondents said that this was "very important" to them. This broad support for access is far from abstract for many Americans. Only 11 percent of respondents described themselves as currently uninsured, but 45 percent of those currently insured said that they had been without insurance at some point in the past. When asked about the likelihood that they (or a family member) would be uninsured over the next five years, one-third said that this was a real possibility. About one in six said that it was very likely that they could be uninsured in the not-so-distant future.

Perhaps in part because of concerns about access and likelihood of being uninsured, respondents were extremely supportive of safety-net institutions, defined as hospitals and clinics where uninsured people go to get medical services. Ninety-seven percent of respondents said that it is very or somewhat

important to have places where the uninsured can go to get care. The support runs wide and deep and cuts across racial and party lines.

Nearly nine out of ten respondents underscored their support by saying that we as a nation should devote tax dollars to safety-net hospitals. Again, strong support is seen across political party lines, with 81 percent of Republicans, 85 percent of Independents, and 92 percent of Democrats expressing this view. When asked how much they would personally be willing to pay each month to help safety-net hospitals continue to care for the uninsured, 21 percent said that they would pay up to \$5, another 21 percent would pay up to \$10, and another 21 percent would pay up to \$20 or more. Fewer than one in five (18 percent) said that they would be unwilling to contribute personally. Of those who said that we should spend more, 59 percent wanted the money to come from the federal government and 25 percent, from state sources.

This strong public support has begun to hit home for policymakers, who are beginning to voice support for strengthening the institutional health care safety net. In particular, there are proposals now before Congress to increase funding and provide managed care protection for community, migrant, and rural health centers, as well as growing support for a new national safety-net initiative that was originally included in the Clinton administration's fiscal year 2000 budget request. Specifically, \$25 million has been requested as seed funding for the coming fiscal year, and \$250 million per year for each of the next four years, to finance safety-net reforms in up to 100 communities around the country.

Although this is no substitute for universal coverage and a relatively small sum in the overall picture, this initiative is important for the attention it pays to the need for a strong safety net. This funding would support grants to local communities to enhance collaboration and cooperation among safety-net clinics and hospitals, helping to produce a more efficient and seamless health care system for the uninsured. This time around, decisionmakers must understand that the debate needs to ex-

tend beyond expanding insurance coverage, to include support for current and future initiatives to strengthen and assure broader access to safety-net providers.

NOTES

1. *America's Health: A Report to the Nation* (Report of the National Health Assembly, 1949).
2. P.L. 97-35 (13 August 1981); and P.L. 98-21, (20 April 1983).
3. Congress enacted legislation in 1989 that established FQHC services as a separate benefit under Medicaid and required states to reimburse these services at 100 percent of their reasonable cost, unless the FQHC agrees to a different amount. See Section 6404 of the Omnibus Budget Reconciliation Act (OBRA) of 1989, which amended Section 1902(a)(13) of the Social Security Act. 42 U.S. Code, sec. 1396a. The Medicaid DSH program was created by P.L. 100-203, 100th Cong., 1st sess., 101 Stat. 1330-149, sec. 4112, codified at 42 U.S. Code sec. 1396r-4.
4. This estimate of the uninsured comes from the March 1998 Current Population Survey (CPS). Some researchers believe that the CPS estimates may be too high. See K. Lewis, M. Ellwood, and J.L. Czajka, *Counting the Uninsured: A Review of the Literature* (Washington: Urban Institute, July 1998). Regardless, the CPS numbers have been increasing by about ten million uninsured persons per decade. At this rate, nearly fifty-four million Americans would be without insurance by 2007.
5. House Majority Leader Richard Armey (R-TX), introduced refundable tax credits to help uninsured people buy health insurance. H.R. 2362, 106th Cong., 1st sess. (1999). The House Education and the Workforce Subcommittee on Employer-Employee Relations approved a bill to allow small-business owners to pool their purchasing power via association health plans. *Small Business Access and Choice for Entrepreneurs Act*, H.R. 2047, 106th Cong., 1st sess. (1999). The Senate approved the *Work Incentives Improvement Act* (S. 331, 106th Cong., 1st sess., 1999) 16 June 1999, which would provide Medicaid and Medicare coverage to disabled persons who are returning to work, by a vote of 99-0, and President Clinton's proposal to reform Medicare contains a "buy-in" for certain persons between the ages of fifty-five and sixty-five who have become uninsured. See "Medicare: Clinton Proposes Sweeping Changes in Program, Including Prescription Drug Plan," *BNA's Health Care Daily Report*, 30 June 1999.
6. DSH caps (1991 and 1993 amendments), 42 U.S. Code, sec. 1396r-4(g). *Balanced Budget Act of 1997*, P.L. 105-33, sec. 4721, modifying 42 U.S. Code, sec. 1396r-4(f).
7. An analysis conducted for the American Hospi-

tal Association found that BBA payment reductions would force total Medicare margins downward to -4.4 percent or even lower. See *The Balanced Budget Act and Hospitals: The Dollars and Cents of Medicare Payment Cuts* (Fairfax, Va.: Lewin Group, May 1999).

8. A report from the Institute of Medicine's Committee on the Changing Market, Managed Care, and the Future of Safety Net Providers is due late fall 1999. See also R.J. Baxter and R.E. Mechanic, "The Status of Local Health Care Safety Nets," *Health Affairs* (July/August 1997): 7-23; S.A. Norton and D.J. Lipson, "Portraits of the Safety Net: The Market, Policy Environment, and Safety Net Response," Occasional Paper no. 19 (Washington: Urban Institute, 1998); and D.J. Gaskin, "Safety Net Hospitals: Essential Providers of Public Health and Specialty Services," Commonwealth Fund Briefing Note (New York: Commonwealth Fund, February 1999).
9. According to a study by Scott Keeter of the Virginia Commonwealth University and the Pew Research Center for the People and the Press, and Carolyn Miller of Princeton Survey Research Associates and the Pew Research Center, presented at the May 1998 meeting of the American Association for Public Opinion Research, many leading U.S. pollsters achieve a response rate of 42 percent for a household survey. Since response rates are generally not published along with findings in peer-reviewed journals, it is difficult to determine whether other national surveys outperform this standard. In the NAPH survey, conducted by Lake, Snell, Perry, and Associates (Washington, D.C.), more than half (52 percent) were women; 72 percent were white, 12 percent black, and 11 percent Hispanic. The sample was weighted to reflect national averages for sex, race, and party affiliation. It was not weighted to adjust the number of uninsured persons in our survey to national averages. Uninsured respondents were slightly more supportive of safety-net services; thus, weighting according to insurance status would push the results marginally higher. The overall effect, however, would be extremely small. Thirty-nine percent of respondents had no more than a high school diploma; 57 percent had attended college or graduate school. Nineteen percent of the sample were under age thirty, and 18 percent were age sixty-five and older. Just over half of respondents said that they were enrolled in a managed care plan; 11 percent said that they were uninsured at the time of the survey. Eighty percent characterized their health as excellent or good. When asked about party affiliation, 32 percent identified themselves as Democrat, 28 percent as Republican, and 32 percent as Independent.

Bio

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Mr. Gage formerly served as Deputy Assistant Secretary for Health Legislation in the U.S. Department of Health and Human Services from 1978-81, and as staff counsel to the U.S. Senate Labor and Human Resources Committee from 1973-1977.

His areas of expertise include the organization and legal structure of hospitals and health systems; medical education including medical school affiliation agreements and faculty practice plans; managed care; capital finance; and reimbursement. He has written or edited several books and book-length studies, authored more than thirty articles, and made over 100 speeches on a variety of health law topics.

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Bio

Marsha Regenstein, Ph.D.

Marsha Regenstein, Ph.D., is vice president for research at NAPH. She is also director of the National Public Health and Hospital Institute (NPHHI), an organization established in 1988 to address the major issues facing public hospitals, safety net institutions, underserved communities and related health policy issues of national significance.

Prior to joining NAPH and NPHHI, Dr. Regenstein was vice president of the Economic and Social Research Institute, where she specialized in research on Medicaid managed care and its impact on children and adults with chronic conditions and disabilities.

She received her Ph.D. in health policy from George Washington University, a Master of City Planning from MIT, and a B.A. with Honors in American Studies from Brandeis University.

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National Association of Public Hospitals & Health Systems (NAPH)

1999-2000 Legislative Priorities

Fix the 1997 Balanced Budget Act.

Cuts initiated in the Balanced Budget Act of 1997 (BBA) are much deeper than anyone anticipated at the time and are threatening the viability of hospitals and other providers. Safety net hospitals are particularly vulnerable. Several recently-released studies detail the impact of BBA cuts on hospitals. If these cuts play out as projected, all hospitals, but particularly safety net hospitals, will be devastated financially.

NAPH has asked Congress and the Administration to restore some of the funding reduced in the BBA, in particular the cuts in the Medicare and Medicaid disproportionate share hospital (DSH) programs. DSH payments are a vital source of financing to support care to low income and uninsured patients. At a time when the number of uninsured continues to rise, maintaining and strengthening these two programs is critical. NAPH has requested that Medicare DSH cuts to be held to the current year level until 2002. Further, we have asked that additional Medicaid DSH cuts be eliminated, and that the level be maintained at the year 2000 level.

Implement the Safety Net Initiative in the 2000 budget.

Another important step in strengthening the health care safety net would be achieved by implementing the new national initiative that was included in the Administration's FY 2000 budget request for the Department of Health and Human Services. The budget request includes \$25 million as seed funding for FY 2000, and \$250 million per year for each of the next four years, to finance safety net reforms in up to 100 communities around the country.

The initiative would pave the way for significant innovation and experimentation at the local level, with local consortia of providers proposing the most effective use of the funding for their communities. For example, the money could be used to develop community health networks that would expand primary care services, or allow safety net providers to share expensive technology such as digital x-rays or automated lab testing equipment. The goal of such an initiative is to develop self-sustaining models for delivering health care to vulnerable and at-risk populations.

Protect the Medicare DSH and GME programs.

Currently, Medicare hospital reimbursement includes explicit adjustments to pay for care for the poor through the disproportionate share hospital (DSH) program and for graduate medical education (GME). Medicare's role in funding both GME and DSH payment adjustments has been debated, and some have called for the removal of these payments from the Medicare trust fund. NAPH strongly opposes efforts to eliminate these necessary payments, although we do agree that Medicare should not be the only payer supporting care for the poor and graduate medical education. Removing these payments from the Medicare Trust Fund would put them at risk and make them vulnerable to reductions or reallocation to other areas of the federal budget.

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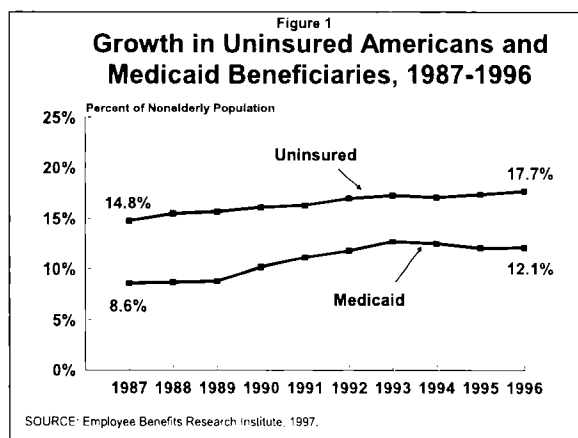
THE UNINSURED AND THEIR ACCESS TO HEALTH CARE

Health insurance makes a substantial difference in the amount and kind of health care people are able to obtain. The consequences of not getting needed medical care are not trivial, and can result in unnecessary hospitalizations and serious health problems.

Nearly all of the elderly are covered through Medicare, so most uninsured Americans are individuals under the age of 65. While the majority of people receive health insurance coverage through their employers, millions of Americans lack access to health coverage either because their employer does not offer it or they cannot afford to pay for it. Medicaid plays an important role by covering millions of low-income people, but millions more do not meet its restrictive income and eligibility criteria and are left uninsured.

HOW MANY ARE UNINSURED?

Over 41 million Americans are uninsured — nearly 18% of the total nonelderly population (Figure 1). The number of Americans without health insurance has grown by nearly 10 million over the past decade. A smaller share of Americans have health insurance today through their jobs and even more would be uninsured were it not for eligibility expansions and enrollment growth in the Medicaid program over the past ten years.

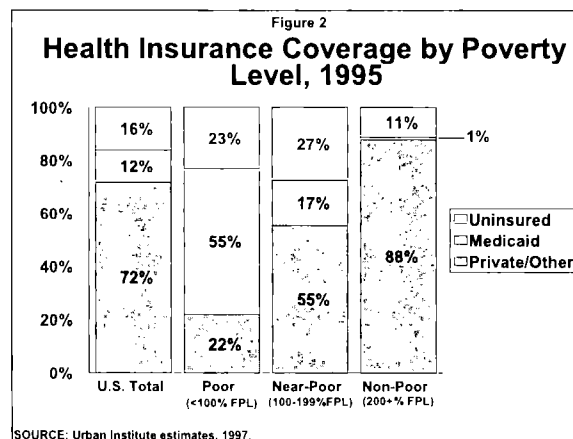


Many more Americans who are currently insured have had a period without health coverage in the recent past. In 1997, almost a third of nonelderly adults (32%) were uninsured at some time in the previous two years. Of these, over 40% were uninsured for more than two years. The majority of the uninsured say they lack coverage because it is too costly; very few claim that they don't want or need health insurance.

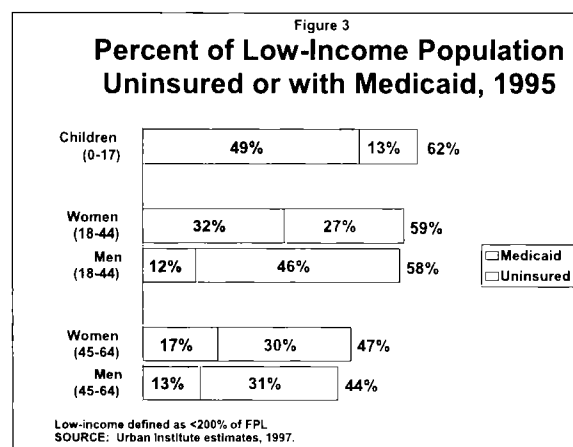
WHO ARE THE UNINSURED?

The uninsured are predominantly workers and their families, many of whom have low incomes.

- Eight out of 10 of the uninsured are full-time workers or their dependents. Only 10% of the uninsured are in families with no connections to the workforce.
- Over half of the uninsured (54%) have low incomes, making less than 200% of the federal poverty level (\$25,180 for a family of three in 1995). The poor comprise a fifth of the uninsured population.
- The near-poor run the highest risk of being uninsured because they may not qualify for Medicaid and they often cannot afford health insurance. Over one quarter (27%) of the near-poor are uninsured (Figure 2).



- Due in part to Medicaid's eligibility categories, low-income, young men are more likely to be uninsured than women. Nearly half (46%) are uninsured compared to 27% of low-income, young women (Figure 3).



- While the majority (56%) of the uninsured are white, Hispanics (22%) and African Americans (17%) are over-represented among the uninsured population.

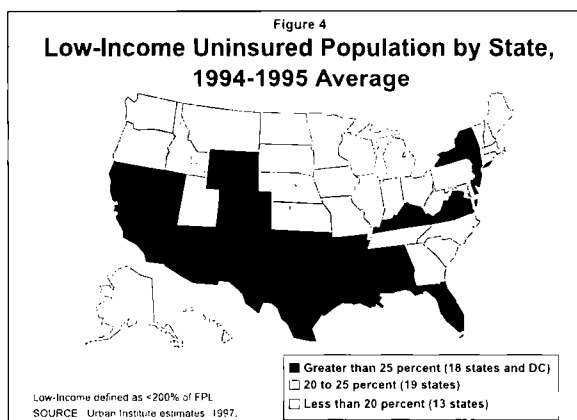
Uninsured Workers. Twenty-two million workers — 17% of the workforce — are uninsured. Over half of the uninsured workers are employed full-time. Where a person works and the wages paid influence the risk of being uninsured.

- Over 1 in 4 (27%) low-income workers (those earning under \$20,000/year) are uninsured compared to 5% of high-income workers (earning over \$40,000/year).
- Part-time workers or those who work only part of a year are at higher risk of being uninsured — over 20% are uninsured compared to 14% of full-time workers.
- Workers in businesses with fewer than 100 employees are more likely to be uninsured. Even in large firms with more than 1,000 employees, 20% of low-income workers, earning under \$20,000, are uninsured.

Uninsured Children. One in 5 (19%) of the uninsured are children. State and Federal Medicaid expansions in the 1980s and 1990s helped to stem the growth of uninsured children. Despite these gains, almost 10 million children lack coverage. It is estimated that up to 4.7 million children are potentially eligible for Medicaid but not enrolled. The new Children's Health Insurance Program may provide access to affordable coverage for more low-income uninsured children.

Over 85% of uninsured children live in families where at least one parent is working full-time. Many live in families who lack access to job-based coverage and others come from low-income families who cannot afford premium costs. Most uninsured children have parents who also are uninsured.

State Variation. The proportion of a state's population who are uninsured varies widely across the country as does the share of a state's low-income population without insurance, ranging from a low of 8% in Hawaii to 38% in Texas (Figure 4). In 18 states, over 25% of the low-income population is uninsured. Some states have developed programs to extend coverage to this group through Medicaid or with separate state funding.

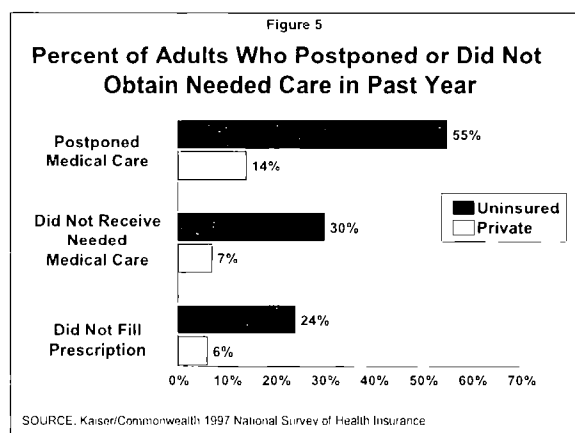


The Kaiser Commission on Medicaid and the Uninsured was established by the Henry J. Kaiser Family Foundation to function as a policy institute and forum for analyzing health care coverage, financing and access for the low-income population and assessing options for reform. The Kaiser Family Foundation is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

WHAT DIFFERENCE DOES HEALTH INSURANCE MAKE?

Health insurance affects access to health care, health outcomes, and the financial well-being of families.

- One in 5 uninsured children have no regular source of care, and uninsured children are 30% more likely to fall behind on well-child care and 80% more likely to never have had routine care.
- Uninsured children are at least 70% more likely than insured children not to have received medical care for common conditions like asthma — illnesses that if left untreated can lead to more serious health problems.
- Over half of uninsured adults have no regular source of care. 55% of uninsured adults say they have postponed care and a quarter have not filled a prescription in the past year — because they could not afford it (Figure 5).



- Uninsured adults are 4 times more likely than the privately insured to say they have not received medical care they believed to be necessary.
- Uninsured adults are less likely than the insured to use preventive services like check-ups and mammograms.

Because their primary health care needs are not addressed, the uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as uncontrolled diabetes. The uninsured are also less likely to have a procedure that is relatively costly or where physicians exercise a great deal of discretion.

Medical bills mount quickly if a person is uninsured. Over a third of adults who are uninsured report they have had a problem paying their medical bills in the past year. Fear of these debts is an important reason why many of the uninsured do not get the medical care they need.

In summary, health insurance matters for the millions of Americans who lack coverage. Decisions made by the uninsured to delay or forego needed care because of its cost, coupled with health providers who tend to order less or different treatments for patients without coverage, ultimately can lead to poorer health outcomes.

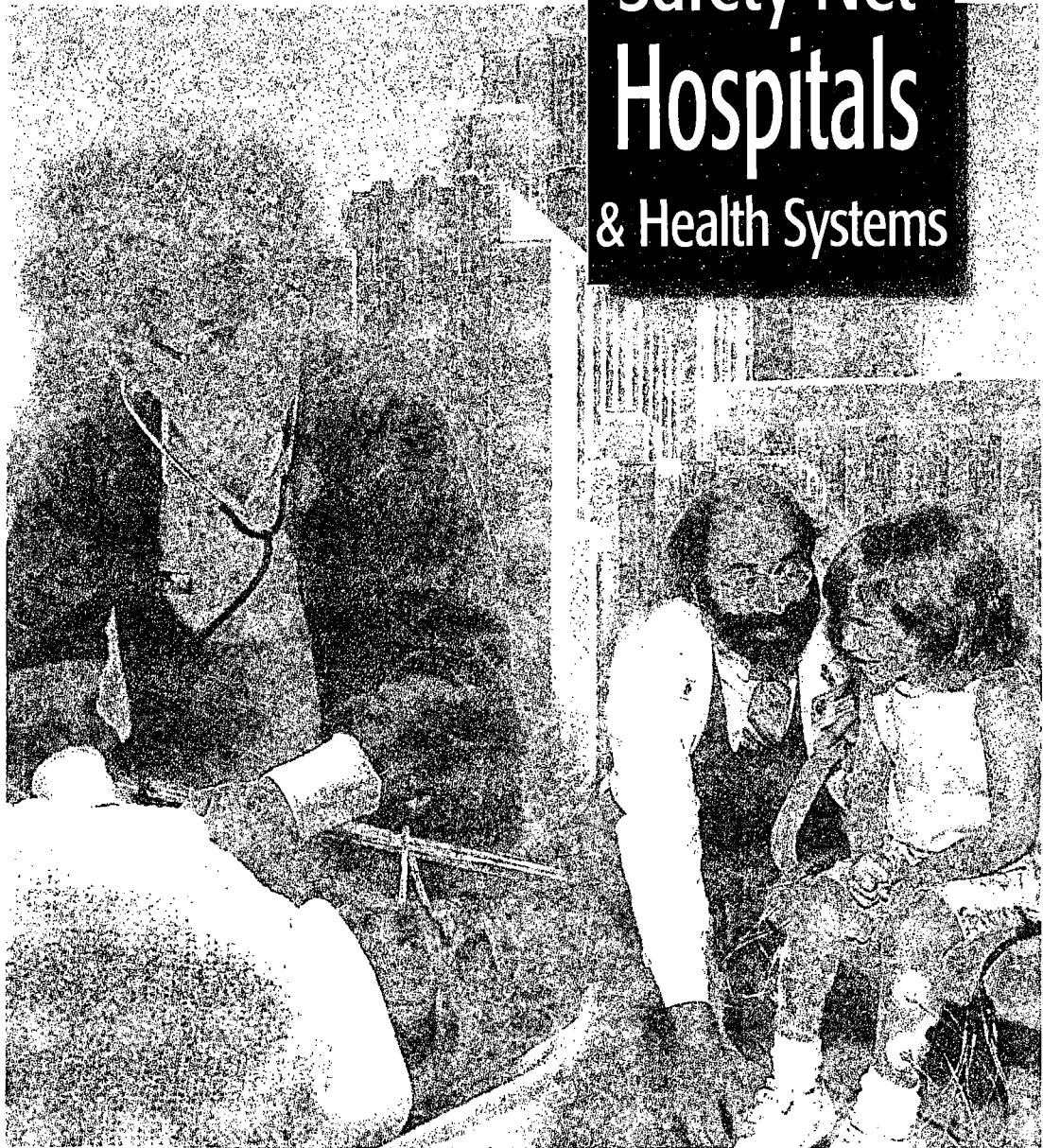
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America's Safety Net Hospitals & Health Systems



**Why Americans
strongly support them**

**What must be done to
protect them**

*Results of a
national poll from the
National Association
of Public Hospitals
& Health Systems*

News Release

National Association of Public Hospitals & Health Systems

September 14, 1999
FOR IMMEDIATE RELEASE

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FIRST NATIONAL POLL ON SAFETY NET HOSPITALS SHOWS BROAD-BASED POLITICAL SUPPORT AMONG VOTERS

Americans Willing to Support Safety Net Hospitals; See Access to Care Diminishing; Want Congressional Action on Health Care Reform

WASHINGTON, DC, September 14, 1999 – The National Association of Public Hospitals & Health Systems (NAPH) today released the results of a national poll showing that Americans in urban and suburban areas overwhelmingly support the nation's system of safety net hospitals, and are willing to pay to preserve and protect that system. The poll also found that American voters, regardless of party affiliation, want Congress to act on long-term solutions to the problem of the uninsured. This is the first poll ever to examine the public's attitudes about public safety net hospitals and the role those hospitals play in America's healthcare system.

"This poll shows conclusively that Americans value safety net hospitals, and they believe that tax dollars should be used to support them – at levels higher than is currently the case," said Larry S. Gage, NAPH president. "The important message here is that there is broad-based support among voters all across the political spectrum to deal boldly and definitively with problems facing the safety net."

The NAPH survey offers an unambiguous, consistent and strong message of support for the nation's healthcare safety net. Key findings include:

- All segments of the American public in urban and suburban areas are extremely supportive of the safety net. A total of 96 percent of respondents said it is important that there are safety net hospitals and clinics.

- MORE -

NAPH represents over 100 hospitals and health systems that together comprise the safety net infrastructure of many of America's largest urban health systems. Our members provide a full range of healthcare services to their patients and communities, from primary care and public health to highly specialized services, regardless of the patient's ability to pay. NAPH was founded in 1981.

- The American public believes that safety net hospitals need increased funding. 86 percent of respondents said that tax dollars should go to these institutions.
- The public feels personally invested in the future of the safety net. Three out of five of respondents (61%) said they would personally be willing to contribute more to support these hospitals.

In addition to these findings about the safety net itself, the poll also found that a relatively high percentage of urban and suburban Americans have been uninsured at some point in their lives, or believe they could be uninsured in the future. Many poll respondents believe that access to health care is diminishing, and fear that they or a member of their family will lose health insurance coverage within five years:

- Overall, 40 percent of respondents said that people have a harder time getting in to see a doctor today than in the past.
- More than half of those currently uninsured (11 percent of the sample respondents) say it is harder now than it was five years ago to see a doctor or to receive hospital services.
- More than one-third of *insured* respondents also believe access has gotten worse.
- Half of all respondents (including those who were uninsured at the time of the survey) said that they had gone without health insurance coverage for some period of their lives.
- One-third of the *currently insured* respondents said it is likely that they or someone in their family might be without health insurance at some time over the next five years.

Other findings in the survey show that the vast majority of Americans (83% of survey respondents), regardless of political party affiliation, believe that the U.S. Congress should pass comprehensive health reform legislation guaranteeing health insurance for everyone. But more than half of the public believes that this is not likely to occur.

“Given the public’s high regard for safety net institutions, and their personal concerns about access to care and availability of insurance for themselves and their families, it is not surprising that the American voter wants something done about the problems facing safety net hospitals and the uninsured population in this country,” said Gage. “They know that they may need those hospitals some day.”

“There is virtually universal support for safety net hospitals among the urban and suburban electorate,” said Marsha Regenstein, Ph.D., NAPH research director. “This support is consistent across gender, age, income level, race, and party affiliation.”

In a report on the poll published today – *America's Safety Net Hospitals & Health Systems: Why Americans Strongly Support Them, What Must be Done to Protect Them* – Larry Gage and co-authors Marsha Regenstein and Christine Burch, NAPH executive director, called on Congress to take action on strengthening the safety net. Those calls to action include:

- Dealing decisively and definitively with the problem of the uninsured in America.
- Developing a new nationwide program of support for providers serving the uninsured.
- Fixing the current system of support for safety net hospitals.

Results of the poll were also published yesterday (September 13, 1999), in *Health Affairs* (Volume 18, Number 5, September/October 1999 issue) in an article authored by Gage and Regenstein.

The poll was conducted for NAPH in May, 1999, by Lake, Snell, Perry & Associates, a Washington, DC-based national opinion research firm. The survey was administered by telephone to 1,000 randomly selected Americans, 18 years of age or older, in urban and suburban households around the country. These households represent 79.6 percent of all households in the country. Given a poll of this size, the findings are statistically accurate within plus or minus 3.1 percentage points at the 95 percent confidence level.

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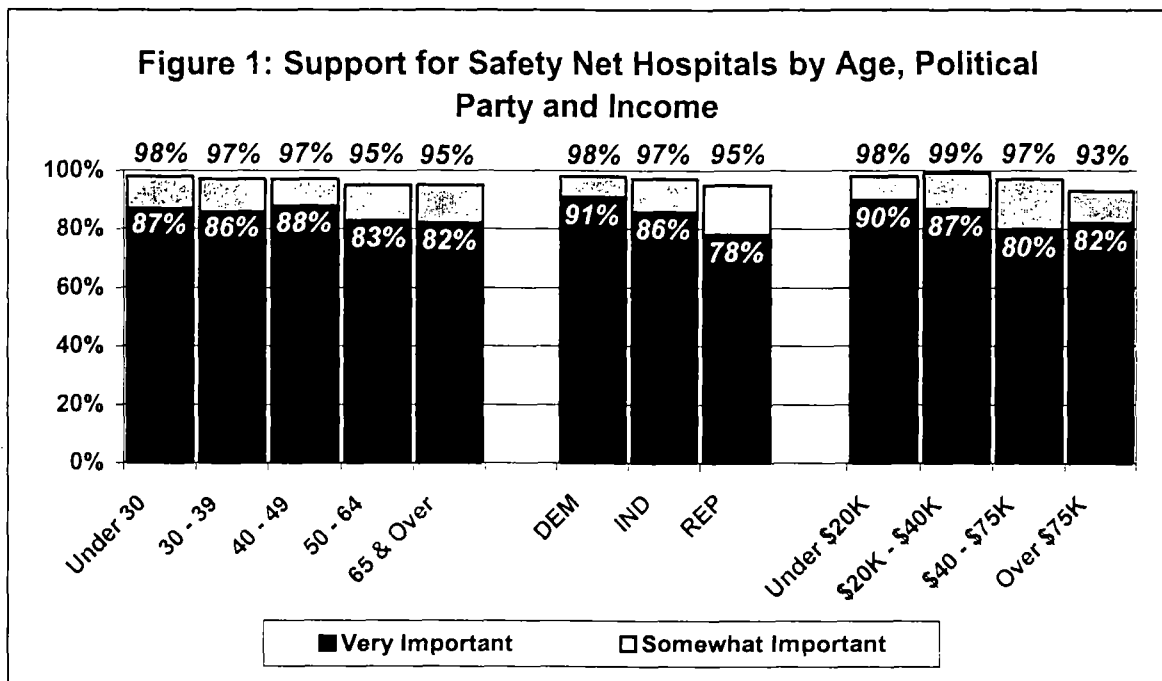
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SUMMARY: Messages from the Opinion Poll Findings

Page references are to poll report in the press kit.

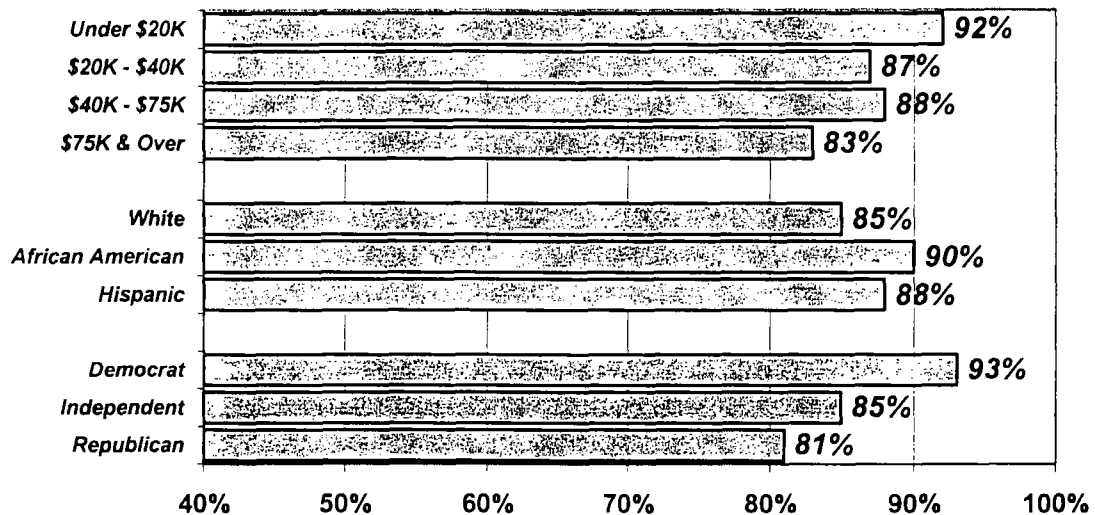
1. An overwhelming majority of Americans in urban and suburban households believe it is very important for safety net hospitals to provide care to the uninsured. (p. 3)
2. Support for safety net hospitals is consistently strong across all demographic groups. Regardless of their gender, age, race, income, or political party affiliation, people wholeheartedly throw their support behind safety net hospitals and clinics. (p. 4)
3. People are willing to pay for supporting the safety net. More than five out of six people believe that tax dollars should be used to pay for safety net services. Again, this support is consistent irrespective of gender, age, race, income, or political party. (p. 4)
4. The American public is willing to go beyond current funding to support safety net hospitals and clinics. They want more public funds to help provider care for the uninsured. And they are willing to contribute personally more money each month to provide care for the uninsured. (p. 4-5)
5. People at all different income levels are willing to contribute more money personally each month to provide care for the uninsured. (p. 5)
6. People generally do not see a difference between the quality of care at safety net hospitals and other hospitals in their areas, with two important exceptions. They say that safety net hospitals do a better job in caring for the health of their communities than other hospitals in the area, but generally also having longer waiting times. (p. 6)
7. There is near universal support for access to care for the uninsured. Regardless of gender, age, race, income or political party affiliation, the public says it is very important that uninsured people have access to medical and hospital services. (p. 7)
8. Despite their strong feelings about the importance of access to care, people say that it has gotten harder over the past five years to get physician or hospital care. People who are currently insured are particularly aware of these difficulties and in greater numbers say that it has gotten harder over the past five years to get these services. (p. 8)
9. The vast majority of Americans, regardless of political party affiliation, believe that the U.S. Congress should pass comprehensive health reform legislation guaranteeing health insurance for everyone. But more than half of the public believes that this is not likely to occur. (p. 9)
10. Half of the respondents in the NAPH indicated that had personally been uninsured at some point in their lives. Minorities and people living in households with lower family incomes were more likely to have been uninsured in their lives than people identifying themselves as white or higher-income. But numbers were high across the groups. (p. 10)
11. About a third of respondents in the NAPH poll *who were insured at the time of the survey* said that it was likely that they or a family could be uninsured at some time in the next five years. Minorities and people living in households with lower family incomes were more likely to see themselves being uninsured in the future than people identifying themselves as white or higher-income. (p. 11)



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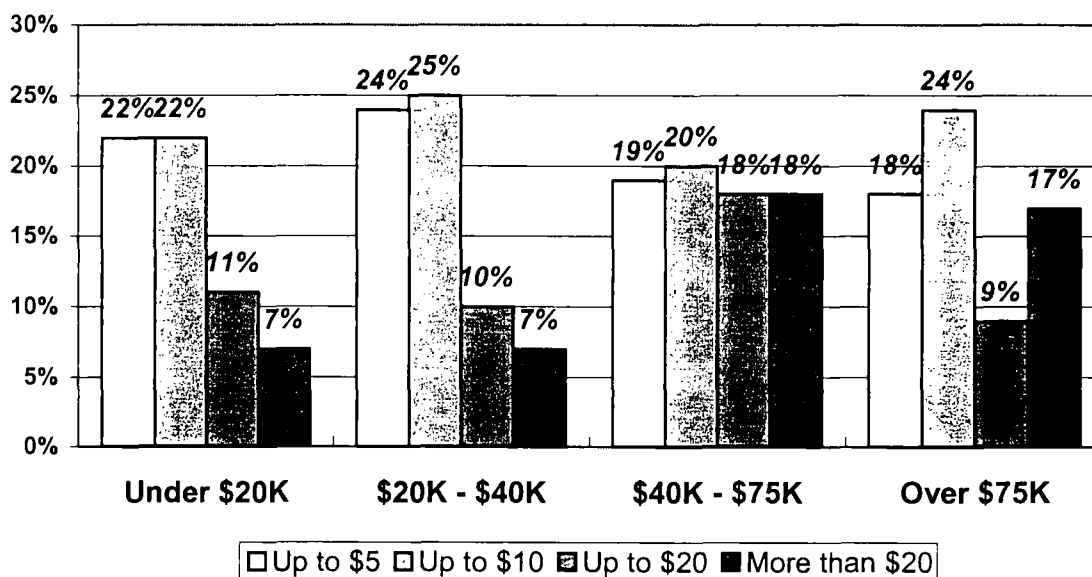
Figure 2: Percent Supporting Tax Dollars for Safety Net Hospitals, by Income, Race and Political Party



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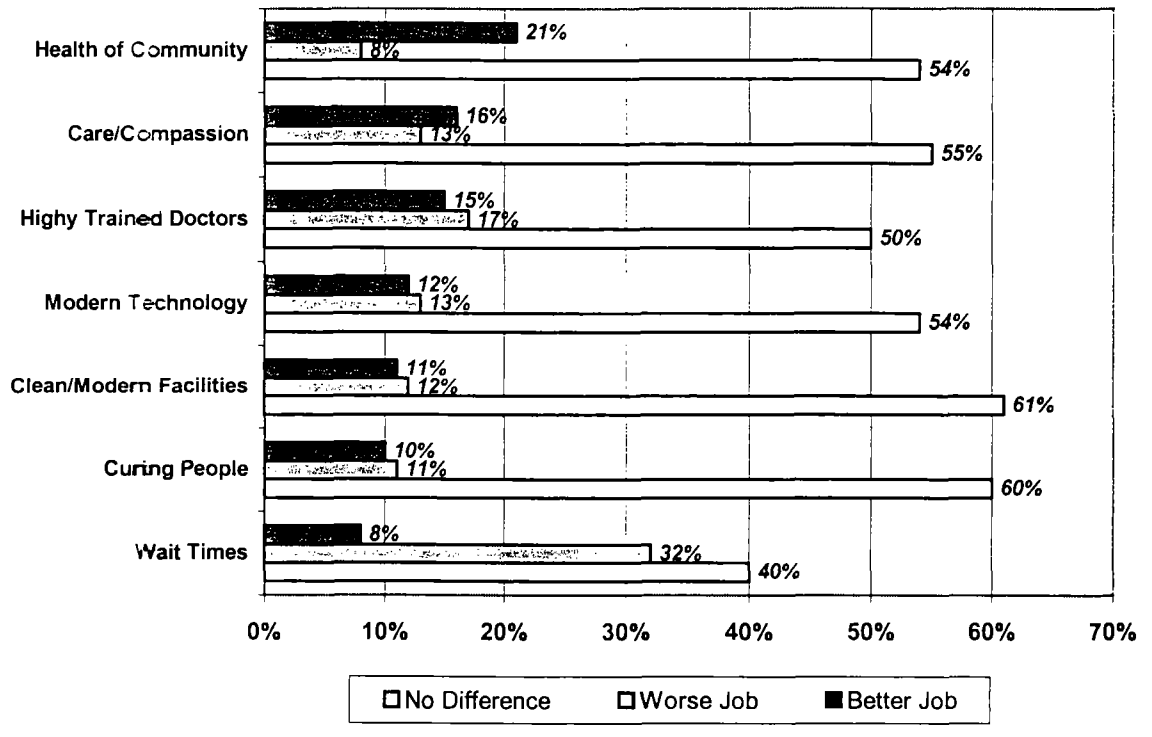
Figure 3: Willingness to Personally Pay More Each Month to Provide Care for the Uninsured, by Income



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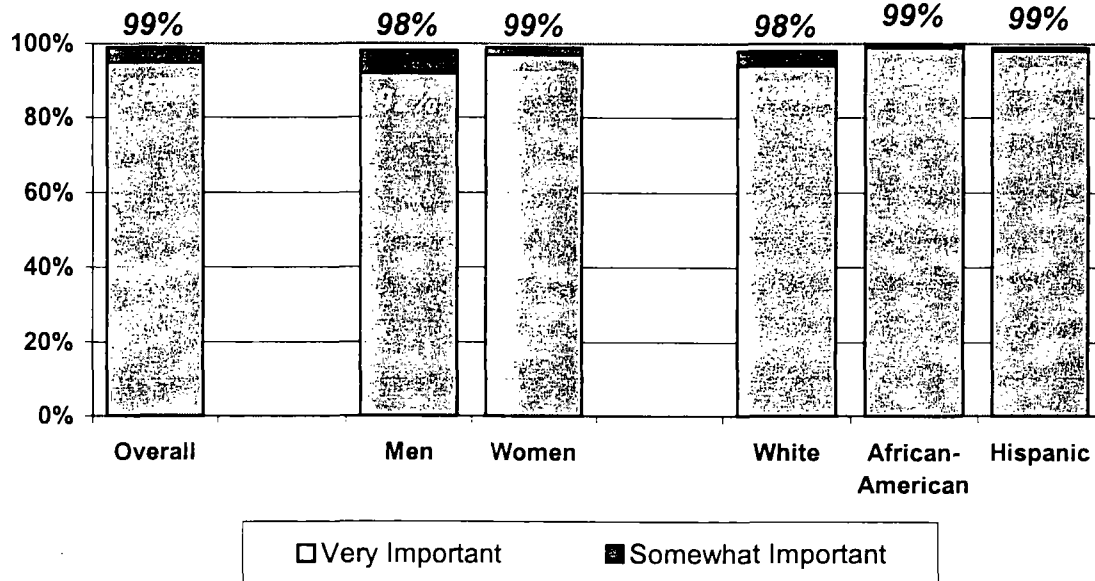
Figure 4: Quality of Care in Safety Net Hospitals Compared to Other Hospitals



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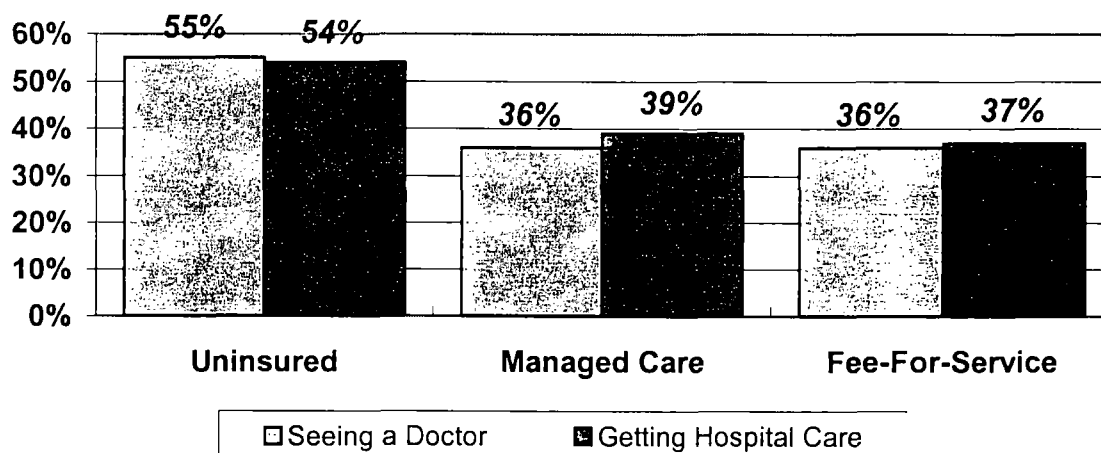
Figure 5: Percent of Respondents Saying it is Important to Have Access to Medical Services, by Gender and Race



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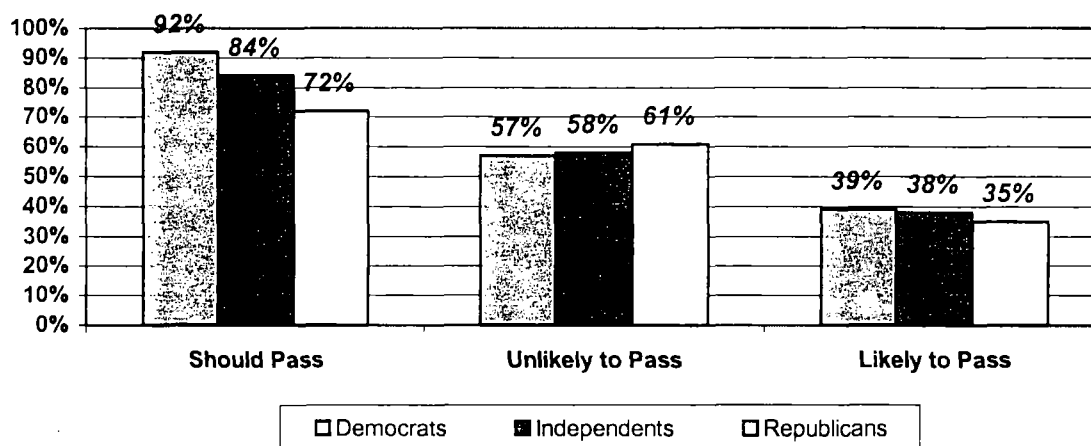
Figure 6: Percent of Respondents Who Say Access to Doctors and Hospitals Has Become More Difficult in Last Five Years, by Type of Health Plan



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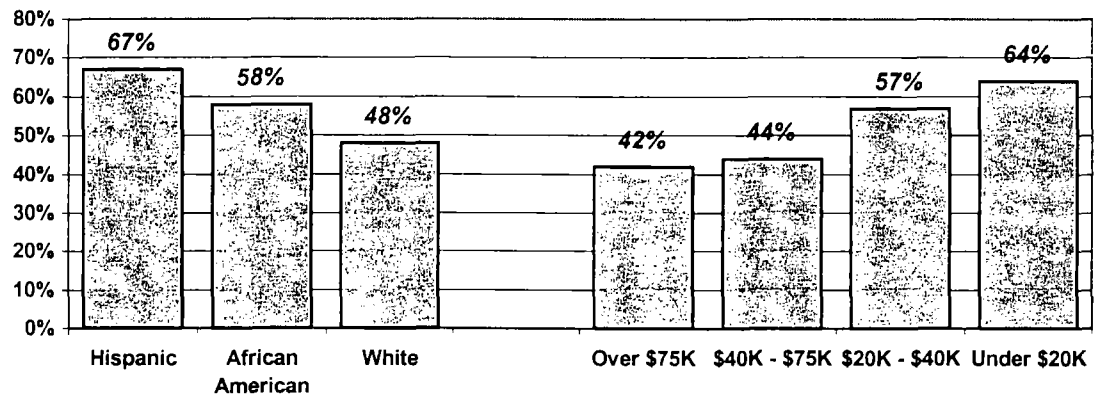
Figure 7: Views about the Likelihood of Congress Passing Comprehensive Health Reform Legislation Guaranteeing Health Insurance for Everyone in America, by Political Party



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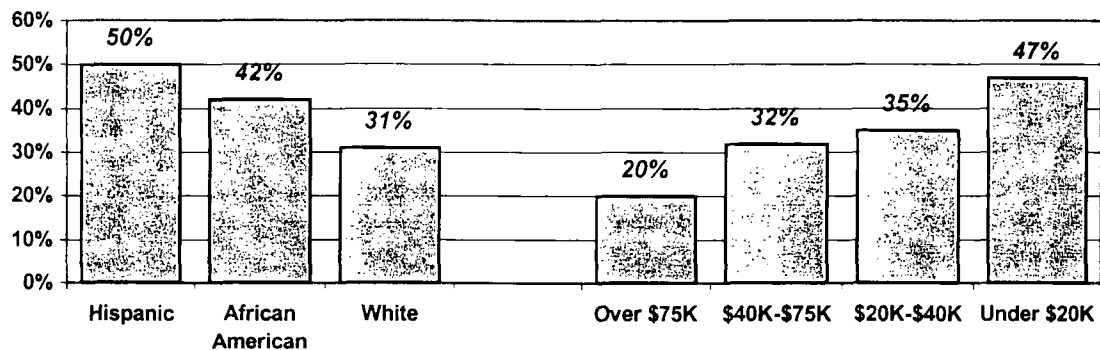
Figure 8: Percent of Respondents Indicating that They Have Been Uninsured, by Race and Income



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Figure 9: Percent of Respondents Who Say It Is Likely They or a Family Member Might be Uninsured in the Next Five Years, by Race and Income



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ILLINOIS PRIMARY HEALTH CARE ASSOCIATION

September 2, 1999

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Community Health Center, Joliet

**Bruce A. Johnson, President &
Chief Executive Officer**

Mr. Chris Jennings
Deputy Assistant to the President for Health Polic
216 Old Executive Office Building
Washington, DC 20502

Dear Mr. Jennings,

As the number of uninsured continues to rise across the United States, the Illinois Primary Health Care Association (IPHCA) is taking steps to address the problem here in our state. We thought you might be interested in part of the overall strategy we are using to do so.

We have confirmed, via our own state research, that the majority (approximately 66%) of Illinois' uninsured are working individuals. Unfortunately, their employers do not offer health coverage, or the coverage offered is sparse and too expensive, and purchasing private insurance is too costly of an option.

There are approximately 1.5 million uninsured people in Illinois. Each of these individuals has a story to tell about how the lack of health insurance has negatively affected their life, and we are helping them tell it. After interviewing such individuals, we develop postcards, letters to the editor and to their state legislators, and other materials that serve as their voice. Enclosed you will find two of the recent postcards we developed, which were mailed to Illinois legislators and their staffs, as well as to various state agencies, media contacts, and state officers. It is our hope that by making their story heard, we can put a face on the uninsured.

These postcards also help promote our legislative agenda, specifically our Comprehensive Primary Medical Care Program (CPMCP) proposal, which is currently being considered before the Illinois State General Assembly. Under this proposal, a State grant program would be established to fund new primary care sites or to expand services at existing sites in order to serve more uninsured residents. Illinois spends a fraction of what other states of equal or lesser size spend in support of primary care services. It is our hope that we can begin the process of maximizing both Federal and State resources to address the problem in our state.

I welcome your thoughts or any feedback you may want to share, so please do not hesitate to contact me directly.

Sincerely,

Philippe J. Largent,
Director of Legislative Affairs, Illinois Primary Health Care Association
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NATIONAL RURAL HEALTH ASSOCIATION

September 7, 1999

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The Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

The NRHA applauds you and your Administration for your tireless and continued efforts to preserve the federal Medicare program for current beneficiaries and future generations of Americans. The NRHA believes major restructuring of the current Medicare program must occur to meet five basic and fundamental principles:

1. Secure the long-term financial solvency of the Medicare program;
2. Guarantee access - availability and affordability - to quality health care services for all Medicare beneficiaries;
3. Reduce the financial constraints currently being placed upon rural health care providers by the Balanced Budget Act of 1997;
4. Expand the choice of health plans available in rural areas; and
5. Provide access to affordable prescription drug benefits for rural Medicare beneficiaries.

Both the Administration and the Breaux-Thomas proposals will have disparate impacts on rural and urban beneficiaries and health care providers. Some of these differential effects are by design and others are unintended. Both plans base Medicare savings on a competitive model in which plans compete on cost and quality for Medicare enrollees. As such, they are urban models and do little to develop a comprehensive approach to health financing and delivery that accounts for the lack of competition in rural areas. By focusing almost exclusively on cost containment, and in the case of your proposal, eligibility and benefit expansion, both plans fail to address the fundamental rural issue of ensuring access to care and the local survival of basic health care services. Such urban-based solutions have historically proven to be inappropriate for rural areas and often lead to unforeseen and unintended consequences for rural providers.

Because the economic health of rural communities is inextricably tied to the economic well-being of the local health care system, a broader approach to health care reform is needed in rural and frontier America. Although the focus on cost containment is

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understandable at the national level, effective reform in rural areas will necessarily combine cost reduction with policies that enhance access, establish appropriate quality standards, and view all aspects of the community — health care, economics, education, etc. — as parts of a greater whole.

The NRHA's comments found below outline the major impacts of the two proposals on rural Medicare beneficiaries and health care providers. The NRHA drew many of its comments and conclusions from the excellent analyses of the Rural Policy Research Institute (RUPRI) and the Federal Office of Rural Health Policy. We hope our comments will provide you and your advisors with constructive feedback and suggestions that will assist you in drafting legislation with the Congress that ensures access to health care services for rural Medicare beneficiaries

Administration Medicare Reform Proposal

1) Medicare Preferred Providers. The Administration proposal creates a new Medicare Preferred Provider Option (PPO), in which the federal government will contract with existing PPOs that meet quality and utilization management standards. Beneficiaries that receive services from PPO providers would be subject to lower cost sharing requirements.

This proposal has two important impacts on rural areas. First, like other provider organization arrangements, PPOs are not as prevalent in rural areas where there is less provider competition than in urban areas. As a result, rural beneficiaries are less likely to have this lower cost option available. Second, if utilization management standards applied to PPOs do not account for differences in practice styles and the types of available providers, rural providers may have difficulty qualifying for PPO membership. For example, rural physicians are less likely to have different patterns for referrals and use of specialty providers due to limited availability of specialty services in many rural areas.

2) Primary Care Case Management and Disease Management. To produce savings in the treatment of the small percentage of beneficiaries that account for a majority of Medicare costs, your plan proposes contracting with entities to coordinate a range of health services, either for particular beneficiaries or for specific diseases. First, Medicare could contract with primary care case managers (PCCMs) to coordinate services for beneficiaries in the FFS system. This option could benefit rural beneficiaries who do not presently have access to case management services. To be designated as PCCMs, however, primary care physicians would have to meet certain performance standards and criteria. As noted above, if these criteria do not take differences in rural practice into account, rural physicians may have difficulty meeting them. The success a number of states have already had in implementing primary care case management for Medicaid beneficiaries should serve as a model.

Second, the disease management authority would allow Medicare to contract with "coordinated care delivery systems" which provide physician-directed nurse-mediated disease management services for beneficiaries with conditions such as diabetes or congestive heart failure. Again, to the extent that such services are less available in rural areas, rural beneficiaries would not have the

option to receive care under such arrangements. Because rural beneficiaries have higher rates of chronic disease than urban beneficiaries, if PCCM and disease management services are not available, the Medicare program may not be able to reach the level of savings expected from this component of the plan.

3) Competitive Defined Benefit Program. Under the current Medicare program, beneficiaries nationwide pay the same Part B premium, regardless of the actual cost of their plan. Under the Administration proposal, plans would be required to offer a standard benefit package and beneficiary premiums would be tied to the cost of the plan — premiums would be lower with lower cost managed care plans, the same if their plan's price is about equal to traditional program costs, and higher if their plan's price is higher than traditional Medicare costs. Beneficiaries who opt to stay in traditional FFS Medicare would pay Part B premiums as they do under the current program. This component of your plan raises similar availability and choice of plan issues for rural beneficiaries as the Breaux- Thomas plan.

4) Geographic Adjustment. Rather than having managed care rates set locally and FFS rates set nationally, your plan would determine payments for managed care and traditional FFS Medicare on the same national basis. In addition, payment adjustments would be made in high cost areas to reflect full local costs and BBA-mandated increases in the AAPCC for low cost areas would be maintained. To the extent that the BBA changes to the AAPCC raise rates in rural areas and encourage plan development, continuation of these policies are beneficial to rural beneficiaries in terms of enhancing choice of plans.

5) BBA Changes. The Administration proposal includes many actions to "smooth" implementation of the BBA. These include:

a) Hospital Outpatient PPS and geographic reclassification. The Administration plan would use the same wage index for calculating Medicare outpatient payments as is currently used to calculate inpatient PPS rates. This will extend to outpatient payment the current inequities in the inpatient wage index adjustment for rural hospitals as recognized by the Secretary of Health and Human Services National Advisory Committee on Rural Health. These inequities may be offset to some extent by proposed changes in the rules for geographic reclassification that will make it easier for rural hospitals to be reclassified as urban for wage index purposes and receive payments based on the higher wage index of nearby urban areas.

In addition, the Administration is considering a three-year transition in outpatient PPS payments to hospitals that would otherwise receive large payment reductions. Small rural hospitals could lose as much as 10-20% of Medicare outpatient revenue under PPS. The NRHA strongly opposes a phase-in because the impact on rural hospitals will ultimately be the same - small, rural hospitals will be placed in a more financially vulnerable situation. A phase-in of the PPS system for hospital outpatient services would be nothing more than a band-aid fix to a very serious problem which merits a more viable and long-term solution. As an alternative, the NRHA supports legislating an exemption for Medicare Dependent Small Rural Hospitals and Sole Community Hospitals from the proposed Medicare hospital outpatient prospective payment system.

b) Home Health Care. Your proposal will make a number of changes to the home health provisions of the BBA, including increasing time for repayment of overpayments, postponing the requirement for surety bonds and lowering the amount of the bonds, and easing reporting requirements. All of these changes have the potential to benefit small rural home health agencies, many of which have experienced severe negative impacts from the BBA. However, these changes are only short-term, in the context of the interim payment system, and are not designed for dealing with the potential inequities in the prospective payment system.

c) Inpatient Hospital Payment. The Administration plan proposes a phased-in reduction in the hospital market basket update for rural hospitals, until the same update applies for rural and urban hospitals in FY 2009. The NRHA commends the Administration for recognizing that rural hospitals have lower Medicare margins than urban hospitals and often provide services that are otherwise unavailable locally. However, the NRHA strongly opposes making any reduction, large or small, to the annual payment update for Medicare inpatient services. A reduction in the annual hospital inpatient update is a cut whether its implemented in its entirety now or phased-in. This is especially true for rural hospitals who are experiencing a greater percentage of negative total Medicare operating margins than their urban counterparts. Recent studies show that if the BBA is fully implemented Medicare operating margins for rural hospitals could fall to negative 10.4 percent (The Lewin Group, 1999).

6) Medicare Management Advisory Boards. The Administration proposes three public/private advisory panels to suggest management reforms for the Health Care Financing Administration (HCFA): a Management Advisory Council; Medicare Coverage Advisory Committee; and Citizens Advisory Panel on Medicare Education. To ensure that rural issues are understood and appropriately considered, all of these panels should include members with rural health experience and expertise.

7) Access to Medigap Policies. The BBA provided for a 63-day Medigap policy open enrollment period for beneficiaries in Medicare+Choice plans that terminated their Medicare contract or reduced their service area. A number of rural beneficiaries were affected by such pull backs. However, many of these beneficiaries were unaware of this open enrollment provision and insurance carriers were not prepared to effectively implement it. Your plan provides a one-time special 90-day open enrollment period for individuals who were enrolled in a plan and had no Medicare+Choice option after the plan terminated its contract or reduced its service area as of January 1, 1999. This provision will benefit those rural beneficiaries who were unaware of or unable to participate in the previous Medigap open enrollment.

8) Medicare Buy-in. The Administration plan allows people aged 62-64 to buy-in to the Medicare program. Because rural residents are less likely to have access to employer-based health insurance and rural areas have a higher rate of uninsured than urban areas, this provision should benefit rural areas more than urban areas.

Breaux-Thomas Medicare Reform Proposal

1) Plan Choice. The Breaux-Thomas proposal assumes that a number of health insurance plans would compete for beneficiary enrollment, or in areas where competition does not exist among private plans, standard and high option government run fee-for-service (FFS) plans would be available. All beneficiaries would therefore have at least two options to choose from, which is an improvement over the current situation, where many rural beneficiaries have access only to traditional FFS Medicare. Breaux-Thomas, however, does not directly provide additional incentives for plan development in rural areas and therefore may not solve the current inequities in plan choice that exist for rural beneficiaries. As a result, urban beneficiaries will continue to choose from a broad range of both FFS and managed care plans, while most rural beneficiaries will be limited to the traditional FFS system (although, as noted above, availability of a high option plan containing prescription drug benefits will be an enhancement in choice for many rural residents).

If the Breaux-Thomas proposal is successful, on the other hand, in spurring private sector development, it would encourage the creation of large regionally integrated health systems between rural providers or rural and urban providers. These regional systems could then develop their own health plans to compete for Medicare beneficiaries or have greater strength in negotiating with other plans. Like the situation faced in rural communities today, such systems offer both opportunities for creating viable health systems and improving access for rural residents and threats to local control of health care decision making.

2) Payment to providers. Under Breaux-Thomas, Medicare will be pay a single premium to health plans, including the government-run fee-for-service (FFS) plan. There will no longer be a legislative role, therefore, for setting payment to health care providers; prices for services would be set by health plans. Although it can be argued that the government has traditionally been unable to determine fair prices for rural providers, this market-based approach does not account for limited competition and the failure of the health care market in many rural areas.

Currently, there are many federally supported programs, both entitlement and discretionary, that recognize the special needs of health care providers in rural and underserved areas by offering enhanced payment rates and subsidies to these providers. The Breaux-Thomas proposal includes a provision that allows Congress to consider separate payments for certain classes of providers under the FFS plan, but these payments must be made in the face of market pressure on the FFS plan to compete with other, presumably lower priced, plans. As a result, rural providers could be negatively impacted by health plans that use their market power to steer patients to larger urban systems that are better able to offset low payments through high volume. Continuation of targeted programs for providers in rural and underserved areas and/or minimum provider payment levels may be necessary to offset these potential effects. In addition, RUPRI recommends periodic review of the financial viability of essential rural providers, targeted payment changes if problems are identified, and mandates that plans seeking enrollment in rural areas provide local primary care and emergency services.

In situations where plans are present and competing in rural areas, providers also face potential payment issues. Discounted or capitated payments offered by competing health plans are likely to be substantially lower for providers that have previously participated in special programs for underserved and rural populations under the current Medicare FFS system. If these providers cannot afford to accept such rates, plans may rely on providers outside the community, thus endangering the survival of local providers in another way, through loss of patient volume. For rural Medicare beneficiaries this may result in a serious access problem. The reality of rural America is that many rural seniors do not have the means or ability to travel long distances to obtain health care services. A mandatory minimum pricing structure under which plans would have to negotiate with providers may remove some of the potential market-based savings of Breaux-Thomas, but provide a more equitable playing field for small rural providers. The NRHA recognizes that plans could choose to pay differential bonuses to rural providers. However, they are not likely to do so if they can meet access requirements without providing such a bonus payment.

3) Beneficiary premiums. Under Breaux-Thomas, beneficiaries will pay a percentage of the premium for their health insurance plan. According to the formula used in the proposal, beneficiary payments will be higher in areas where most plans cost more than the national average and lower where they cost less. For example, if a beneficiary chooses a plan that costs only 85 percent of the national average, no beneficiary premium payment would be required. On the other hand, if a plan costs more than the national average, the beneficiary is responsible for covering the entire difference between the national average and the plan's actual premium.

Because only the FFS plan will be available in most rural areas (as is mostly the case in the Federal Employees Health Benefits Plan, upon which Breaux-Thomas is based), premiums for most rural beneficiaries will be set according to a national rate. Assuming that the FFS plan will cost more than other plans (as is also currently the case in FEHBP), rural beneficiaries in the future will be subject to higher premium payments than their urban counterparts and there will be a redistribution of premium dollars from rural to urban beneficiaries. The NRHA supports RUPRI's recommendation that numerous regional FFS plans, rather than a single national plan, could offset this inequity.

4) Extending Balanced Budget Act Provisions. Breaux-Thomas states that Medicare and Medicaid payment reductions and policy reforms included in the BBA should be extended beyond its current five-year window. Although Congress may make supplemental payments to certain classes of providers under Breaux-Thomas, there is an implicit approach in the legislation to continued cost reductions. In addition, as noted above, it may be difficult for Congress to make supplemental FFS provider payments in the face of price competition from other health plans. As a result, some rural providers that rely on FFS Medicare payments may continue to face the financial difficulties created by the BBA's FFS payment cuts. The NRHA already opposes any extension of BBA provisions beyond 2002. In fact, the NRHA recently communicated with members of Congress about the need to provide targeted BBA relief to rural providers who are suffering from the cumulative impact of the BBA.

5) Medicare Board. Under Breaux-Thomas, a Medicare Board will oversee enrollment and provision of information to beneficiaries. Both this Board and its staff should include members with rural health knowledge and expertise.

General Comments

Both plans fail to address the current inequity in the wage index which is used to determine reimbursement rates under the Medicare hospital inpatient prospective payment system. Rural hospitals have been traditionally paid less than urban hospitals, and the wage index bases payments on this differential - even if the wage market in an area changes and becomes more competitive. Currently, the Medicare wage index calculation does not adjust for occupational or skill mix. Rural hospitals are disadvantaged by the calculation of the Medicare wage index currently used, because rural hospitals generally employ a lower proportion of highly skilled level personnel. As a result, their average hourly wage rate will be lower than a hospital with a higher proportion of highly skilled personnel - even if they are situated in a wage market with similar wage levels.

The NRHA strongly supports incorporating an occupational mix adjustment into the calculation of the Medicare hospital wage index for purposes of the Medicare hospital inpatient prospective payment system so that it accurately reflects differing wage rates for similar mixes of employees. Such a policy change would require the Health Care Financing Administration to begin gathering data on wage and hours by occupational category in the Medicare cost report or by obtaining it from the Bureau of Labor Statistics.

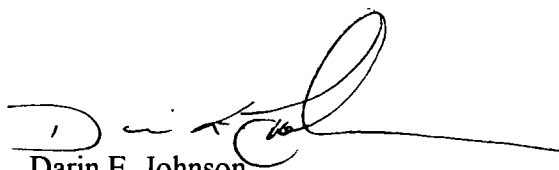
Additionally, the NRHA would also like to convey its strong support for developing separate Medicare wage indexes for the prospective payment systems being developed by HCFA for skilled nursing, home health and hospital outpatient services. To simply expand the use of the hospital inpatient wage index to post-acute care services would only perpetuate the very serious problem outlined above.

The NRHA stands ready to work with you and your Administration to ensure any Medicare restructuring legislation that moves forward meets the goals for Medicare restructuring outlined above. If you have questions about the NRHA's comments, please feel free to contact us at (202) 232-6200.

Sincerely,

Gail R. Bellamy, PhD

Gail R. Bellamy, Ph.D.
President

A handwritten signature in black ink, appearing to read 'Darin E. Johnson', with a long horizontal line extending to the right.

Darin E. Johnson
Government Affairs Director



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**A Rural Perspective on Medicare Policy:
An Initial Assessment of the
Premium Support Approach**

P99-7

June 16, 1999

RUPRI Rural Health Panel

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*The Rural Policy Research Institute provides objective analyses and facilitates dialogue
concerning public policy impacts on rural people and places.*

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PREFACE

On August 5, 1997, President Bill Clinton signed the Balanced Budget Act (BBA) of 1997, an omnibus legislative package primarily intended to balance the federal budget by 2002. This legislation contained major Medicare and Medicaid reforms, as well as a number of key rural health provisions which will eventually alter the way health care is provided and financed in rural areas. In previous documents, the RUPRI Rural Health Panel has assessed the rural implications of various provisions of the BBA. They also provided more specific analyses of the provisions related to payment to Managed Care Organizations (MCOs), changes in policies concerning Graduate Medical Education (GME), and rural implementation of regulations concerning Provider Sponsored Organizations (PSOs).

The RUPRI Rural Health Panel, formed in 1993, is a distinguished group of national rural health policy experts, assembled to provide ongoing research and decision support resource for Congressional decision makers, as they address these continuing changes in rural health care delivery and finance. Members of the panel are listed below:

RUPRI Rural Health Panel

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This Panel has recently been asked by the Senate Rural Health Caucus, the House Rural Health Care Coalition, and numerous Members of Congress to examine the rural health implications associated with converting the Medicare program to one which provides health coverage to the elderly, through direct government payments to competing health plans. This "premium support" approach, embodied in the principles outlined by Senator Breaux and Representative Thomas, is assessed in this Panel overview. This Panel will continue to analyze this alternative, along with others proposed to restructure the Medicare program, as these plans are developed in more detail. Keith Mueller provided principal authorship for this Panel document.

We appreciate and acknowledge the funding support and collaboration contributed by our research and policy partners. An ongoing Congressional Special Grant, administered through the Cooperative State Research, Education, and Extension Service, U.S. Department of Agriculture, continues to provide core support for this Panel's activities, including this report. The Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services continues to provide support for this Panel's continuing analyses of Medicare policy reform. However, none of these aforementioned organizations are responsible for the specific content of this report.

Charles W. Fluharty
Director

A Rural Perspective on Medicare Reform: An Initial Assessment of the Premium Support Approach

Executive Summary

The Health Panel of the Rural Policy Research Institute (RUPRI) has reviewed the premium support proposal offered by Senator Breaux and Representative Thomas in the final meeting of the Bipartisan Commission on the Future of Medicare. This *Policy Paper* contains our analysis of the rural implications of that plan, and is intended to inform further debate regarding a general approach to Medicare redesign using the premium support model. We are unable to provide a more detailed analysis, as plan specifics regarding this approach are not yet available for assessment.

The document accompanying this Executive Summary contains the Panel's analysis of this proposal, in its current form. This analytical approach considers the major changes contained within the proposal, categorized as:

- changes in Medicare payment policies;
- changes in choices for beneficiaries;
- changes in beneficiary cost-sharing; and
- other legislative changes.

We provide analysis of 14 separate provisions of the premium support plan and their likely impacts on rural Medicare beneficiaries and the rural health care infrastructure. Where the analysis indicates there may be special concerns related to availability and affordability of services in rural areas, we offer some suggestions for addressing those concerns. ***Our efforts to suggest improvements in the premium support plan do not constitute either endorsement of or opposition to this approach.***

This Executive Summary provides highlights of the more detailed document. Three principle components of the premium support approach are discussed: 1) determining a premium and the government payment toward the cost of any premium; 2) assessing the value of competitive insurance markets for rural Medicare beneficiaries; and 3) assessing likely impacts of a competitive approach on financial support for the rural health care delivery infrastructure.

1) Determining a premium and government payment toward the cost of any premium

Premiums would be submitted by health plans wishing to compete for Medicare enrollees, either in a specific service area, or nationally. Plans would be required to submit bids for both a basic benefits plan (set to be the currently offered Medicare benefits) and a high option plan (which would include a benefit for prescription medication). A Government-run Fee-For-Service (FFS) plan would be available everywhere, and would be required to include a high-option alternative. A national weighted average would be calculated based

on enrollment into each plan. In the example used by the Commission staff, with 80% of enrollees expected to remain in FFS, the weighted average is the government rate. The Federal Government's contribution is variable, ranging between 85% and 100% of that average, set to be 100% of the premium cost at or below 85% of the national average, and 88% of the national average. Above the average, the government contribution remains the same, 88% of the national average. Adjustments made to premium payments would be for the age, sex, institutional status, Medicaid enrollment, employment and eligibility of enrollees, just as is now done with Medicare payments for risk contracts. Geographic adjusters would correct for variation in the cost of doing business (not historical expenditures), and health status adjusters would be created and used.

The proposal includes two measures to assist persons vulnerable to higher premiums:

Subsidies: The government would increase its payment toward the premiums of high options plans for individuals up to 135% of poverty, 100% of premiums at or below 85% of the national average, and more where there is little or no competition.

Caps On Premiums: In areas where no competition to the government-run plan exists, beneficiary obligations for the premiums are capped at 12% of the government plan or the weighted national average, whichever is lower.

Rural implications

Rural Medicare beneficiaries, at least initially, will not benefit from the gains made through a competitive market. Instead, they will pay premiums that shift dollars from rural to urban areas. However, if the entire Medicare program is restructured to promote alternatives to the Government FFS plan, there may be ways to create provider panels and offer alternative plans at lower premium costs in rural areas.

Rural beneficiaries are likely to pay a premium equivalent to a higher share of actual costs, as compared to urban beneficiaries, and perhaps higher than the current equivalent of Medicare Part B and Medigap coverage for deductibles and co-insurance. In reaching this judgement, the following assumptions are made:

- 1) In much of rural America, the Government FFS plan is likely to be the only plan available. There is currently little or no enrollment in managed care among rural Medicare beneficiaries, and under the Federal Employee Health Benefits Plan, the model for the premium support approach, the managed care plans offered tend to be limited to metropolitan areas.^a

^aSee the information available through the Office of Personnel Management: <http://apps.opm.gov/insure/98/html/download/guide4.pdf> Accessed May 15, 1999.

- 2) The Government-run FFS plan will be using a single national premium, which means areas in which costs are below the average will generate revenues that transfer to expenses incurred in areas with above average costs.
- 3) Much of the variation around the average costs, especially if risk adjustment is used to factor in health status, will be similar to the historic differences that explained variation in capitation payment (adjusted average per capita cost, AAPCC).
- 4) The historic variation has been from low cost rural areas to high cost urban areas.
- 5) One might think other plans would then underbid the Government FFS plan in those areas where the FFS premium is higher than actual cost, but those are the same areas with low numbers of Medicare enrollees and are therefore not attractive to managed care plans.
- 6) The 12% cap on beneficiary premiums, then, is 12% of the national weighted average, which initially will be very close to the Government FFS plan.

2) **Assessing the value of a competitive insurance market for rural Medicare beneficiaries**

The advocates of a premium support approach believe it would help contain Medicare expenditures, as well as offer greater choices to Medicare beneficiaries. The variation in plans would be in benefits offered (in addition to those currently included in Medicare) and in premiums charged. The federal employee health benefits plan (FEHBP) model upon which this approach is based, for example, includes 21 different plans in Nebraska. However, six of those are for particular groups of employees (such as secret service, rural carriers, foreign service), and the four managed care plans are offered in limited areas of the state (metropolitan areas).

Rural implications

The most likely scenario is that most rural beneficiaries would still be selecting from a limited number of plans, or have no choice. This may change if health plans believe they can enroll sufficient numbers of Medicare beneficiaries to create a risk pool or if they believe Medicare beneficiaries can be added to an existing risk pool. Finally, rural providers may become involved in developing health plans if they see an advantage in taking a premium payment from Medicare rather than the payments from the Government-run FFS plan.

In much of the nation, the promise of alternatives is not likely to have meaning for rural beneficiaries. This may change if there are general market conditions encouraging more development of alternative health plans in rural areas. Extension into Medicare business may be logical for health plans that are already active in the area. However, the Medicare population is not the same type of risk pool as are groups based on employment of the

principal wage earner (such as the FEHBP model). Therefore, the responsiveness of health plans to new incentives in Medicare cannot be determined.

3) Assessing the impacts of a premium support approach on the rural health infrastructure

The impacts of restructuring Medicare to a premium support plan would depend on the actions of health plans. Two sets of decisions will influence the impacts. First, plans will determine providers with whom they will work in providing access to services. Second, plans will determine payment to providers. Plans that rely on selecting provider panels as a means to be as cost-effective as possible may not even choose providers in rural areas, and may set boundaries of their service areas accordingly. The new Medicare Board will have the authority to approve plans and service areas, so presumably blatant discrimination will not be tolerated. However, not all rural Medicare beneficiaries would be in a position to take advantage of choices offered. There may not be providers in particular preferred provider plans in a location near the beneficiaries, as is true for plans participating in the FEHBP.

The second decision plans would make is how to pay providers. They would be expected to employ the same means now used in competitive markets – discounts from usual charges, capitation, salary, and negotiated FFS. Plans would also, presumably, employ strategies of managed care including utilization management. The Government-run FFS plan is also encouraged to use market-based strategies in order to be competitive. This would be a change from current Medicare payment policies, but the impact on providers is uncertain. The current system in recent years has included sharp reductions in scheduled payment to providers, so any criticism of potential impacts would need to be compared to recent experiences, not to a base line that assumes Medicare FFS payment would be driven by provider charges. Special payments (either cost-based reimbursement or bonus payments) are unlikely to continue for the following classes of providers: sole community hospitals, rural health clinics, physicians practicing in shortage areas, Medicare dependent hospitals, federally qualified health centers, and critical access hospitals.

Rural implications

Advocates of the premium support approach should consider including requirements to pay full costs to essential rural providers, and requirements that health plans provide access to primary and emergency care throughout their service areas within reasonable distance of any beneficiary.

Unless otherwise specified as protected categories in any legislation that implements the premium support approach, any special payment currently part of Medicare policy could be eliminated. The new policy would allow the Health Care Financing Administration (HCFA) to behave like any other insurer, employing “modern” techniques of controlling

expenditures that would not include paying any provider based solely on self-reported costs. The Government-run FFS plan is the only one in this approach that would pay all providers, based on treating Medicare beneficiaries. Other plans would be free to select only the providers they want for panels. While the current trend in the market seems to be that plans are more inclusive in selecting panels, there is no assurance that rural providers would be included in panels caring for Medicare beneficiaries. This combination of change in the Government-run program and the possibility of exclusive provider panels could jeopardize the rural health infrastructure in some communities.

General Remarks

The following document includes much more detail than this Executive Summary. The vast majority of beneficiaries live in urban areas where assumptions regarding the benefits of competitive markets may apply. These assumptions are unlikely to apply in many rural areas. Therefore, this Executive Summary has focused on issues for which the application of this approach may be problematic in rural areas. The RUPRI Health Panel encourages policy makers and others to focus on these issues, to assure that any restructuring of Medicare, at a minimum, does no damage to the availability and affordability of services in rural areas, and that any new approach creates the best possible opportunity for improvement in rural health care delivery.

An Initial Assessment of the Premium Support Approach

I. Introduction

This policy paper is an assessment of an *approach to reforming the Medicare program*. While a particular proposal is used as “data” to form this analysis, the “Breaux/Thomas” proposal is, at the time of the analysis, more conceptual than detailed. From the written document offered by the Bipartisan Commission on the Future of Medicare after their March meeting (<http://medicare.commission.gov/medicare/bbmt31599.html>) we can discern the fundamental assumptions supporting the premium support approach, and some of the fundamental decisions needed before a final program could be drafted and implemented. We examine the assumptions and actions in the context of details that were included in the document as considered by the Commission. *In so doing, the RUPRI Rural Health Panel is not endorsing or opposing any particular plan or legislation.*

II. Framework for Analysis

Earlier work by the Health Panel of the Rural Policy Research Institute (RUPRI), in collaboration with a broader task force assembled to examine Medicare policy, established the framework used in this analysis.¹ In this framework, proposed changes to Medicare are grouped into categories reflecting new payment policies, changes in choices for beneficiaries, new cost-sharing arrangements, and other changes (including health professions training). Those categories are assessed in terms of impacts on rural beneficiaries and the rural health infrastructure.

A. Changes in Medicare Payment Policies

A fundamental change is that the Medicare program would not be constituted as Part A and Part B, with separate sources of funding for each. There would be a unified Medicare program, with the government funding to come from sources to be determined, presumably some combination of payroll and general taxes.

A. 1. Determining Medicare premiums to pay health plans

Medicare payment to health plans will be a function of the premiums submitted by the plans, not a pre-determined (fixed contribution) value set by government. Health plans would submit their service area, benefit design, and annual premium charge to the Medicare Board, which would set a weighted national average premium and negotiate premiums with health plans (*we have insufficient detail at this time to determine what is “negotiable”*). The federal government would continue to offer a fee-for-service plan as one of the plans available to all beneficiaries. Calculations of the government contribution to a plan’s premium would be determined as follows:

1. All premiums that cover the standard benefits (see below under beneficiary options) submitted to the Board would be arrayed, least expensive to most expensive, and their projected percentage of total Medicare enrollment would be estimated.

2. A weighted average value would be calculated based on the table from the first step. Consider this illustration from the Commission staff's analysis:

Plan A	\$6,000 premium	5% of enrollees
Plan B	6,000 premium	5% of enrollees
Plan C	5,300 premium	5% of enrollees
Plan D	5,500 premium	5% of enrollees
Govt FFS	5,700 premium	80% of enrollees
Calculation: $(6,000 \times .05) + (6,000 \times .05) + (5,300 \times .05) + (5,500 \times .05) + (5,700 \times .80) = 5,700$		

3. The government's contribution would range from 100% of plans paid at 85% of the national average, to 88% of premiums set at the national average. The latter is the maximum government payment, with exceptions for low income populations and beneficiaries in noncompetitive areas.
4. Payment to a particular plan will also vary according to the service area of the plan. The Medicare Board would apply risk adjusters to the premium, including:
 - age, sex, institutional status, Medicaid enrollment, employment, and eligibility based on disability;
 - geographic location (based on historical Medicare costs, the cost of living, and the cost of doing the business of providing health care in an area; areas are Metropolitan Statistical Areas and one area for all non-metropolitan counties in each state); and
 - health status.
5. Annual premiums would be based on the above process, not adjustments from the previous year.
6. Individual contributions will vary according to income (see below), so the government payment will vary across enrollees.

Medicare's payment would be the single premium to health plans, including the Government-run Fee-For-Service plan. ***Thus, at least implicitly, there would no longer be a federal legislative role for setting payment for health care providers.*** Each health plan, including the traditional Medicare plan managed by the Health Care Financing Administration, would receive a monthly premium payment from the federal treasury and would be expected to deliver services within that budgeted amount. Prices for services, including the FFS payments from HCFA, would be set by the health plan and not by Congress as is the annual practice now for hospital inpatient payment.

A. 2. Payment from the Government-run Fee-For-Service (FFS) plans

The Health Care Financing Administration (HCFA) would continue to manage the

government-run program, but instead of doing so under an array of legislative requirements for pricing, would submit plans annually to the Medicare Board. The benefits offered would be subject to action by Congress and the President. *The proposal as described to the Commission had removed the details of health plans (other than setting minimum benefits) from legislative influence, but also projected savings based on "modernization" of the FFS program. Coincidentally, the savings would be approximately the same as would be achieved by "BBA extenders," continuing the 1997 reductions in payment to providers, to years beyond 2002.* The general category of modernization includes suggestions identified by Commission staff: enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements.

A. 3. Payment from other health plans

There is no clear expectation in a premium support plan about how the plans that contract with the Medicare program in turn would pay providers participating in those plans. A premium support plan would presumably not reverse the provisions of the BBA that allow for a variety of health plans to contract with Medicare for the purposes of insuring beneficiaries for the fixed monthly contribution by Medicare. These include Medical Savings Accounts, Preferred Provider Organizations, and Provider Sponsored Organizations. Payment to providers could well vary as a function of which type of plan is used by their Medicare patients.

C. Options for Beneficiaries

B. 1. Minimum benefits

All plans would be required to offer the legislatively defined standard benefits package. Any change in that basic package would require Congressional action. Plans could vary copayment and deductible amounts, and establish rules and procedures necessary to assure delivery of benefits. Thus, some benefit provision flexibility remains but is subject to approval by the Medicare Board.

B. 2. High option benefits

Private plans would be required to offer a high option alternative that includes coverage for outpatient prescription drugs and stop-loss protection (maximum out of pocket expenses). Health plans could include any other set of benefits they wish to offer. The Government-run FFS plan would also be required to offer a high option plan.

B. 3. Choosing among alternative plans

Beneficiaries would always be able to choose the Government-run FFS plan. Presumably, they will have multiple options beyond that plan. Modeled after the Federal Employee Health Benefits Plan (FEHBP), the premium support approach assumes a

number of health insurance plans will be offered nationwide, creating options for all Medicare beneficiaries. However, when competition does not exist among private plans, there would always be at least a choice between two FFS options (standard and high). Presumably, there would be health plans offering the full array of traditional Medicare benefits plus what is now done through Medigap. The proposal considered by the Commission is silent on this point. *We can speculate that national Medigap plans, such as the AARP-sponsored plan, would convert to high option benefit plans and compete for enrollees. We suspect, though, that some Medigap plans would not be able to make this transition.* There will be little reason to continue offering "gap" insurance once the market includes high option alternatives that offer all benefits, minimum and others, through a single plan. However, supplemental plans may retain a market niche in those areas where choices other than the traditional FFS plan are quite limited. We assume the choices created by the BBA, including Medical Savings Accounts, will remain in place as competitors in the redesigned program.

C. New Cost-Sharing Arrangements

C. 1. Beneficiary premiums

The premium paid by the beneficiary, which is for all services covered by the plan (different than the current policy of charging a premium only for Part B in the traditional Medicare program) varies according to the premium charged by the health plan, the beneficiary's income, and the nature of the competitive market. The base calculation is that beneficiaries pay 12% of the national weighted average premium. The variations from the base are:

Beneficiaries pay a declining percentage of plans with premiums below the average; for example, 10% of those between 85% and 91% of the average.

Low-income beneficiaries would be eligible for premium assistance, as they are now.

Beneficiaries generally pay the full costs of any difference between the plan's premium and the national average.

Beneficiaries living in areas with limited or no competition will not pay more than 12% of the FFS premium or 12% of the national average, whichever is lower.

For low income beneficiaries (below 135% of poverty), the federal government payment will be 100% of the premiums of high option plans at 85% of the national weighted average of all high option plans. This may vary in an area where all available high option plans charge premiums higher than 85% of the national average.

C. 2. Beneficiary deductible

The new Medicare program, combining current Part A and Part B, would have a single annual deductible of \$400, indexed to growth in Medicare costs.

C. 3. Beneficiary coinsurance

A 10% coinsurance would be applied to all services except inpatient hospital stay and preventive care, except where higher copayments exist under current law.

D. Other Changes

D. 1. Graduate Medical Education

Payment for direct medical education (DME) would be removed from the Medicare payment system and provided separately, either as a mandatory entitlement or a multi-year discretionary appropriation program.

D. 2. Excluding non-insurance functions

The March proposal calls for Congress to consider separate payments to replace all payments now channeled through Medicare that are not included in payments made by health plans to providers. These payments include special reimbursement calculations for classes of providers such as sole community hospitals and federally qualified health centers, bonus payments for physicians practicing in shortage areas, and disproportionate share payments. The cost of these payments would not be included in calculating the premium to be paid to the Government-run Fee-For-Service plan.

D. 3. Age of eligibility^b

The age would be changed to conform to that of Social Security, gradually raising the minimum age, and a buy-in subsidy would be available at age 65.

D. 4. Medicare Board

A Medicare Board would have the responsibility to oversee and negotiate with health plans, both private and government-run. The Board would do the following:

- oversee open enrollment periods;
- provide information about health plans to beneficiaries;
- transmit necessary information to the Social Security Administration for

^bSenator Breaux removed this provision in his May 26, 1999 testimony to the Senate Committee on Finance.

collection of premiums from beneficiaries;
enforce financial and quality standards;
review and approve benefit packages and service areas;
negotiate premiums with health plans; and
compute payment to plans (including risk and geographic adjustment).

Members of the Board would be appointed by the President and confirmed by the Senate. Board membership would encompass beneficiaries, working taxpayers, and providers (including plans and health care providers).

D. 5. Long term care

The proposal recommends that the Institute of Medicine conduct a study to estimate future demands for long-term care and analyze financing options available to seniors.

III. Analysis

This section is organized using the features of the premium support approach. Each feature is analyzed by using the two major categories of impacts -- beneficiaries and rural health infrastructure. Where appropriate we will suggest considerations for further development of this approach. We are not endorsing any particular plan or legislation.

A. Changes in Medicare Payment Policies

A. 1. Determining Medicare premiums to pay health plans

Impacts on rural beneficiaries

Analysis

Beneficiaries (except for low-income) will pay a percentage of the premium, consequently, the amount of that premium will have a direct impact on rural beneficiaries. Since a national weighted average will determine the government payment and hence individual payment, beneficiary payments will be higher where most plans cost more than the national average, and less where plans are available for as little as 85% of the national average. The premium support proposal, as detailed in supporting documentation from the Commission, allows for the percentage contribution of the beneficiary to be lower when the premium is less than the national average, to a zero contribution if the plan's premium is 85% of the average. Conversely, when the premium is higher than the national average, the beneficiary is responsible for 100% of the difference. To illustrate, consider a range of capitated payments, taken from the work sheets completed by the staff of the Bipartisan Commission on the Future of Medicare (available on the Commission's web site):

National:	weighted average premium is \$5700
Beneficiary pays:	12%: \$684
Area A:	weighted average premium is \$6500
	beneficiary payment is $\$684 + 800 = \$1484$, 18.2%
Area B:	weighted average premium is \$5000
	beneficiary payment is \$555, 11%

The above scenario could depict a difference between rural (Area B) and urban (Area A) premiums if plans developed separately in those areas. However, a more likely scenario for rural is that the only plans available would be national FFS plans, as is the case with the FEHBP. In fact, as advocates of premium support concede, in many rural areas the only plan available is likely to be the Government-run FFS plan. In that scenario, the rural premium will be set according to a national rate, regardless of differences in costs to the plan. This scheme would generate transfers of premiums from well to sick patients to cover costs, and from low cost areas to high cost areas. If that were to be the case a different scenario could unfold:

National average premium:	\$5700
Plan premium:	\$6200
Beneficiary pays:	\$684 + 500 = \$1184
Actual cost, Area A:	\$6500
Beneficiary pays:	18.2% (\$1184)
Actual cost, Area B:	5000
Beneficiary pays:	13.7% (based on 12% of the national premium)

Given that rural enrollment is mostly in fee-for-service now, and likely to remain that way for the near future, ***this methodology has the impact of redistributing premiums from rural to urban beneficiaries***. Since the new premium is calculated by combining Part A and Part B, this transfer of premium dollars will be greater than any similar transfer is now.

Considerations

A modification of the current proposal would be to convert the Government run FFS plan from a single national plan to a number of regional plans. Since managing a FFS plan does not require the aggregation of beneficiaries needed to make a managed care plan work, there is little reason not to have regional plans. Using regional plans has the further advantage of making the most of one of the assumptions driving this redesign in Medicare policy — that consumers are price sensitive and will create pressures to drive premiums down and benefits up. If beneficiaries in an urban area realize they are paying more than rural counterparts in another region of the country, they would be expected to demand lower cost premiums, which they would not do if their premium was the same. ***We recommend that proponents of the premium support approach rely on regional FFS plans rather than a single national Government-run plan.***

Impacts on rural health infrastructure

Analysis

Rural health care providers may be affected by changes in the behavior of health plans as they respond to a new methodology of setting payment. To the extent that the new premium calculation means payment to the plan will meet or exceed costs, and there is a critical mass of beneficiaries that makes marketing attractive, we would expect an increase in plan offerings in rural counties. This would be true especially for rural counties adjacent to metropolitan areas, where populations are higher and plans can extend their reach for little additional investment in marketing. Currently, for managed care plans, the county-specific premium payment is lower in adjacent rural counties, creating a disincentive to offer plans there (in part contributing to recent market withdrawals). Under this new approach, the premium would be the same throughout the service area and would be determined by the plan's decision regarding what the market will allow.

If contracting with Medicare includes standards to have services reasonably accessible to the beneficiaries, this activity could strengthen the infrastructure by redressing any current

shortcomings in services offered locally. However, the local infrastructure would be weakened if urban-based plans insist that beneficiaries use the providers based in urban areas. Local providers may have very little to say about the nature of the health plan, minimizing local input.

Conversion to a premium support approach that would determine Medicare payment may encourage further integration and consolidation among rural providers. The redesigned Medicare policy would encourage development of large plans that could spread risk effectively. Achieving the requisite risk pools in rural areas would require integration of providers in a large geographic area. Such an integrated network of providers could develop its own health plan to compete for Medicare beneficiaries, or at least have greater strategic strength in negotiations with health plans.

Considerations

Under the present system Medicare pays providers directly (through fiscal intermediaries) for services rendered. Using that system, Medicare is able to create differential payment to account for special needs, as in the instances of sole community hospitals, federally qualified health centers, rural health clinics, providers practicing in underserved areas (bonus payments), and critical access hospitals. Private health plans are under no obligation to make such differential payments, and they do not do so. When the marginal costs of caring for a particular Medicare patient are determining payment to the provider, there is no ability to cost shift additional fixed costs into the Medicare payment. Instead, there could be pressure to shift costs away from Medicare. For rural providers who receive a high percentage of revenue from Medicare and any appreciable burden of caring for the uninsured (which would be the case for sole community providers and safety net providers), payment based on marginal costs will not be sufficient. The new Government-run FFS plan will be under pressure to pay by the same principles as private plans -- discounted fees that account only for the marginal costs of care to Medicare patients.

We recommend that there be periodic reviews of the financial viability of essential rural providers currently receiving special Medicare payments. If problems are identified, there should be accompanying recommendations for targeted payment changes or establishing separate subsidies. We recommend that any health plan seeking enrollment in rural areas be required to provide primary care and emergency services locally.

A. 2. Payment from Government-run Fee-For-Service (FFS) plans

Effects on rural beneficiaries

Analysis

There are no direct impacts on beneficiaries. Any effects will be the consequence of effects on rural health care providers. For example, if payment to providers is reduced to below their marginal costs for providing the service in question, effects on beneficiaries could include:

- providers billing for the difference (if allowed);
- providers withholding care; and/or
- providers deciding to no longer serve Medicare beneficiaries.

Effects on rural health infrastructure

Analysis

While not necessarily linked to adopting a premium support approach for redesigning Medicare policies, the March proposal did assume savings for Medicare that were at least implicitly based on extending the fee-for-service provisions of the Balanced Budget Act for five additional years. Doing so with no other changes in those provisions creates difficulties for rural health providers, as pointed out in the Panel's other work ("Taking Medicare into the 21st Century," P99 - 2. February, 1999). In the context of the Medicare program, extending the BBA provisions would affect the following sources of payment to rural providers: hospital inpatient, hospital outpatient and other ambulatory centers, any home health, any skilled nursing, graduate medical education, durable medical equipment and bad debt. As we reported in February, many of these payments are made to the same rural providers. Under current law, with no extensions into additional years, an analysis completed by Ernst & Young shows total hospital margins for small rural hospitals falling from 4.2% in FY 1998 to *negative* 5.6% by FY 2002, a 233% drop.² Most rural hospitals are affected by payment changes beyond inpatient and outpatient care; many offer skilled nursing care, home health services, and hospice care to their communities. As shown in analysis completed by the Congressional Budget Office (published in April, 1999), significant reductions are expected in the growth rate of payment for home health, skilled nursing, and hospice payments between 1998 and 2002 when the current BBA provisions are in effect. Were those provisions to be extended, it is reasonable to expect more years of reduced growth that may not keep pace with costs and demand. Already early signals of the ultimate, unintended consequences are apparent: the 18-bed rural hospital in Shattuck, Oklahoma reduced home health visits from an average of 2,583 visits per month to about 400 as it laid off 45 employees from that program;^c and the Phillips

^cFrom the AHA website's grassroots section: www.aha.org/grasroots/faxshuttuck.html

County Medical Center (14 beds) in Montana reduced its home health visits from 1,100 per month to 400 per month in the 5,000-square mile area in which it is the only home health provider.^d ***Extending the BBA provisions for payment in the Government-run Fee-For-Service program could have the unintended consequence of crippling providers in rural communities, affecting availability of services for all rural residents, including Medicare beneficiaries.***

The Government-run Fee-For-Service program strategies of “modernization” could change current FFS payment to rural providers, presumably in a manner that generates savings (reduced growth). Three of the suggestions offered by the staff of the Bipartisan Commission are particularly meaningful for rural providers. Using negotiated pricing might enable the FFS plan to force prices below current levels, similar to what was just described for BBA extenders. Selective contracting could have the Government-run plan favoring providers in a large geographic region such that local rural providers are excluded from the program. This is especially likely in situations in which the local rural provider is a safety net provider recovering a higher percentage of fixed costs through the Medicare payment system. Those providers may not be competitive with others that are close enough to be in the same broad service area but not as proximate to some beneficiaries (for example, within 35 to 50 miles but in a different community). A shift in Medicare contracting could affect entire communities if the result is fiscal insolvency for some rural providers. The third modernization strategy with likely impact is using Preferred Provider Organizations (PPOs). The effect could be similar to selective contracting, in that the preferred providers may not include providers in the immediate community of residence for Medicare beneficiaries. The potential impacts on rural providers of the change in the Government-run FFS system are related to the end of the current practice of paying whatever provider a beneficiary chooses, using a rate established in statute for all similar providers. Until this system is actually in place, the impact of changing the Medicare FFS approach to pricing services cannot be assessed definitively. Instead, we have pointed to three potential rural concerns.

Considerations

Using extensions of the BBA cost savings could be quite problematic for rural providers. However, they may be reasonable for providers with higher total operating margins. Therefore, one possibility is to ***exempt small rural providers from BBA extensions.*** Another possibility is to have complete faith in the savings that would result from a competitive market and ***not use BBA extenders at all.*** This seems consistent with recent reports that the savings through the BBA and other actions already exceed expectations, thereby reducing the need to continue them.

^dFrom the AHA website’s grassroots section: www.aha.org/grassroots/maltafax.html

A. 3. Payment from private health plans

Impacts on rural beneficiaries

Analysis

To state the obvious, beneficiaries will have choices among health plans only if those plans are able to remain financially solvent. If plans are unable to negotiate reasonable payment rates with providers, choices would be limited. However, if the rates demanded by health plans are below the actual costs of providing services, the community could lose its local health care providers. The balance between adequate payment for providers and sufficiently low expenses to plans to generate competition, though, is not an issue unique to the premium support approach.

Considerations

Public policies could set the parameters for negotiations between health plans and health care providers. Current experiences in markets with competing managed care plans are demonstrating the market power of both sides of the negotiations, as providers are refusing to sign managed care contracts. Given Medicare's responsibility to the beneficiaries, the federal government may need to develop regulations related to minimum payments and maximum charges, or set guidelines for negotiations that take place.

Impacts on rural health infrastructure

Analysis

Allowing health plans to determine their own means of paying health care providers could be disruptive to rural providers who have become financially dependent on Medicare fee-for-service payments. If plans are able to exert pressure by threatening to sign up providers from outside the community, local providers may be forced into financially untenable positions.

Considerations

Government policy could set a minimum price structure below which no health plan would be able to negotiate with providers. This is another means of encouraging fair competition.

B. Options for Beneficiaries

B. 1. Minimum benefits

Impacts on rural beneficiaries

Analysis

With the premium support approach requiring new legislation, presumably Congress could alter the current mix of benefits contained in the traditional Medicare program. Given political pressure, Congress is not likely to begin a restructured program with basic benefits worth less than those currently included in Medicare. The proposal made to the Bipartisan Commission in March of 1999 specifically said the basic benefit package would be all services covered under the existing Medicare statute. The benefits package would be updated by the Medicare Board, but any expansion would require Congressional approval. The requirement for action by Congress could limit Medicare's ability to adapt quickly to changes in the delivery of medical care. For example, only since the BBA have some preventive measures (mammograms, screening for prostate cancer) been covered by Medicare. Though not a particularly rural concern, this limiting the adaptability of Medicare benefits to change in health care delivery could be detrimental to beneficiaries.

The proposal before the Commission in March did not include standards for delivering the basic benefits in any proximity to beneficiaries. Instead, health plans are to follow procedures similar to those used by private purchasers. Such procedures could include using providers outside of local communities for primary care, presuming mobility among the insured. That assumption is not easily made for Medicare beneficiaries. The same procedures, then, are not necessarily applicable.

Considerations

If legislation requires Congressional approval of changes in the standard benefits package, such provisions should be subject to review and modification. If the legislative process slows adaptation to new delivery modalities proven to be cost effective, Congress may want to reconsider the requirement for legislative approval.

The minimum standards for access to care need to be different for Medicare beneficiaries as compared to the privately insured. There are important differences in the mobility of the population, and the federal government has to consider the fundamental responsibility of assuring access to care.

Impacts on rural health infrastructure

Analysis

Health plans, including those operated by providers, would need to assure the Medicare Board that they are offering the standard benefits to all beneficiaries “in a manner consistent with prevailing private standards and procedures offered to employer groups and other major purchasers” (from the text of the March 1999 proposal). Holding Medicare to a standard based on what is offered to private purchasers could damage the rural delivery infrastructure. Private purchasers can more readily assume mobility among their insured groups, and more readily exclude local providers from preferred provider panels, forcing travel to more distant providers. Doing this for the Medicare beneficiaries is far more problematic. Not only are the beneficiaries more at risk, but the local health care delivery infrastructure could not sustain the loss of Medicare revenues.

Requiring any health plan to include at least the standard benefits may contribute positively to the development of integrated systems in rural areas. Health plans wanting to offer services in a rural area would likely encourage coordination across providers, facilitating more cost effective management of episodes of illness and chronic illness.

Considerations

The philosophy of promoting choice among health plans should be based on a foundation of requiring those plans to make primary care, emergency care, and limited secondary care available to beneficiaries within a reasonable distance of their residence. Doing so helps assure the availability of health care services locally.

B. 2. High option benefits

Impacts on rural beneficiaries

Analysis

Private health plans *and* the Government-run Fee-For-Service plan are *required* to offer a high option plan wherever the basic plan is marketed. High option plans are required to offer prescription drug benefits. This requirement for participation in the Medicare program will assure rural beneficiaries of access to high option plans. Those plans will be monitored by the Medicare Board.

Considerations

The Medicare Board should release to the general public the quality standards it uses when assessing health plans. It should also release the results of the assessments.

Impacts on the rural health infrastructure

Analysis

Requiring that the high option plan be available everywhere a plan is offered could precipitate initiatives to make more services available in geographic proximity to beneficiaries, should that prove to be cost effective. The local infrastructure could be improved through greater use of rotating specialty clinics, if the combination of Medicare volume and private demand warrants local delivery of services. This presumes that making the services in the high option plan available to rural beneficiaries will lead to greater demand that in turn would be met cost-effectively with local delivery.

Considerations

Congress could authorize and fund new demonstration grants to encourage health care systems to initiate new services in rural areas.

B. 3. Choosing among alternative plans

Impacts on rural beneficiaries

Analysis

There would always be choice for rural beneficiaries, at a minimum between two FFS options. As a minimal assurance, this represents an improvement over the current situation.

Impacts on rural health infrastructure

Analysis

There is no particular effect associated with this provision.

C. New Cost-Sharing Arrangements

C. 1. Beneficiary premiums

Impacts on rural beneficiaries

Analysis

As explained earlier in this paper, beneficiary premium payments, as a percentage of the plan's actual cost, may be higher for rural than for urban beneficiaries. However, the actual dollar amount of the beneficiary contribution will be a function of the choices the beneficiary makes between standard option and high option plans, and therefore is at least

somewhat controllable. The beneficiary contribution is capped in areas with no competition. However, unless the premium is determined based on local costs, some rural beneficiaries could still be paying more out of pocket than counterparts in other areas, because they would be paying 12% of the national premium charged in the traditional Medicare program (perhaps the only option available to them).

Considerations

The maximum payment in non-competitive rural areas could be set using a different standard than the national premium or local premium, whichever is lower. Two possibilities to consider:

set a maximum payment based on historical Medicare expenditures in the area, as determined when calculating the risk contract payment (adjusted average per capita cost); or

set a maximum dollar amount rather than a percentage of premium.

Impacts on rural health infrastructure

Analysis

There are no direct effects on the health care infrastructure.

C. 2. Beneficiary deductible

C. 3. Beneficiary coinsurance

Impacts on rural beneficiaries

Impacts on rural health infrastructure

Analysis

There are no particular rural impacts from these provisions.

D. Other Changes

D. 1. Graduate Medical Education (GME)

Impacts on rural beneficiaries

Analysis

There is no direct impact on beneficiaries.

Impacts on rural health infrastructure

Analysis

The proposal as submitted in March is the first step toward removing all GME payment from Medicare payment and creating a separate system for reimbursing for such costs. The initial change, and perhaps the only change if there is not political support for anything further, is that the plan would remove direct medical education (DME) payment from Medicare payment and provide it separately. The immediate impact of this proposal is unclear. There would be no impact if the dollars removed from Medicare payments were replaced with other sources and payments are the same to the same institutions. However, removing the DME supplemental payment would mean supporting DME through an annual appropriation, which means it is subject to change, in both eligibility and amount of funding. Since very few rural providers currently receive DME payments, any change in distribution might be to the advantage of rural training programs. If the only change is to reduce the appropriation, without any shift in spending patterns, teaching programs would likely be forced to reduce the size of classes of medical residents. If the decisions of how to accomplish reductions are left to large teaching hospitals, recently innovative attempts to enhance training tracks targeted to meeting a rural need may suffer. When programs are forced to retrench, the most powerful forces within those programs should be expected to protect their self-interests. For most training programs those interests will be medical specialists in urban-based teaching hospitals. Fewer resources than current allocations would be targeted to meeting the health professions needs of rural areas.

Considerations

Any legislation removing GME payment from traditional Medicare payment must be specific about new sources of funding, levels of funding, and rules for allocating the funds. The following principles should guide those decisions:

splitting GME payment from Medicare payment, even the \$2.2 billion in DME (smaller than the payment for indirect medical education, IME) should be used as an opportunity to underwrite the costs of graduate medical education regardless of the setting; and

payment should remain a reflection of the cost of graduate medical education, and not be subject to arbitrary budget-driven reductions.

Separate funding for GME creates an opportunity to involve different expertise in developing policies to drive spending decisions. For example, the Council on Graduate Medical Education (COGME) could play a direct role in helping to associate public funding with meeting public goals. Policies would likely include supporting training programs focused on the types of physicians appropriate to meet population-based needs, and supporting programs whose graduates practice in communities most

in need of medical services. For a more complete discussion of the possibilities for reform in GME policies, see the RUPRI Rural Health Panel Brief, "Can Medicare Medical Education Policies Better Address Rural Provider Shortages?"³

D. 2. Excluding non-insurance functions

Effects on rural beneficiaries

Analysis

The effect on beneficiaries will be through the impacts on health care providers. The "non-insurance functions" include special payments to rural providers thought by Congress and others to be essential to assuring access to care. To the extent those providers are affected adversely (see below) beneficiaries will lose access to services. Instead of seeing local providers they could be forced to travel significant distance to others.

Effects on the rural health infrastructure

Analysis

Much like the situation for GME payment, the effects of this policy change would be a function of the adequacy of replacement funding if special Medicare payments are discontinued. While the March proposal did not explicitly discontinue special payments for anything other than DME, ***the premium paid to the Government-run Fee-For-Service plan would not include the costs of currently supported "non-insurance functions and special payments."*** The March proposal also did not require that such payments be made by the government-run plan. At a minimum, then, there is a powerful implication that fee-for-service payments would no longer include any non-insurance functions and special payments. Supplemental documents prepared by the Bipartisan Commission staff identified these subsidies as currently included and subject to evaluation of the wisdom to continue them:

- sole community providers,
- swing beds,
- a Medicare incentive program (bonus payments to physicians),
- equalization of PPS standardized amounts,
- rural health clinics,
- a floor on Medicare+Choice payments,
- critical access hospitals,
- geographic reclassification of hospitals,
- rural referral hospitals, and
- enhanced payments for federally qualified health clinics (FQHCs).

An important point is recognized in the staff document: "DSH (disproportionate share

hospital) and other subsidy programs could be revisited by Congress to ensure that Medicare's support is reasonable and appropriate. ***A premium support model may not recognize the needs addressed by these subsidies***⁷ (emphasis added). If the premium support approach is adopted in its "pure" form, the HCFA would not be obligated to extend special payments.

The March proposal explicitly recognizes that cost containment measures would be needed, and states that the Balanced Budget Act of 1997 should be extended or comparable savings achieved. The proposal also says the government-run plan could operate on the basis of contracts negotiated with local providers, much as other plans do now. The combination of the language of the proposal and the supporting staff document leads to the conclusion that the above list of special payments will no longer be made by the government-run program, unless Congress were to modify the premium support approach to require such payment of all health plans so none are at a competitive disadvantage; or include a special premium supplement for the government-run plan.

While the loss of special subsidies is a near certainty with the premium support approach, any replacement funds are much less certain. Presumably, such payment would need to be part of an annual appropriation process instead of an annually renewable component of a payment system. Advocates for the payment subsidies would need to assess the comparative likelihood of securing appropriations versus level of payment through Medicare when the fee-for-service plan is trying to negotiate contracts competitive with other plans. Given the importance of Medicare revenues for rural providers, and especially for the providers identified in the list above, this is a critical concern – the fate of entire classes of providers could hinge on the choice between the current practice of securing supplemental Medicare payment versus securing subsidies through an appropriations process.

Considerations

Rural providers are at financial risk now, without operating under a premium support system. The Balanced Budget Act of 1997 has already created financial strain for many rural providers,⁵ and any future efforts to "save Medicare" could further exacerbate the stress. Under the current system, the scenario for rural providers is not bright because of a reliance on Medicare revenues and an absence of any alternative Medicare payment (e.g., very little managed care in rural America). Under premium support, a sense of certainty is created – Medicare would not be paying special subsidies. The financial battle for rural providers would shift from Medicare to general appropriations. From the perspective of those providers, this is a "frying pan to oven" scenario. ***The potential negative impacts of the premium support approach could be ameliorated by:***

using Medicare revenues to pay special subsidies directly, under the assumption that the purpose is to assure availability of services for rural

beneficiaries;

appropriating funds for special subsidies once every 2 to 5 years instead of annually;

creating a special trust fund to support services deemed essential to assure appropriate access to care for Medicare beneficiaries;

continuing to incorporate special subsidies into the Medicare program and require that all health plans pay special rates, not just the Government-run Fee-For-Service plan; and/or

requiring the special payment only from the FFS plan, but allow for that in setting the premium paid to the FFS plan and paying the difference from the government contribution thereby keeping the choices among plans comparable for the beneficiary.

D. 3. Age of eligibility^e

Impacts on rural beneficiaries

Analysis

There are no immediate impacts of this element of the premium support proposal offered in March, since the increase in age of eligibility would be phased in, parallel to the change in the Social Security program. Because of the phase-in, the age cohort affected by this proposal would be those not yet 65. An important rural-urban difference to recognize for that cohort, persons age 55-64, is in the percentage without any form of health insurance, for whom Medicare eligibility will mean improved financial access to care. Using data from the 1996 Current Population Survey, of persons age 55-64, 14.4% of rural (non-metropolitan) residents lack any health insurance, compared with 13.1% of urban residents of the same age.

Considerations

Should the age of eligibility be raised, a provision to allow early buy-in to obtain Medicare benefits will be important. *Two elements of such a provision will be critical to rural residents: 1) the cost of the buy-in, scaled by the income of the potential beneficiary; and 2) efforts to market the buy-in possibility, such that rural residents are aware of the option and how to exercise it.*

^eSenator Breaux removed this provision in his May 26, 1999 testimony to the Senate Committee on Finance.

D. 4. Medicare Board

Impacts on rural beneficiaries

Analysis

The Medicare Board would oversee enrollment and provide information to beneficiaries. These are functions that would affect rural beneficiaries as they choose among alternatives that may be available to them (as argued earlier in this analysis, most rural residents will be selecting one of two FFS options, at least initially). The Board will need the capacity to reach all beneficiaries in a direct manner (not merely mailing campaigns) with information. Techniques for doing so will vary according to how beneficiaries customarily receive information and learn from it. Rural residents, for example, may rely on informal channels of communication more than their urban counterparts.

Considerations

Presumably, the Medicare Board would have its own staff, perhaps transferred from the Medicare Payment Advisory Commission (which should no longer be necessary). ***The staff should include persons with knowledge of populations and their environments. The Board should include representatives with rural health experience and expertise.***

Impacts on the rural health infrastructure

Analysis

The Medicare Board would review and approve benefit packages and service areas, negotiate premiums with health plans, compute payment to plans, and enforce financial and quality standards. These activities could determine the likelihood of rural providers succeeding financially in a restructured Medicare program. The premium negotiations and payment computations will be critical in setting the boundaries for payment to rural health providers. That is, plans will be able to pay only up to a maximum as determined by their revenue, which is the payment determined by the Board after premium negotiations have been completed. Quality standards enforced by the Board will have a direct impact on rural providers who must abide by them. Quality standards could require data collection and reporting that add to the expense of providing care, especially for providers who have not already installed advanced information systems.

Considerations

The Medicare Board will need to obtain input and advice from persons and organizations knowledgeable about the rural impacts of its decisions regarding

premiums, payment to plans, and quality standards. The impacts are often different, as this document and other work of the Health Panel demonstrate. ***Congress should require that the Board issue a separate rural impact statement for any major decision it makes. The Board's staff would then, by necessity, include expertise in rural health care delivery systems. Those making appointments to the Board should be required to include rural representatives with rural health experience and expertise.***

D. 5. Long term care

Analysis

Since this provision is to conduct a study, particular impacts on beneficiaries and rural health providers cannot be identified. In general, any changes in financing long term care will have significant impacts in rural areas because of the high percentage of elderly residents and thus the reliance by rural health providers on revenue from Medicare.

Considerations

If a study of long term care is recommended in the legislation, the recommendation should include a statement that the study consider models for enhancing the availability and appropriate mix of services in rural areas. For example, financing that encourages use of home and community based services should consider how those services might be provided in rural areas. As that is done, the payment may need to be different because the same economies of scale are not possible. Current experiences in providing home health care services, which are undergoing changes in Medicare finance since the BBA was enacted, could provide a basis for understanding differential impacts of other financing decisions in long term care.

End Notes

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Appendix

Questions Concerning Breaux/Thomas Proposal

These are questions that need to be addressed in further discussions of the premium support approach, as more details are available for any specific plan.

1. The proposal calls for the Government-run plan to use modern strategies to be cost competitive with other plans. What would those strategies be? Would the impact on health care providers be similar to what we are learning about the impacts of the adjustments made in the Balanced Budget Act of 1997?
2. The proposal would have HCFA become a competing insurance company, albeit run by the government. Does that mean HCFA will make decisions regarding payment to providers, use of cost management strategies such as utilization management, and structuring benefits other than the traditional benefits, without Congressional action? What would be the status of current policies regarding Medicare payment for special categories of providers, such as sole community hospitals, critical access hospitals, federally qualified health centers, rural health clinics, and Medicare dependent hospitals? Can those payment classifications be preserved in an environment in which HCFA is expected to compete with other health plans?
3. How would the practices of private plans be monitored and regulated? Would a private plan that includes rural counties in its service area have to abide by access to care standards in those counties? If so, what would those standards be? And how would they be enforced?
4. Would payment from private plans to providers be regulated in any way? If not, how would rural providers, for whom Medicare is the leading source of revenue, fare?
5. How would the Medicare program, through its payment for health professions training, be used as a tool to help assure the nation that we are training the appropriate types of providers, with incentives to practice in underserved areas?

RUPRI Rural Health Panel

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1990 Health Policy Documents

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RUPRI Mission

The Rural Policy Research Institute provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places.

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NATIONAL RURAL HEALTH ASSOCIATION

September 7, 1999

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The Honorable William Jefferson Clinton
President of the United States
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Dear President Clinton:

The NRHA applauds you and your Administration for your tireless and continued efforts to preserve the federal Medicare program for current beneficiaries and future generations of Americans. The NRHA believes major restructuring of the current Medicare program must occur to meet five basic and fundamental principles:

1. Secure the long-term financial solvency of the Medicare program;
2. Guarantee access - availability and affordability - to quality health care services for all Medicare beneficiaries;
3. Reduce the financial constraints currently being placed upon rural health care providers by the Balanced Budget Act of 1997;
4. Expand the choice of health plans available in rural areas; and
5. Provide access to affordable prescription drug benefits for rural Medicare beneficiaries.

Both the Administration and the Breaux-Thomas proposals will have disparate impacts on rural and urban beneficiaries and health care providers. Some of these differential effects are by design and others are unintended. Both plans base Medicare savings on a competitive model in which plans compete on cost and quality for Medicare enrollees. As such, they are urban models and do little to develop a comprehensive approach to health financing and delivery that accounts for the lack of competition in rural areas. By focusing almost exclusively on cost containment, and in the case of your proposal, eligibility and benefit expansion, both plans fail to address the fundamental rural issue of ensuring access to care and the local survival of basic health care services. Such urban-based solutions have historically proven to be inappropriate for rural areas and often lead to unforeseen and unintended consequences for rural providers.

Because the economic health of rural communities is inextricably tied to the economic well-being of the local health care system, a broader approach to health care reform is needed in rural and frontier America. Although the focus on cost containment is

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understandable at the national level, effective reform in rural areas will necessarily combine cost reduction with policies that enhance access, establish appropriate quality standards, and view all aspects of the community — health care, economics, education, etc. — as parts of a greater whole.

The NRHA's comments found below outline the major impacts of the two proposals on rural Medicare beneficiaries and health care providers. The NRHA drew many of its comments and conclusions from the excellent analyses of the Rural Policy Research Institute (RUPRI) and the Federal Office of Rural Health Policy. We hope our comments will provide you and your advisors with constructive feedback and suggestions that will assist you in drafting legislation with the Congress that ensures access to health care services for rural Medicare beneficiaries

Administration Medicare Reform Proposal

1) Medicare Preferred Providers. The Administration proposal creates a new Medicare Preferred Provider Option (PPO), in which the federal government will contract with existing PPOs that meet quality and utilization management standards. Beneficiaries that receive services from PPO providers would be subject to lower cost sharing requirements.

This proposal has two important impacts on rural areas. First, like other provider organization arrangements, PPOs are not as prevalent in rural areas where there is less provider competition than in urban areas. As a result, rural beneficiaries are less likely to have this lower cost option available. Second, if utilization management standards applied to PPOs do not account for differences in practice styles and the types of available providers, rural providers may have difficulty qualifying for PPO membership. For example, rural physicians are less likely to have different patterns for referrals and use of specialty providers due to limited availability of specialty services in many rural areas.

2) Primary Care Case Management and Disease Management. To produce savings in the treatment of the small percentage of beneficiaries that account for a majority of Medicare costs, your plan proposes contracting with entities to coordinate a range of health services, either for particular beneficiaries or for specific diseases. First, Medicare could contract with primary care case managers (PCCMs) to coordinate services for beneficiaries in the FFS system. This option could benefit rural beneficiaries who do not presently have access to case management services. To be designated as PCCMs, however, primary care physicians would have to meet certain performance standards and criteria. As noted above, if these criteria do not take differences in rural practice into account, rural physicians may have difficulty meeting them. The success a number of states have already had in implementing primary care case management for Medicaid beneficiaries should serve as a model.

Second, the disease management authority would allow Medicare to contract with "coordinated care delivery systems" which provide physician-directed nurse-mediated disease management services for beneficiaries with conditions such as diabetes or congestive heart failure. Again, to the extent that such services are less available in rural areas, rural beneficiaries would not have the

option to receive care under such arrangements. Because rural beneficiaries have higher rates of chronic disease than urban beneficiaries, if PCCM and disease management services are not available, the Medicare program may not be able to reach the level of savings expected from this component of the plan.

3) Competitive Defined Benefit Program. Under the current Medicare program, beneficiaries nationwide pay the same Part B premium, regardless of the actual cost of their plan. Under the Administration proposal, plans would be required to offer a standard benefit package and beneficiary premiums would be tied to the cost of the plan — premiums would be lower with lower cost managed care plans, the same if their plan's price is about equal to traditional program costs, and higher if their plan's price is higher than traditional Medicare costs. Beneficiaries who opt to stay in traditional FFS Medicare would pay Part B premiums as they do under the current program. This component of your plan raises similar availability and choice of plan issues for rural beneficiaries as the Breaux- Thomas plan.

4) Geographic Adjustment. Rather than having managed care rates set locally and FFS rates set nationally, your plan would determine payments for managed care and traditional FFS Medicare on the same national basis. In addition, payment adjustments would be made in high cost areas to reflect full local costs and BBA-mandated increases in the AAPCC for low cost areas would be maintained. To the extent that the BBA changes to the AAPCC raise rates in rural areas and encourage plan development, continuation of these policies are beneficial to rural beneficiaries in terms of enhancing choice of plans.

5) BBA Changes. The Administration proposal includes many actions to "smooth" implementation of the BBA. These include:

a) Hospital Outpatient PPS and geographic reclassification. The Administration plan would use the same wage index for calculating Medicare outpatient payments as is currently used to calculate inpatient PPS rates. This will extend to outpatient payment the current inequities in the inpatient wage index adjustment for rural hospitals as recognized by the Secretary of Health and Human Services National Advisory Committee on Rural Health. These inequities may be offset to some extent by proposed changes in the rules for geographic reclassification that will make it easier for rural hospitals to be reclassified as urban for wage index purposes and receive payments based on the higher wage index of nearby urban areas.

In addition, the Administration is considering a three-year transition in outpatient PPS payments to hospitals that would otherwise receive large payment reductions. Small rural hospitals could lose as much as 10-20% of Medicare outpatient revenue under PPS. The NRHA strongly opposes a phase-in because the impact on rural hospitals will ultimately be the same - small, rural hospitals will be placed in a more financially vulnerable situation. A phase-in of the PPS system for hospital outpatient services would be nothing more than a band-aid fix to a very serious problem which merits a more viable and long-term solution. As an alternative, the NRHA supports legislating an exemption for Medicare Dependent Small Rural Hospitals and Sole Community Hospitals from the proposed Medicare hospital outpatient prospective payment system.

b) Home Health Care. Your proposal will make a number of changes to the home health provisions of the BBA, including increasing time for repayment of overpayments, postponing the requirement for surety bonds and lowering the amount of the bonds, and easing reporting requirements. All of these changes have the potential to benefit small rural home health agencies, many of which have experienced severe negative impacts from the BBA. However, these changes are only short-term, in the context of the interim payment system, and are not designed for dealing with the potential inequities in the prospective payment system.

c) Inpatient Hospital Payment. The Administration plan proposes a phased-in reduction in the hospital market basket update for rural hospitals, until the same update applies for rural and urban hospitals in FY 2009. The NRHA commends the Administration for recognizing that rural hospitals have lower Medicare margins than urban hospitals and often provide services that are otherwise unavailable locally. However, the NRHA strongly opposes making any reduction, large or small, to the annual payment update for Medicare inpatient services. A reduction in the annual hospital inpatient update is a cut whether its implemented in its entirety now or phased-in. This is especially true for rural hospitals who are experiencing a greater percentage of negative total Medicare operating margins than their urban counterparts. Recent studies show that if the BBA is fully implemented Medicare operating margins for rural hospitals could fall to negative 10.4 percent (The Lewin Group, 1999).

6) Medicare Management Advisory Boards. The Administration proposes three public/private advisory panels to suggest management reforms for the Health Care Financing Administration (HCFA): a Management Advisory Council; Medicare Coverage Advisory Committee; and Citizens Advisory Panel on Medicare Education. To ensure that rural issues are understood and appropriately considered, all of these panels should include members with rural health experience and expertise.

7) Access to Medigap Policies. The BBA provided for a 63-day Medigap policy open enrollment period for beneficiaries in Medicare+Choice plans that terminated their Medicare contract or reduced their service area. A number of rural beneficiaries were affected by such pull backs. However, many of these beneficiaries were unaware of this open enrollment provision and insurance carriers were not prepared to effectively implement it. Your plan provides a one-time special 90-day open enrollment period for individuals who were enrolled in a plan and had no Medicare+Choice option after the plan terminated its contract or reduced its service area as of January 1, 1999. This provision will benefit those rural beneficiaries who were unaware of or unable to participate in the previous Medigap open enrollment.

8) Medicare Buy-in. The Administration plan allows people aged 62-64 to buy-in to the Medicare program. Because rural residents are less likely to have access to employer-based health insurance and rural areas have a higher rate of uninsured than urban areas, this provision should benefit rural areas more than urban areas.

Breaux-Thomas Medicare Reform Proposal

1) Plan Choice. The Breaux-Thomas proposal assumes that a number of health insurance plans would compete for beneficiary enrollment, or in areas where competition does not exist among private plans, standard and high option government run fee-for-service (FFS) plans would be available. All beneficiaries would therefore have at least two options to choose from, which is an improvement over the current situation, where many rural beneficiaries have access only to traditional FFS Medicare. Breaux-Thomas, however, does not directly provide additional incentives for plan development in rural areas and therefore may not solve the current inequities in plan choice that exist for rural beneficiaries. As a result, urban beneficiaries will continue to choose from a broad range of both FFS and managed care plans, while most rural beneficiaries will be limited to the traditional FFS system (although, as noted above, availability of a high option plan containing prescription drug benefits will be an enhancement in choice for many rural residents).

If the Breaux-Thomas proposal is successful, on the other hand, in spurring private sector development, it would encourage the creation of large regionally integrated health systems between rural providers or rural and urban providers. These regional systems could then develop their own health plans to compete for Medicare beneficiaries or have greater strength in negotiating with other plans. Like the situation faced in rural communities today, such systems offer both opportunities for creating viable health systems and improving access for rural residents and threats to local control of health care decision making.

2) Payment to providers. Under Breaux-Thomas, Medicare will be pay a single premium to health plans, including the government-run fee-for-service (FFS) plan. There will no longer be a legislative role, therefore, for setting payment to health care providers; prices for services would be set by health plans. Although it can be argued that the government has traditionally been unable to determine fair prices for rural providers, this market-based approach does not account for limited competition and the failure of the health care market in many rural areas.

Currently, there are many federally supported programs, both entitlement and discretionary, that recognize the special needs of health care providers in rural and underserved areas by offering enhanced payment rates and subsidies to these providers. The Breaux-Thomas proposal includes a provision that allows Congress to consider separate payments for certain classes of providers under the FFS plan, but these payments must be made in the face of market pressure on the FFS plan to compete with other, presumably lower priced, plans. As a result, rural providers could be negatively impacted by health plans that use their market power to steer patients to larger urban systems that are better able to offset low payments through high volume. Continuation of targeted programs for providers in rural and underserved areas and/or minimum provider payment levels may be necessary to offset these potential effects. In addition, RUPRI recommends periodic review of the financial viability of essential rural providers, targeted payment changes if problems are identified, and mandates that plans seeking enrollment in rural areas provide local primary care and emergency services.

In situations where plans are present and competing in rural areas, providers also face potential payment issues. Discounted or capitated payments offered by competing health plans are likely to be substantially lower for providers that have previously participated in special programs for underserved and rural populations under the current Medicare FFS system. If these providers cannot afford to accept such rates, plans may rely on providers outside the community, thus endangering the survival of local providers in another way, through loss of patient volume. For rural Medicare beneficiaries this may result in a serious access problem. The reality of rural America is that many rural seniors do not have the means or ability to travel long distances to obtain health care services. A mandatory minimum pricing structure under which plans would have to negotiate with providers may remove some of the potential market-based savings of Breaux-Thomas, but provide a more equitable playing field for small rural providers. The NRHA recognizes that plans could choose to pay differential bonuses to rural providers. However, they are not likely to do so if they can meet access requirements without providing such a bonus payment.

3) Beneficiary premiums. Under Breaux-Thomas, beneficiaries will pay a percentage of the premium for their health insurance plan. According to the formula used in the proposal, beneficiary payments will be higher in areas where most plans cost more than the national average and lower where they cost less. For example, if a beneficiary chooses a plan that costs only 85 percent of the national average, no beneficiary premium payment would be required. On the other hand, if a plan costs more than the national average, the beneficiary is responsible for covering the entire difference between the national average and the plan's actual premium.

Because only the FFS plan will be available in most rural areas (as is mostly the case in the Federal Employees Health Benefits Plan, upon which Breaux-Thomas is based), premiums for most rural beneficiaries will be set according to a national rate. Assuming that the FFS plan will cost more than other plans (as is also currently the case in FEHBP), rural beneficiaries in the future will be subject to higher premium payments than their urban counterparts and there will be a redistribution of premium dollars from rural to urban beneficiaries. The NRHA supports RUPRI's recommendation that numerous regional FFS plans, rather than a single national plan, could offset this inequity.

4) Extending Balanced Budget Act Provisions. Breaux-Thomas states that Medicare and Medicaid payment reductions and policy reforms included in the BBA should be extended beyond its current five-year window. Although Congress may make supplemental payments to certain classes of providers under Breaux-Thomas, there is an implicit approach in the legislation to continued cost reductions. In addition, as noted above, it may be difficult for Congress to make supplemental FFS provider payments in the face of price competition from other health plans. As a result, some rural providers that rely on FFS Medicare payments may continue to face the financial difficulties created by the BBA's FFS payment cuts. The NRHA already opposes any extension of BBA provisions beyond 2002. In fact, the NRHA recently communicated with members of Congress about the need to provide targeted BBA relief to rural providers who are suffering from the cumulative impact of the BBA.

5) Medicare Board. Under Breaux-Thomas, a Medicare Board will oversee enrollment and provision of information to beneficiaries. Both this Board and its staff should include members with rural health knowledge and expertise.

General Comments

Both plans fail to address the current inequity in the wage index which is used to determine reimbursement rates under the Medicare hospital inpatient prospective payment system. Rural hospitals have been traditionally paid less than urban hospitals, and the wage index bases payments on this differential - even if the wage market in an area changes and becomes more competitive. Currently, the Medicare wage index calculation does not adjust for occupational or skill mix. Rural hospitals are disadvantaged by the calculation of the Medicare wage index currently used, because rural hospitals generally employ a lower proportion of highly skilled level personnel. As a result, their average hourly wage rate will be lower than a hospital with a higher proportion of highly skilled personnel - even if they are situated in a wage market with similar wage levels.

The NRHA strongly supports incorporating an occupational mix adjustment into the calculation of the Medicare hospital wage index for purposes of the Medicare hospital inpatient prospective payment system so that it accurately reflects differing wage rates for similar mixes of employees. Such a policy change would require the Health Care Financing Administration to begin gathering data on wage and hours by occupational category in the Medicare cost report or by obtaining it from the Bureau of Labor Statistics.

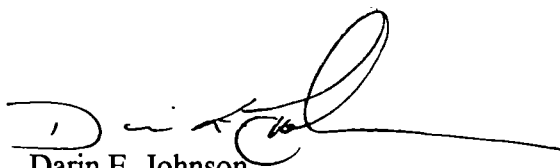
Additionally, the NRHA would also like to convey its strong support for developing separate Medicare wage indexes for the prospective payment systems being developed by HCFA for skilled nursing, home health and hospital outpatient services. To simply expand the use of the hospital inpatient wage index to post-acute care services would only perpetuate the very serious problem outlined above.

The NRHA stands ready to work with you and your Administration to ensure any Medicare restructuring legislation that moves forward meets the goals for Medicare restructuring outlined above. If you have questions about the NRHA's comments, please feel free to contact us at (202) 232-6200.

Sincerely,

Gail R. Bellamy, Ph.D.

Gail R. Bellamy, Ph.D.
President


Darin E. Johnson
Government Affairs Director



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Richard N. Atkins, M.D.
President

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November 18, 1999

President William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

Thank you for all of your efforts in completing the Fiscal Year 2000 budget, particularly for your support of increased funding for cancer research at the National Institutes of Health and the Department of Defense. As you know, NIH is scheduled to commit \$260 million to prostate cancer research next year, and the DOD prostate cancer research program has been funded at \$75 million. These investments will improve America's public health and protect families from the deadly effects of one of the nation's most dangerous diseases.

Unfortunately, cancer survivors now face a new challenge: the recent budget agreement calls for across-the-board spending reductions. Although these reductions are small, you know how critical expanded cancer research is to all Americans, and especially to the millions touched by prostate cancer. As a member of the National Prostate Cancer Coalition and its network of activists across the country, CaP CURE requests that you use the discretion you've been given in the budget agreement to protect cancer research funding in general and prostate cancer research funding in particular. First, please assure that the cancer research programs at the Department of Defense will not be subjected to any cuts. Second, the more than \$150 million that we understand must come out of the Department of Health & Human Services budget should not derive from the commitment to the National Institutes of Health cancer research programs.

In fact, statistics demonstrate an urgent need to boost prostate cancer research. Prostate cancer is the most commonly diagnosed nonskin cancer in America. Each year, almost 200,000 men are diagnosed with this disease, and nearly 40,000 die from it. While prostate cancer accounts for 15% of all cancer cases and 15% of cancer deaths among men, just 5% of every cancer research dollar is allocated to find its control or cure. Any budget cuts, therefore, could be especially devastating. In fact, funding is so important that we request that all available dollars be committed to research and not to federal agency overhead, particularly at DOD.

The fight against prostate cancer does not, of course, end with this year's budget agreement. I hope you will make cancer research – and prostate cancer research – priorities in your FY01 budget. We urge you to request full funding for the Department of Defense prostate cancer research program (\$200 million) and to strengthen research funding at the NIH. These increases in research funding are needed to support Vice President Gore's laudable proposal to double funding at the NIH within five years. We appreciate his strong commitment to cancer research. We hope you will also consider opportunities to bring the NCI budget to \$10 billion within five years, in accordance with the MARCH Research Task Force report.

Mr. President, research opportunities to bring new cancer treatments to the marketplace abound. This is the time to end the nation's 28-year-old war on cancer. The cost of cancer to this country is already enormous and rising. The MARCH Research Task Force report indicates that, unchecked, cancer incidence could increase by 29% and deaths by 25% in the next decade – at double (\$200 billion) the current annual cost.

Since coming to office, your Administration has strongly supported cancer research, helping to raise public awareness and sending a message of hope to the 10 million cancer survivors across the country. As you manage the budget reductions and develop your FY01 budget, please invest in cancer – and prostate cancer – research. Too many lives are at stake.

Thank you in advance for your support and consideration.

Cordially,

A handwritten signature in black ink, appearing to read "Richard N. Atkins", written over the printed name.

Richard N. Atkins, M.D.



NATIONAL RURAL HEALTH ASSOCIATION

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Charlotte Hardt
President-elect

Susan Wilson
Treasurer

Janet Ivory
Secretary

Tim Size
Past President

To: Chris Jennings, White House Office of Domestic Policy
From: Darin Johnson, Government Affairs Director
Re: Balanced Budget Act Relief Priorities
Date: August 18, 1999

At the request of several members of Congress, the National Rural Health Association (NRHA) would like to share its members' legislative priorities as Congress begins to draft legislation providing relief to health care providers being adversely impacted by Medicare and Medicaid provisions contained in the Balanced Budget Act of 1997 (BBA). Because of the cumulative negative impact that reforms contained in the BBA are having on the rural health care delivery system, it is imperative that the reforms outlined below be included in any BBA relief measure considered by the Congress.

Attached is a report by the non-partisan Rural Policy Research Institute (RUPRI) that provides data and examples of how the BBA is cumulatively impacting our rural health care delivery system. The findings contained in the RUPRI report clearly support the need to implement BBA relief targeted at rural health care providers. Without such relief, access to health care for rural Medicare beneficiaries will be put at risk.

Recognizing the need for targeted BBA relief, both the Senate Rural Health Caucus and the House Rural Health Care Coalition introduced omnibus rural health care bills, S. 980 and H.R. 1344, which include a number of important BBA relief provisions. The NRHA, along with a number of other national health care organizations, has endorsed both the Senate and House rural health bills. Because of the scope of each of the measures, the NRHA would like to identify those provisions included in the bills which are of greatest priority to our membership. Inclusion of these provisions in a BBA relief measure is crucial to the NRHA's support of any Medicare reform legislation considered by the Congress this year.

Below are the NRHA's BBA relief priorities in order of importance as identified by the association. If you need additional information or have questions about the NRHA's BBA relief priorities, please feel free to contact me at (202) 232-6200 or by e-mail at johnson@nrharural.org.

1. Medicare Hospital Outpatient Prospective Payment System

Exempt Medicare Dependent Small Rural Hospitals, Critical Access Hospitals and Sole Community Hospitals from the proposed Medicare hospital outpatient prospective payment system. [S. 980 - Section 107 and H.R. 1344 - Section 101]

2. Medicaid Reimbursement to Community Health Centers and Rural Health Clinics

Repeal the phase-out of Medicaid cost-based payments to Federally Qualified Health Centers and Rural Health Clinics that was contained in the BBA of 1997. [H.R. 1344 - Section 201 - technical change to language needed]

Donna M. Williams
Executive
Vice President

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3. Health Professional Shortage Area Designations

- Require consideration of pending physician retirements or resignations in designating Health Professional Shortage Areas (HPSAs);
- Require revised standards for HPSA designation through expedited negotiated rule-making process;
- Require DHHS to consider the needs of medically underserved populations and individuals and the percentage of the population over age 65 in developing such standards; and
- Prohibit new methodology for HPSA designation if the methodology is detrimental to rural or frontier communities including that it results in the provision of fewer services.

[S. 980 - Section 201 and H.R. 1344 - Section 405]

4. Critical Access Hospital Reforms

- Allow hospitals that closed or downsized to a clinic within three years of enactment of this law to reopen as or convert to a Critical Access Hospital (CAH);
- Allow CAHs to choose between two options for payment for outpatient services: (1) reasonable costs for facility services, or (2) an all-inclusive rate which combines facility and professional services;
- Require Medicaid programs to reimburse for services in CAHs;
- Change the 96 hour length of stay limit to a 96 hour average;
- Exempt CAH swing beds from PPS for skilled nursing facilities; and
- Grant CAHs deemed status that will allow for accreditation.

[S. 980 - Sections 102, 105 and 106 and H.R. 1344 - Section 104 - technical change to language needed]

5. National Health Service Corps Scholarships

Exempt National Health Service Corps scholarships and stipends from federal income taxes. [S. 980 - Section 202 and H.R. 1344 - Section 301]

6. Rural Impact Statements

Require the DHHS, when promulgating or proposing a regulation related to a health care program, to include an analysis of the impact of implementation of the regulation on rural areas, including its impact on: (1) rural safety net providers; (2) rural primary care providers; (3) rural hospitals; (4) FQHCs and RHCs; (5) the economies in rural areas; and (6) rural residents. [H.R. 1344 - Section 401]

7. Graduate Medical Education Reforms

- Increase indirect GME payments to some hospitals by changing the way interns and residents are counted, from including those who were in the hospital during the most recent cost reporting period ending on or before December 31, 1996, to those who were appointed by the hospital's medical residency training programs for the same time period;
- Allow a hospital that sponsors only one residency program to count one additional intern/resident for each calendar year up to a maximum of three more than the limit otherwise determined under this provision; and
- Require DHHS to give special consideration in rule-making not only to facilities that meet the needs of underserved rural areas, as currently required, but to facilities that are not located in an underserved rural area but have established separately accredited rural training tracks.

[S. 980 - Section 103]

8. Wage Indices for Skilled Nursing Facilities and Home Health Agencies

Require that area wage adjustments for the skilled nursing facilities (SNFs) and home health agencies (HHAs) prospective payment systems be based on wage levels at SNFs and HHAs.

[S. 980 - Section 130]

9. Medicare Rural Waiver

For purposes of Medicare payments, establish waiver process to allow rural providers located in Metropolitan Statistical Areas (MSAs) to be classified as "rural" if they are located: (1) in a rural area as defined by the Goldsmith Modification published in the *Federal Register* on February 27, 1992; (2) outside of an urbanized area as defined by the U.S. Census Bureau; or (3) in an area designated by a State as rural. [S. 980 - Section 126 and H.R. 1344 - Section 123]

DEJ 8/16/99

August 30, 1999

The Honorable Bruce Reed
Assistant to the President for Domestic Policy
Executive Office of the President
Washington DC 20502

Dear Mr. Reed:

The undersigned organizations, which share interests in ending homelessness and securing health services for medically underserved persons, request your leadership in developing and expanding treatment and recovery opportunities for homeless persons with addictive and mental disorders as you prepare the Clinton Administration's Fiscal Year (FY) 2001 budget for the Department of Health and Human Services (HHS).

Persons experiencing homelessness face major barriers to accessing and utilizing addiction and mental health services. Such obstacles include a lack of documentation to prove income eligibility for public programs, difficulties in maintaining schedules because of conflicts with obtaining other priority services such as nutrition and shelter, and lack of transportation to services.

Many addiction and mental health providers are not equipped at this time to handle the complex social and health conditions that homeless persons present and may reject them or provide ineffective care. Resource constraints and lack of familiarity with the unique needs and life circumstances of the homeless population preclude many providers from offering the long-term, residentially-based aftercare and recovery services that have been found to be essential in homeless persons' adherence to treatment and maintenance of improved health condition. Furthermore, these providers are not typically linked to the full range of health, housing, social, and maintenance services that homeless people with addictive and mental disorders require for recovery and residential stability.

To redress the serious gaps in outreach, residential treatment, and supportive housing for homeless persons with addictive disorders and the full range of mental disorders, we urge you to include \$100 million in the HHS FY 2001 budget request for an addiction and mental health services initiative targeted to the unique needs and life circumstances of homeless people. This special effort would enable community-based public and nonprofit organizations throughout the nation to respond to the addiction and mental health treatment and recovery service needs of the range of homeless subpopulations (e.g., single adults, families, veterans, and youth). A targeted HHS initiative would also stimulate the replication of proven homeless treatment and recovery models, such as those identified through research supported by the National Institute on Alcohol Abuse and Alcoholism and the Center for Mental Health Services.

We also urge you to include \$75 million—the authorized funding level—in the HHS FY 2001 budget request for the Projects for Assistance in Transition from Homelessness (PATH) program. PATH assures access to mental health and related services for homeless persons with serious mental illnesses and co-occurring addictive and serious mental disorders. While PATH has enabled many homeless persons to return to secure and stable lives, limited funds have prevented the program from reaching the universe of eligible participants. This group continues to grow as a result of continued deinstitutionalization of patients from mental health facilities and the denial of services, or premature and unplanned discharge, brought about by managed care. Additional federal funds are necessary for PATH to reach the substantial number of homeless, seriously mentally ill people still not receiving—or losing—mental health services.

The Honorable Bruce Reed
August 30, 1999
Page Two

We strongly believe that the development and expansion of treatment and recovery services targeted to the unique needs and life circumstances of the homeless population will lead to the resolution of their homeless condition, a decrease in their utilization of safety net health services, and an increase in the availability of these services for other vulnerable groups. Certainly, you share these desires. Please assert your influence to assure that the Administration's FY 2001 budget includes the resources necessary to meet these aims.

Sincerely,

AIDS Action
AIDS Policy Center for Children, Youth, and Families
Alliance for Children and Families
American Association for Marriage and Family Therapy
American College of Nurse-Midwives
American Medical Student Association
American Nurses Association
American Psychiatric Association
American Society of Addiction Medicine
Center for Women Policy Studies
Center on Disability and Health
Clinical Social Work Federation
Corporation for Supportive Housing
Federation of American Health Systems
Friends Committee on National Legislation (Quaker)
International Association of Psychosocial Rehabilitation Services
Lutheran Office for Governmental Affairs, ELCA
Migrant Clinicians Network
National Alliance to End Homelessness
National Association of Community Health Centers
National Association of Counties
National Association of Public Hospitals and Health Systems
National Coalition for the Homeless
National Coalition for Homeless Veterans
National Council on Alcoholism and Drug Dependence
National Health Care for the Homeless Council
National Low-Income Housing Coalition
National Mental Health Association
National Network for Youth
National Rural Mental Health Association
National Women's Health Network
Neighbor to Neighbor
NETWORK: A National Catholic Social Justice Lobby
Phase: Piggy Back, Inc.
Summit Health Institute for Research and Education, Inc.
The Better Homes Fund
The National Hispanic Medical Association
The Salvation Army
United Church of Christ, Office for Church in Society

The Honorable Bruce Reed
August 30, 1999
Page Three

Universal Health Care Action Network
Volunteers of America
YWCA of the U.S.A.

Identical Letters Sent to:

The Honorable Jacob Lew
Director
Office of Management and Budget
Executive Office of the President

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services