

Special Committee on Capture of Federal Resources

Representative Tom Sykora, Chairperson

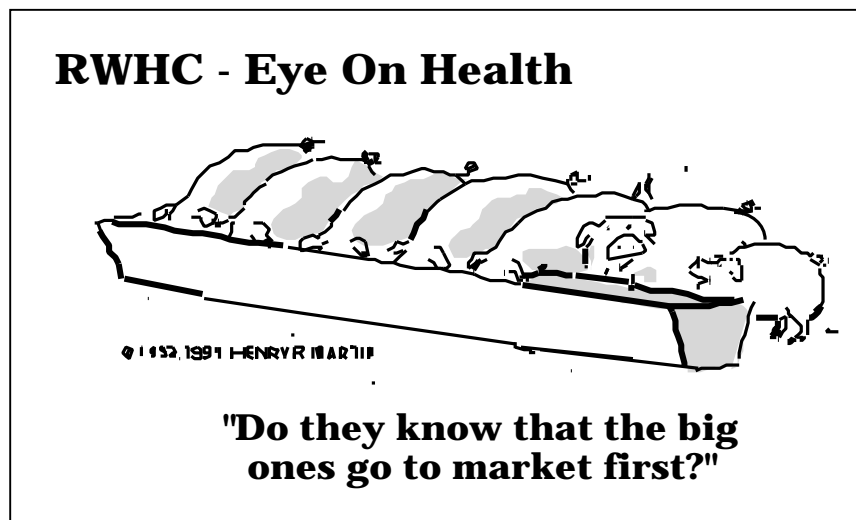
Public Hearing
Wednesday, November 18th, 1998
Room 417 North
State Capitol, Madison, Wisconsin

Medicare: a \$2 Billion State Biennial Shortfall

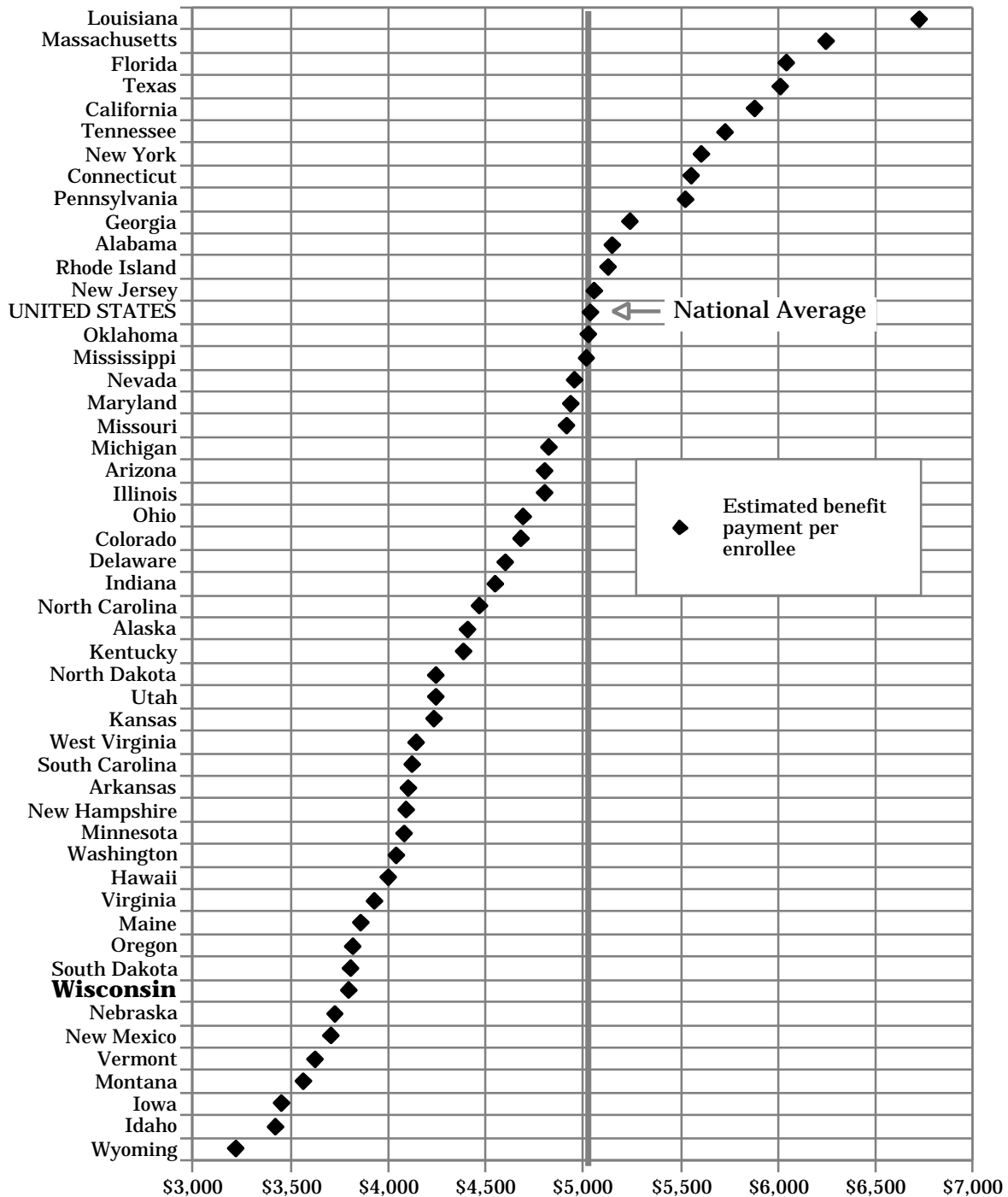
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The Cooperative, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

The Bright Side of Being Last in Federal Funding:



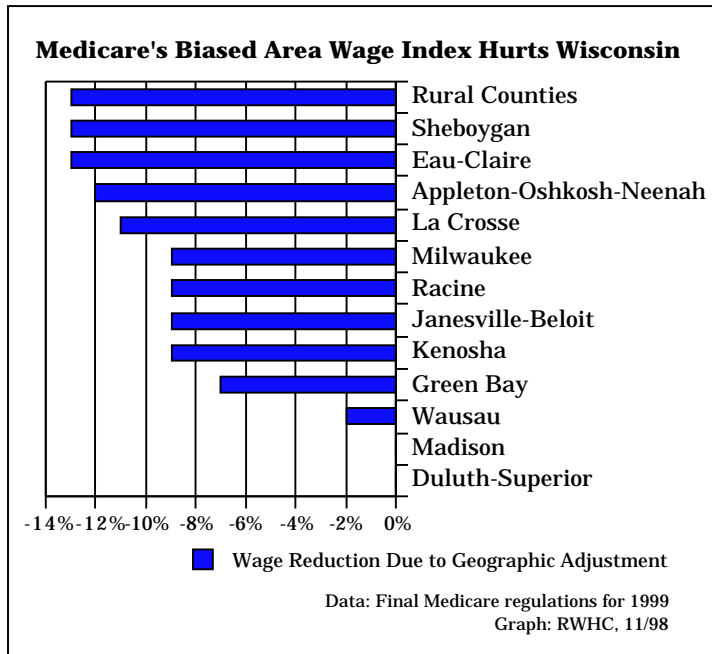
Medicare Program Payments per Enrollee in 1996 By State of Residence



Data: House Ways and Means 1997 Green Book, 1997
 Graph: RWHC 1/98

Medicare--Key Reason Wisconsin Near Bottom in Federal Funding

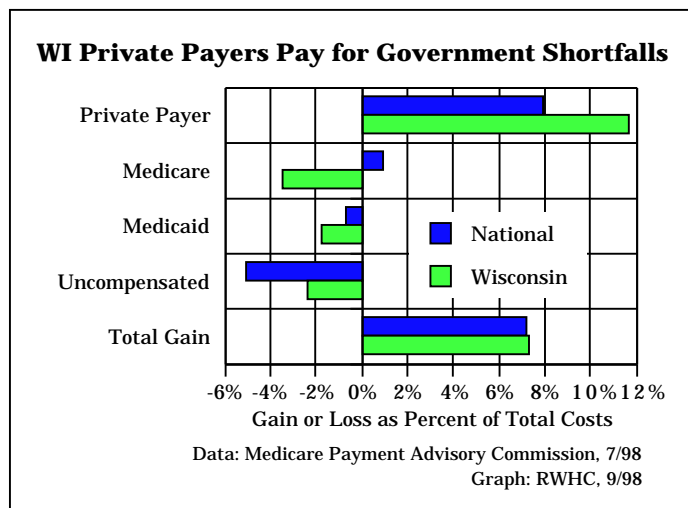
A recent State Journal column by Tom Still suggested that Wisconsin's Congressional Delegation could be asked why we are nearly last in total federal spending.



As shown on the prior graph, part of the answer is that Medicare spending per enrollee is eighth from the bottom and 25% below the national average--\$3,795 estimated annual benefit payments per Medicare enrollee compared to a national average of \$5,034. (*House Ways and Means 1997 Green Book*).

If Wisconsin's average payment had been at the national rate, the state would have received almost another billion dollars--\$1,239 in benefits lost for each of 766,000 Wisconsin Medicare enrollees or \$950 million lost each year.

Part of the lower Medicare spending in Wisconsin may be due to area differences in the average need for health care, is due to our more efficient delivery systems and most certainly is due to ongoing inequitable federal payment policies, particularly the application of very flawed adjustments for regional wage differences. (Several years ago, we were able to win a phase out of such an adjustment for physician payments.)



Our failure to obtain equitable Medicare benefits and payments effects all Wisconsin sectors; for example, compared to private payers in other states, those in Wisconsin pay a higher share of total costs to make up for Wisconsin's Medicare shortfall.

Wisconsin needs a coordinated Medicare strategy among Wisconsin's state government, congressional delegation and other key allies.

Medicare's Wage Adjustment: a Root Cause of Wisconsin's Problem

Medicare has a complex formula to determine what it pays any hospital for providing a particular service to a Medicare beneficiary. In brief, about three-quarters of that payment is increased or decreased by applying a "hospital wage index." The index is intended to adjust for the fact that market wage rates for nurses and other hospital employees vary somewhat across the country.

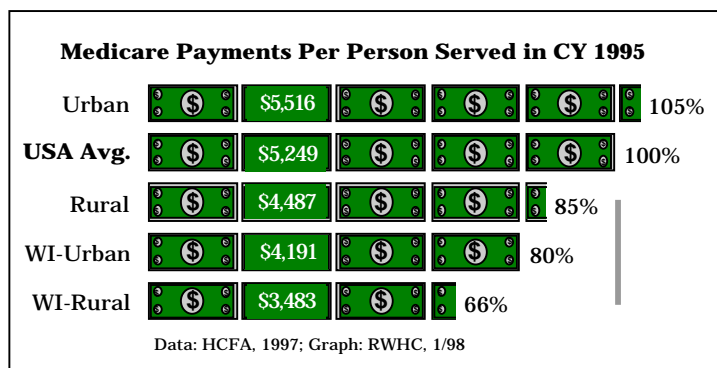
The index actually goes well beyond the original intent, adjusting not only for differences in local wage rates but also rewarding hospitals in areas where a greater than average number of high salary employees are hired (even after adjusting for hospitals with sicker patients). This hurts Wisconsin's more efficient health care system in general and rural counties in particular.

The problem is about to get significantly worse. Medicare is expanding the use of the hospital wage index to be used to adjust payments for hospital outpatient, Medicare Choice health plans, home health and nursing home services--the wage index isn't just for hospitals any more.

Wisconsin's Urban Problem Bad, Rural Impact Even Worse

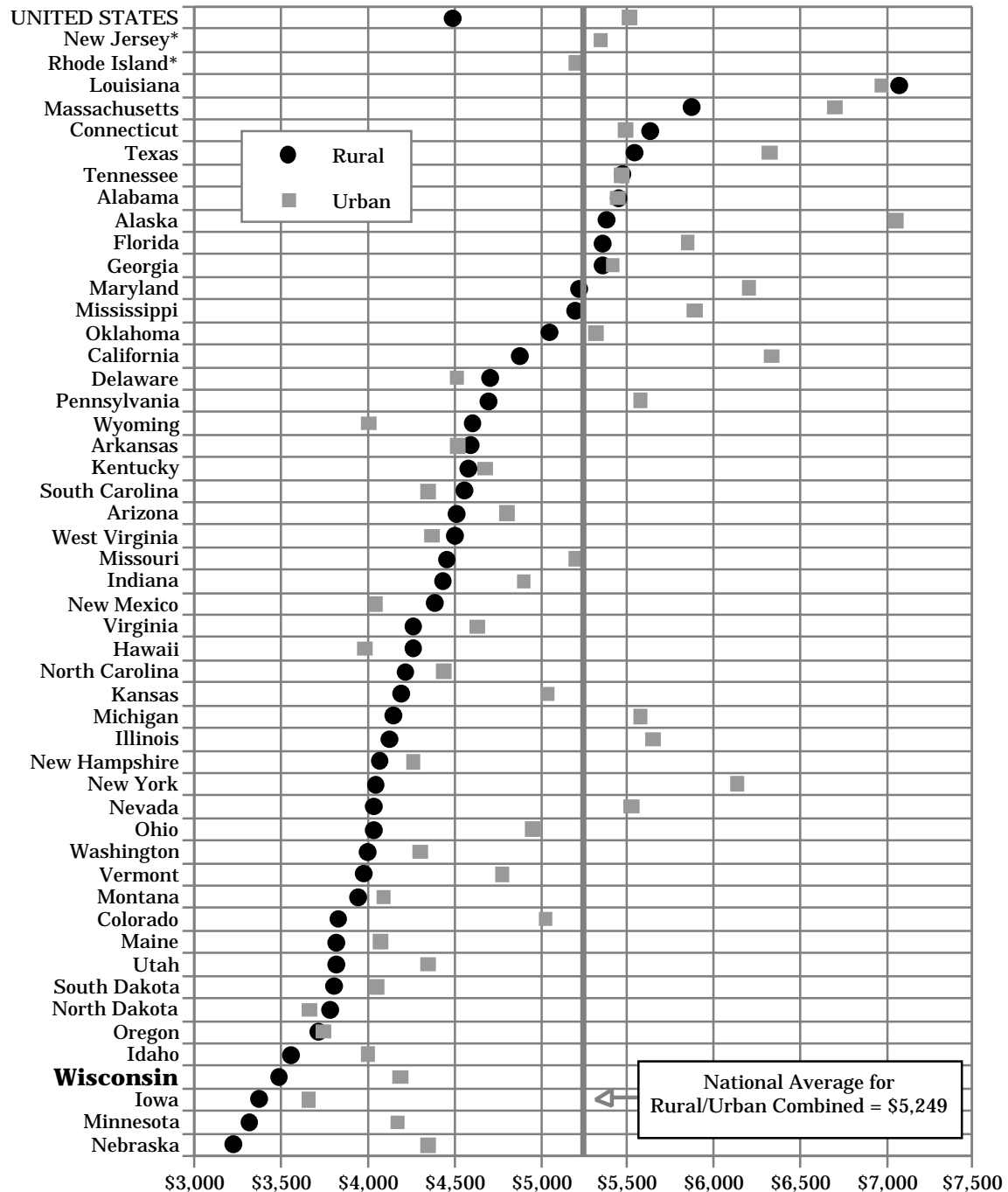
As a result of these manipulations, the wage index swings widely, ranging from a low of 70% of the national average in rural Mississippi and South Dakota to nearly double that or 140% of the national average in some urban areas of California and New York. The current wage index is the primary reason payments to rural hospitals and their resulting Medicare inpatient margins ("profits") are less than half that of urban hospitals (4.4% versus 9.7% in 1995.) As shown on page 4, the federal wage index adjustment for Medicare ranges to as low as 13% below the national norm (some improvement over earlier years but still unjustifiably low.)

As can be seen on the graph to right and on the following page, there is also a serious bias against rural counties in Wisconsin. While urban beneficiaries receiving services have benefits paid on their behalf equal to 80% (\$4,191) of the national average (\$5,249), rural Medicare beneficiaries receive benefits payments equal only to 66% (\$3,483) of the national average.



Wisconsin should be proud that its health care system is more efficient than the country as a whole but it can not be satisfied when it is underpaid for those Medicare expenses it fairly incurs.

Medicare Program Payments per Person Served in 1995 By State & Rural/Urban County of Residence



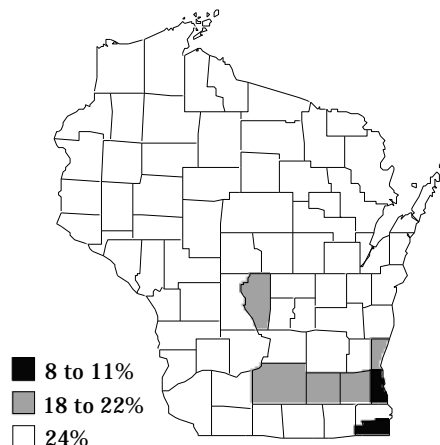
Data: Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1997
 Note: New Jersey & Rhode Island have no rural residents.
 Graph: RWHC 1/98

The Problem with Medicare Choice Payments and Benefits

A second major shortfall for Medicare is the inequitable payment formulas that Medicare will be using with their new "Medicare Choice" initiative. Payments on behalf of Medicare enrollees in Wisconsin will be from 8% to 24% below the national average, greatly limiting the availability and benefits of these new alternatives.

From a Medicare press Release, 6/18/98: "Starting in January 1999, in addition to original fee-for-service Medicare and health maintenance organizations, a broader array of health plans will be able to join Medicare, including preferred provider organizations (PPOs), provider sponsored organizations (PSOs), private fee-for-service plans (PFFS), and a Medical Savings Account (MSA) demonstration project. These expanded health plan choices, known as Medicare+Choice, were created as part of the bipartisan Balanced Budget Act of 1997." (See appendix.)

Medicare Choice Payment Rates Penalize Every Wisconsin County



Percent Below 1999 National Average

Data: HCFA 11/98

Graph: RWHC 11/98

As shown below, with Medicare HMOs and other Medicare Choice options, beneficiaries pay more when Medicare pays less; below average federal payments simply translate into greater out-of pocket costs for Medicare beneficiaries. Specifically, HMOs in high payment localities (such as South Florida) can be offered with no premiums, offer a prescription drug benefit, limited to no co-payments and free eye-glasses.

Visit the new Medicare Consumer site on the internet at:

www.medicare.gov

to make your own comparisons;
you've got to see it to believe it.

Medicare's Second Class Rural Benefit

Medicare HMO Benefits Vary Widely

| | South Florida Urban | North Dakota Rural |
|---------------------|-------------------------------|------------------------------|
| Member Premium: | \$0 | \$25 |
| Prescription Drugs: | Unlimited | No Benefit |
| Office Copay: | \$5 | \$10 |
| Hospital Copay: | None | \$100 |
| Vision Care: | 1 Pair Glasses/Year | Exam Only |

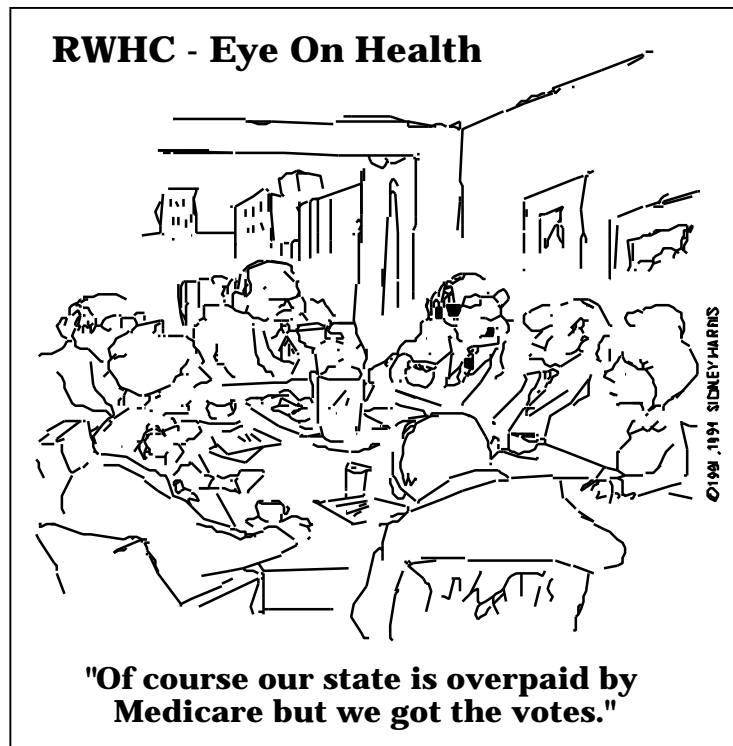
Source: Towers Perrin.

Graph: RWHC.

Suggestions to Capture Increased Medicare Funding

- I. Make Medicare Equity a State and Congressional Delegation Priority
- II. Develop & Implement a Wisconsin Strategy
- III. Develop & Implement a Strategy with Other States Similarly Disadvantaged
- IV. Limit Medicare's Geographic Adjustment for Wages
 - (1) Require a wage index methodology that only measures the geographic variation in relevant wage rates. Any other appropriate geographic variations should be separately and explicitly addressed.
 - (2) Implement a hospital wage index that adjusts only for differences in wage rates by either (a) occupationally mix adjusting current cost base data or (b) working off of a separate Bureau of Labor Statistics wage survey.
 - (3) If Medicare cost report data continues to be used to develop the hospital wage index, it must be "cleaned" and consistent among the multiple state fiscal.
 - (4) To the degree that the wage index is used to support "social" missions such as graduate medical education and uncompensated care, these purposes should be funded explicitly, using a "rifle" rather than the current "shotgun" approach.
- V. Limit Medicare's Geographic Adjustment for Health Plan Payments
 - (1) Federal payments for Medicare Choice plans must begin to converge to a national mean, from both high and low payment localities, with geographic variations in payment being limited to only proven differences in the price of labor and capital as well as proven differences the need for health care services be allowed to effect payment rates.

Medicare is Not Immune to Political Horse Trading:



Appendix: Terms

From a HCFA Press Release, Thursday, June 18, 1998:

Access to Medicare+Choice options will depend on where the beneficiary lives and what types of plans are available in that community. Among the options are:

Health Maintenance Organizations (HMOs). In HMOs, beneficiaries must obtain services from a designated network of doctors, hospitals, and other health care providers who have agreed to serve plan enrollees, usually with little or no out-of-pocket payments.

Health Maintenance Organizations with a Point of Service (POS) Option. When combined with a basic HMO package, the POS permits beneficiaries to selectively go out of network to receive services, with higher out-of-pocket payment requirements.

Preferred Provider Organizations (PPOs). Beneficiaries in PPOs obtain services from a network of health care providers that has been set up by the health plan. Unlike an HMO, beneficiaries can choose to go to providers who are not in the network and the plan will pay a percentage of the costs while the beneficiary is responsible for the rest.

Provider-Sponsored Organizations (PSOs). PSOs are a relatively new form of managed care that work much like an HMO, except that they are formed by a group of hospitals and doctors who directly take on the financial risk of providing comprehensive health benefits for Medicare beneficiaries.

Private Fee-For-Service Plans (PFFS plans). The Medicare beneficiary elects a private indemnity-type insurance plan. The insurance plan, rather than the Medicare program, decides how much to reimburse for services provided. Medicare pays the private plan a premium to cover traditional Medicare benefits. Providers are allowed to bill beyond what the plan pays (up to a limit), and the beneficiary is responsible for paying whatever the plan doesn't cover. The beneficiary may also be responsible for additional premiums.

Medical Savings Accounts (MSAs). Congress has authorized up to 390,000 Medicare beneficiaries to participate in a MSA demonstration. The beneficiary chooses a Medicare MSA Plan -- a health insurance policy with a high deductible. Medicare pays the premium for the MSA Plan and makes a deposit into the Medicare MSA that is established by the beneficiary. The beneficiary uses the money in the Medicare MSA to pay for services provided before the deductible is met and for other services not covered by the MSA Plan. Unlike other Medicare plans, there are no limits on what providers can charge above the amount paid by the Medicare MSA Plan. Unlike other Medicare+Choice options, individuals who enroll in MSAs are locked in for the entire year, with a one-time option of withdrawing by December 15 of the year in which they enrolled.