

ENT-27 INCREASE USER FEES ON PRODUCTS REGULATED BY THE FDA

	Annual Added Receipts (Millions of dollars)					Cumulative Five-Year Addition
	1996	1997	1998	1999	2000	
Addition to Current- Law Receipts	86	93	97	101	105	482

Increasing the level of fees charged by the Food and Drug Administration (FDA) for new drug applications and establishing user fees for other products regulated by the FDA could increase revenues by \$86 million in 1996 and by \$482 million for 1996 through 2000. The Administration's 1995 budget proposed new FDA user fees that would have raised \$252 million in the first year, but those new fees were not levied. This option proposes various fees and fee increases that would raise about a third of the Administration's proposed revenue level.

The FDA's regulatory activities are beneficial to both the consumer and industry. The primary function of the FDA is to ensure public safety by monitoring the quality of pharmaceutical products, medical devices, and food. Firms benefit from the public confidence that results from FDA's quality standards. Ensuring a high level of product quality is essential to the success of these industries. Proponents of establishing new user fees argue that since firms benefit from these regulatory services, they should bear a share of the costs.

The Prescription Drug User Fee Act of 1992 established application fees and set a projected revenue schedule. The FDA charges a fee of \$208,000 for each new drug application. The fee is \$104,000 for each generic drug and supplemental application. In addition, pharmaceutical firms that have had a new drug application pending with the FDA at any time since September 1992 must pay an annual fee of \$126,000 per manufacturing establishment and \$12,500 per product on the market. In 1995, those fees are scheduled to raise \$75 million, covering about 20 percent of the FDA's expenditures on regulating prescription drugs. The fees will increase slightly through 1997, when they are scheduled to raise \$94 million. A 40 percent increase in the fee

schedule above that specified by law would produce an additional \$35 million in revenues in 1996 and \$193 million between 1996 and 2000.

The Food, Drug, and Cosmetic Act requires that firms register all new medical devices before they are marketed and obtain FDA approval for certain types of new medical devices (class III). Currently, manufacturers of medical devices do not pay fees to the FDA. Recent legislation proposed submission fees for the approval and registration of new medical devices that would have raised \$24 million, but it did not pass the Congress. Fees of \$60,000 for the application of each new medical device would raise \$4 million in 1996. Fees of \$6,000 for new product registration would raise \$24 million in 1996. Combined, those fees would cover about 20 percent of the costs of regulating the medical device industry. If the new fees were used to increase FDA expenditures, they would not reduce the deficit. Industry would be likely to agree to new application fees and fee increases if the raises were accompanied by promises to speed up the approval process, but that could increase FDA expenditures.

Finally, the food industry could be charged user fees that would raise \$22 million in 1996, covering about 10 percent of the FDA's costs of regulating the industry. The FDA inspects domestic food processors, analyzes more than 17,000 domestic food samples a year, and monitors the quality of seafood. If the FDA charged domestic food processors employing more than 250 people and processing all foods except meat and poultry an annual fee of \$10,000, it could raise \$12 million. If the Food and Drug Administration also charged each domestic establishment employing 100 to 249 people an annual fee of \$5,000, it could raise another \$10 million.

Higher user fees for the entire food industry would be cumbersome. There are more than 15,000 domestic food processors who employ fewer than 100 people. Smaller establishments have a much lower sales volume and therefore must be charged a much lower annual fee. Collecting a low fee from so many establishments, however, might be counterproductive. And charging higher fees than those proposed for the larger establishments could hamper the

ability of those large firms to compete with smaller establishments that would pay no fees.

In general, people opposing FDA user fees might argue that the FDA's current regulations are excessive. Rather than increasing user fees, the FDA could cut costs by scaling back its regulatory activities.

**ENT-28 LIMIT THE GROWTH OF FOSTER CARE ADMINISTRATIVE COSTS
TO 10 PERCENT A YEAR**

Savings from Current- Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Budget Authority	110	220	210	220	220	980
Outlays	90	200	210	220	220	940

The Federal Foster Care program, authorized under title IV-E of the Social Security Act, is an open-ended entitlement program that provides federal matching funds to assist states in providing foster care to children who meet certain eligibility requirements. In 1996, the program is expected to serve an average of about 280,000 children a month at a federal cost of \$3.5 billion. Administration of the program will account for about 45 percent of that total. Each state administers its own program within the federal mandates established in title IV. The federal government reimburses states for one-half of certain administrative costs, including those for determining eligibility, certain preplacement services, and child placement, as well as for administrative overhead.

Policymakers have been concerned about the rapidly escalating costs for administering this program. Those costs increased from \$50 million (in 1993 dollars) in 1981 to \$1.1 billion in 1993. This option would limit annual increases in payments to each state for administrative costs to 10 percent a year, reducing federal outlays by \$940 million in the 1996-2000 period.

This option would exclude the expense of installing new computer systems, which are eligible for 75 percent federal funding through September 30, 1996.

The process is already under way. In order to calculate the savings, installation expenses were not included in the base used to calculate the allowable increases in administrative expenses, nor were they included in subsequent administrative expenses.

During the 1980s, costs increased much more rapidly than caseloads. At some point in the past decade, many states' administrative costs increased sharply. In about one-half of the states, the annual increase in such costs per child exceeded 1,000 percent in at least one year, supporting the theory that much of the growth resulted from changes in states' methods for claiming funds rather than from expanded services to children.

It might not be advisable, however, to slow the growth in federal funding to child welfare agencies when these groups are struggling to deal with reported increases in child abuse and neglect. If states responded to the restriction by cutting back services, children in need of foster care could be harmed. Limiting the percentage increase that each state could receive would also lock in the current differences in costs per child. In 1993, estimates of average federal costs per child for title IV-E administration ranged from less than \$150 a month in five states to more than \$600 a month in four states.

ENT-29 REDUCE THE 50 PERCENT FLOOR ON THE FEDERAL SHARE OF MEDICAID,
AFDC, FOSTER CARE, AND ADOPTION ASSISTANCE PAYMENTS

Savings from Current- Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Medicaid Outlays	4,600	5,090	5,650	6,240	6,860	28,440
AFDC Outlays	560	570	580	590	610	2,910
Foster Care/Adoption Assistance Outlays	240	310	350	390	420	1,710
Offsets in the Food Stamp Program	<u>-110</u>	<u>-110</u>	<u>-110</u>	<u>-110</u>	<u>-110</u>	<u>-550</u>
Total	5,290	5,860	6,470	7,110	7,780	32,510

The Medicaid program provides medical assistance to current or recent beneficiaries of the Aid to Families with Dependent Children (AFDC) program, low-income people who receive Supplemental Security Income, and certain other low-income individuals. The AFDC program provides cash assistance to low-income families in which one parent is absent or incapacitated or in which the primary earner is unemployed. The Foster Care and Adoption Assistance programs provide benefits and services to children who are in need.

The federal government and the states jointly pay for the Medicaid, AFDC, and Foster Care and Adoption Assistance programs. The federal share of the costs of these programs varies with a state's per capita income. High-income states pay for a larger share of benefits than low-income states. By law, the federal share can be no less than 50 percent and no more than 83 percent. The 50 percent federal floor currently applies to 12 jurisdictions: Alaska, California, Connecticut, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, and New York.

Under this option, the 50 percent floor would be reduced to 45 percent, generating savings of about \$5.3 billion in 1996 and \$32.5 billion through 2000.

Federal savings for the Medicaid program would be \$4.6 billion in 1996 and \$28.4 billion over the 1996-2000 period; outlays for AFDC would be reduced by \$560 million in 1996 and \$2.9 billion over the five-year period; and outlays for Foster Care and Adoption Assistance would decline by \$240 million in 1996 and \$1.7 billion over the five-year period. The estimates assume, however, that states would partially offset their higher costs by reducing benefits. Lowering AFDC payments would make some families eligible for larger Food Stamp benefits. Under this assumption, then, outlays for the Food Stamp program would increase by \$110 million in 1996 and \$550 million over the five-year period.

Proponents of this change argue that high-income states that choose to be generous should bear a larger share of the cost. If the floor was reduced to 45 percent, federal contribution levels would be more directly related to the state's income, and eight of the 12 jurisdictions would still be paying less than the formula alone would require. In January 1994, 11 of the 12 jurisdictions that would be affected by this proposal paid AFDC benefits that were at or above the median when states were ranked by size of benefits (for a three-person family). The higher benefit levels in these states mean that more families are eligible for AFDC and thus for Medicaid.

Opponents of the change stress that the higher incomes and benefit levels in the affected states partly reflect higher costs of living. If this proposal was adopted, the affected states would have to compensate for the lost federal grants by reducing Medicaid, AFDC, and Foster Care and Adoption

Assistance benefits, lowering spending on other services, or raising taxes. If states chose to compensate by partially reducing benefits, as the estimates assume, program beneficiaries would be adversely affected.

**ENT-30 REDUCE MATCHING RATES FOR ADMINISTRATIVE COSTS IN THE
MEDICAID, FOSTER CARE, AND ADOPTION ASSISTANCE PROGRAMS**

Savings from Current- Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Reduce Matching Rates to 50 Percent						
Budget Authority	605	685	760	835	920	3,805
Outlays	605	685	760	835	920	3,805
Reduce Matching Rates to 45 Percent						
Budget Authority	1,180	1,340	1,470	1,620	1,770	7,380
Outlays	1,180	1,340	1,470	1,620	1,770	7,380

The Medicaid program provides medical assistance to low-income people who are recipients of Supplemental Security Income and to current or recent recipients of Aid to Families with Dependent Children, as well as certain other low-income individuals. The Foster Care and Adoption Assistance programs provide benefits and services to children in need.

In all of these programs, the federal government pays half of most administrative costs; state and local governments pay the remaining share. Higher matching rates have been set for some types of expenses as an inducement for local administrators to undertake more of a particular administrative activity than they would if such expenses were matched at 50 percent. For example, in Medicaid, enhanced matching rates are applied to the costs of automating claims processing, reviewing medical and health care use, and establishing and operating fraud control units. In Foster Care and Adoption Assistance, training costs are matched at 75 percent.

Reducing the higher matching rates to 50 percent would decrease federal outlays by \$0.6 billion in 1996 and by \$3.8 billion over the 1996-2000 period. Medicaid would account for virtually all of the reduction; outlays would decline by only \$0.4 billion over the period for Foster Care and Adoption Assistance. Considerably greater savings would be gener-

ated if all the matching rates for administrative costs were reduced to 45 percent, because an additional 5 percent of the total administrative expenses would be shifted to the states. Federal outlays would fall by \$1.2 billion in 1996 and by \$7.4 billion over the 1996-2000 period. Medicaid would account for \$6 billion of the total over the five years.

Reducing the higher matching rates to 50 percent would be appropriate if the need to provide special incentives for these activities no longer exists. For example, all state Medicaid programs have already established computer systems and are currently operating units to control fraud and abuse. Reducing all matching rates to 45 percent would provide states with stronger incentives to reduce administrative inefficiencies, because the states would be liable for a greater share of the cost of such inefficiencies.

States might respond to either option by reducing their administrative efforts, however, and might thereby raise program costs and offset some of the federal savings. Specifically, states might make less effort to eliminate waste and abuse in payments to providers. In addition, this proposal might harm recipients by encouraging states to lower benefits or to limit services provided under these programs in order to constrain total costs.

ENT-31 RESTRICT THE INCOME CRITERIA THAT STATES MAY USE
TO ESTABLISH MEDICAID ELIGIBILITY FOR CHILDREN AND PREGNANT WOMEN

Savings from Current- Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Budget Authority	600	800	1,000	1,300	1,600	5,200
Outlays	600	800	1,000	1,300	1,600	5,200

In recent years, the Congress has expanded Medicaid to provide coverage for low-income children and pregnant women who would not otherwise qualify for the program. States are now required to cover children under 6 years old and pregnant women in families with income up to 133 percent of the poverty level, plus children under age 19 born after September 30, 1983, whose families have income below the poverty level. States have the option to cover infants under one year of age and pregnant women in families with income up to 185 percent of the poverty level, and the majority of states do so. They may also cover older children under a state-selected age (21, 20, 19, or 18 years) who meet the income and resource requirements for Aid to Families with Dependent Children (AFDC).

When determining the income and resource criteria to be used in establishing Medicaid eligibility for children and pregnant women, some states have taken advantage of provisions included in section 1902(r)(2) of the Social Security Act in order to expand coverage. The provisions state that for these and certain other population groups, states "may be less restrictive and shall be no more restrictive" than when they determine eligibility for similar population groups that receive categorical welfare benefits such as AFDC. That language has enabled states to disregard larger amounts of income when establishing Medicaid eligibility for children and pregnant women than can be disregarded when establishing eligibility for AFDC. Consequently, some states have been able to expand coverage to children and pregnant women whose income is considerably higher than the levels nominally permitted by legislation. By July

1994, 12 states were obtaining federal matching funds for such expansions, and more are likely to do so in the future; some states applying for statewide Medicaid demonstration waivers under section 1115 of the Social Security Act are incorporating expansions of eligibility under section 1902(r)(2) into their waiver applications.

This option would require the states to use the AFDC program's criteria to determine countable income when establishing the eligibility of children and pregnant women for Medicaid. The income eligibility criteria used by the states would then reflect more closely the maximum levels of income specified in recent legislation. The requirement would, however, restrict states' initiatives to expand health insurance coverage to other low-income people. Since the option would include the states that have already expanded eligibility using a plan amendment under section 1902(r)(2), it could cause some people in those states to lose their health care coverage.

The anticipated savings would be \$600 million in 1996 and \$5.2 billion over the 1996-2000 period. These estimates are highly tentative, however, because the number of states that will seek, obtain, and put into effect section 1115 waivers that incorporate expansions of eligibility under section 1902(r)(2) is uncertain. The timing of any such waivers and the extent of any eligibility expansions are also uncertain. An alternative option would restrict future plan amendments under section 1902(r)(2) but allow existing ones to continue. Savings from that approach would be less.

ENT-32 MAKE CAPITATION PAYMENTS TO THE STATES FOR MEDICAID SERVICES

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Budget Authority	1,000	1,900	3,200	4,700	6,700	17,500
Outlays	1,000	1,900	3,200	4,700	6,700	17,500

The Medicaid program is administered by the states and jointly funded by the federal and state governments. Each state designs its own program subject to federal requirements and guidelines, but the federal government has an open-ended financial commitment to match each state's expenditures for the coverage of eligible people. Federal matching rates for medical services are higher for states that have lower per capita incomes but can never be less than 50 percent or more than 83 percent of medical assistance payments. The federal government also pays 50 percent of most associated administrative costs (with higher rates for a few services).

This proposal would replace the current federal financing mechanism for acute care services with a system under which the federal government would make fixed payments to the states for each person enrolled in their Medicaid programs. (The only exception would be federal payments on behalf of people who are jointly eligible for Medicare and Medicaid. Those payments would continue in their current form.) At the same time, states would be given greater flexibility to tailor their Medicaid programs to meet the needs of their populations without having to seek waivers of federal legislation and regulations to do so. The federal capitation payments would vary according to broad categories of eligibility, with differing amounts for beneficiaries of Supplemental Security Income, other adults, and other children.

Payments to each state would be based on its per capita spending in 1995 for all Medicaid services except long-term care (but would exclude payments to disproportionate share hospitals). The 1995 per capita amounts would be indexed by the rate of growth of gross domestic product per capita. The anticipated savings would be \$1 billion in 1996 and \$17.5 billion over the 1996-2000 period.

The proposed financing structure would provide states with both the incentives and the flexibility to limit Medicaid spending and seek cost-effective managed care providers for their Medicaid beneficiaries. Medicaid expenditures would become much more predictable for the federal government and would grow no faster than the rest of the economy on a per capita basis. The proposal would, however, lock in the existing differences in the generosity of states' programs and in their reimbursement rates. Moreover, federal per capita payments for Medicaid would grow much more slowly than overall per capita health expenditures. States might have to increase their relative contributions to the program in order to ensure that providers would continue to serve Medicaid's beneficiaries. Concerns might also arise about the quality of care received by Medicaid beneficiaries if they were enrolled in managed care plans at rates significantly lower than those prevailing in the private sector.

ENT-33 FREEZE MEDICARE'S PROSPECTIVE PAYMENT SYSTEM RATES FOR ONE YEAR

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	950	1,280	1,360	1,450	1,550	6,590

Under Medicare's prospective payment system (PPS), payments for the operating costs of inpatient hospital services provided to beneficiaries are determined on a per-case basis, according to preset rates that vary with the patient's diagnosis and characteristics of the hospital. For 1988 through 1994, separate rates applied to hospitals in three types of location: urban areas with a population of more than 1 million, other urban areas, and rural areas. Beginning with 1995, hospitals in rural and "other urban" areas receive the same payment rates. The annual amount of increase in the payment rates, called the update factor, is usually based on the increase in an index of hospitals' costs known as the hospital market-basket index.

For 1996, under the Omnibus Budget Reconciliation Act of 1993, the update factor for all PPS hospitals will equal the percentage increase in the market-basket index minus 2 percentage points. Based on the Congressional Budget Office's current estimate

of 3.8 percent growth in the market-basket index, the update factor will be 1.8 percent for 1996.

Under this option, Medicare would freeze PPS hospital rates for 1996 at their 1995 levels by setting the update factor to zero, thereby saving nearly \$1 billion in 1996 and \$6.6 billion over the 1996-2000 period. In response to the freeze, some hospitals could increase their efficiency, absorb the reductions through lower profits, or increase their revenues from other sources. It might be difficult, however, for others to adjust to the cuts. For example, the Prospective Payment Assessment Commission estimates that in 1992 approximately one-fourth of hospitals had greater total costs than revenues. As a result, some Medicare beneficiaries might have less access to hospital and other services or lower quality care. In addition, some facilities might cut back on the amount of uncompensated care they provide to patients who are uninsured and unable to pay for it.

ENT-34 ELIMINATE THE DISPROPORTIONATE SHARE ADJUSTMENT FOR HOSPITALS IN
MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

Savings from Current- Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Immediately Eliminate the Disproportionate Share Adjustment						
Outlays	3,660	4,360	4,560	4,820	5,040	22,440
Gradually Eliminate the Disproportionate Share Adjustment						
Outlays	730	1,630	2,620	3,730	4,690	13,420

Under Medicare's prospective payment system (PPS), higher rates are paid to hospitals with a disproportionately large share of low-income patients. In 1985, the Congress added this "disproportionate share" adjustment to account for the presumed higher costs of treating Medicare beneficiaries at these hospitals. One rationale for the adjustment is that low-income Medicare patients may be sicker and therefore more expensive to treat than other Medicare patients. Another rationale is that hospitals with large numbers of low-income patients may provide additional staffing, facilities, and services in response to such patients' needs. In 1996, outlays for disproportionate share payments are expected to total \$3.7 billion, or more than 5 percent of all PPS payments for operating expenses.

Data on hospitals' costs provide only limited support for any disproportionate share adjustment. Although more than 1,900 hospitals receive disproportionate share payments, the only group for which such an adjustment would be supported by the data is large urban hospitals that have extremely high values of the disproportionate share index. This group is made up of approximately 160 hospitals and accounts for about one-fifth of all disproportionate share payments.

If the disproportionate share adjustment was eliminated immediately, outlays would fall by \$22.4 billion over the 1996-2000 period. Phasing out the disproportionate share adjustment by the end of 2000 would reduce outlays by about \$13.4 billion over the same five years. Alternatively, the adjustment could be eliminated for all hospitals except large urban institutions with the highest disproportionate share indexes. If the adjustment was restricted to that group and lowered to 5 percent--the level suggested by the data on costs--savings for the five-year period would be about \$500 million less under the first option and about \$300 million less under the second one.

Without the disproportionate share adjustment, Medicare's payments to all hospitals would be similar in relation to their costs of treating Medicare beneficiaries. Phasing out the adjustment over several years would give affected hospitals time to adjust. Nevertheless, many of those institutions are in poor financial condition, and since 1990, Medicare's PPS payments to hospitals have been less, on average, than the costs of treating patients who are covered. If eliminating the disproportionate share adjustment led some hospitals to cut back on charity care, or if some were forced to close, residents of the areas the hospitals serve could have less access to care.

ENT-35 REDUCE MEDICARE'S PAYMENTS FOR THE INDIRECT COSTS OF PATIENT CARE THAT ARE RELATED TO HOSPITALS' TEACHING PROGRAMS

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Reduce the Teaching Adjustment to 6 Percent						
Outlays	930	1,120	1,200	1,280	1,360	5,890
Reduce the Teaching Adjustment to 3 Percent						
Outlays	2,600	3,150	3,350	3,600	3,800	16,500

The Social Security Amendments of 1983 established the prospective payment system (PPS) under which Medicare reimburses hospitals for inpatient services provided to beneficiaries. Higher rates are paid to hospitals with teaching programs to cover their additional costs of caring for Medicare patients. In particular, payments to these hospitals are raised by approximately 7.7 percent for each 0.1 increase in a hospital's ratio of full-time interns and residents to its number of beds. This adjustment was included in order to compensate hospitals for indirect teaching costs--such as the greater number of tests and procedures thought to be prescribed by interns and residents--and to cover higher costs caused by factors that are not otherwise accounted for in setting the PPS rates. These factors include more severely ill patients, location in inner cities, and a more costly mix of staffing and facilities--all of which are associated with large teaching programs.

Estimates based on data from the 1984-1990 period suggest that the teaching adjustment could be lowered to between 2 percent and 7 percent, depending on which year's data are used and which of many possible assumptions are used in forming an assessment. If the teaching adjustment was lowered to 6

percent, outlays would fall by about \$5.9 billion from current-law spending over the 1996-2000 period. Alternatively, if the teaching adjustment was lowered to 3 percent, outlays would fall by about \$16.5 billion from current-law spending over that period.

This option would better align payments with the actual costs incurred by teaching institutions. Furthermore, since the training that medical residents receive will result in a significant increase in their future income, it is reasonable for some or all of a hospital's indirect training costs to be passed on to residents. Some of these costs are now passed on in the form of stipends that are lower than the value of the residents' services to the hospital. A lower teaching adjustment would probably lead to even lower stipends, as well as smaller residency programs. Although this might be considered a disadvantage to some individuals who are seeking residency positions, several health policy groups, including the Physician Payment Review Commission, believe that a decline in the number of residency positions is desirable. Finally, if these hospitals now use some payments to fund such activities as charity care, low-income people could have less access to care.

ENT-36 REDUCE MEDICARE'S DIRECT PAYMENTS FOR MEDICAL EDUCATION

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	650	710	760	820	880	3,820

Medicare's prospective payment system does not include payments to hospitals for the direct costs they incur in providing graduate medical education (GME); namely, residents' salaries and fringe benefits, teaching costs, and institutional overhead. Instead, Medicare makes these payments separately, based on Medicare's share of a hospital's 1984 cost per resident indexed for increases in the level of consumer prices. Medicare's GME payments, which are received by about one-fifth of all U.S. hospitals, totaled about \$1.8 billion for 1994.

In effect, this option would reduce teaching and overhead payments for residents, but continue to pay their salaries and fringe benefits. Hospitals' GME payments would be based on the national average of salaries paid to residents in 1987, updated annually by the consumer price index for urban areas. Reimbursement would be based on 120 percent of the national average salary. Unlike the current system, under which GME payments vary considerably from hospital to hospital, this option would pay every hospital the same amount for the same type of resident. The option would also continue the current-law practice of reducing payments for all residents who have gone beyond their initial residency period. The savings from current-law spending over the 1996-2000 period would total about \$3.8 billion.

The overall reduction in the level of subsidies might be warranted since market incentives appear to be sufficient to encourage a continuing flow of new physicians. Moreover, since hospitals use resident physicians to care for patients and since residency training helps young physicians earn higher incomes in the future, both hospitals and residents might reasonably contribute more to those training costs. Residents would contribute more to those training costs if hospitals responded to the changes in reimbursements by cutting residents' salaries or fringe benefits.

Opponents of reducing Medicare's GME payments point out that some physicians incur substantial debts during their medical education. If hospitals lowered residents' salaries or benefits, the terms of the loan repayment agreements could exert greater influence on these young physicians' decisions about specialty or practice location. For example, a resident who must begin repaying loans after three years of a medical residency might choose to begin primary care practice rather than specialize further. That outcome could be negative for the individual resident; by contrast, the Physician Payment Review Commission and other groups believe that a relative increase in the number of primary care practitioners would be desirable. Finally, decreasing GME reimbursement could force some hospitals to reduce the resources they commit to training, possibly jeopardizing the quality of their medical education programs.

ENT-37 ELIMINATE MEDICARE'S ADDITIONAL PAYMENTS TO SOLE COMMUNITY HOSPITALS

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	220	260	270	285	295	1,330

Under Medicare's prospective payment system (PPS) for inpatient hospital services, special rules apply to providers designated as sole community hospitals (SCHs). At present, there are more than 700 SCHs, about 95 percent of which are located in rural areas. Thus, more than one-fourth of rural hospitals qualify for SCH status. Under the current rules, a hospital may be designated as an SCH if it meets specific criteria that define a sole provider of inpatient, acute care hospital services in a geographic area. In addition, many SCHs have been permitted to retain that status regardless of whether they meet the current sole-provider criteria.

Payments to SCHs are equal to the highest of three amounts: the regular PPS payment that would otherwise apply, an amount based on the hospital's costs in 1982 updated to the current year, or an amount based on the hospital's costs in 1987 updated to the current year. In addition, rural SCHs receive a higher "disproportionate share" adjustment--that is, a higher PPS adjustment for hospitals that treat a disproportionately large share of low-income patients--than other rural hospitals. As a result of the special rules, total PPS payments to SCHs for 1995 are estimated to be about 10 percent higher than they

would be otherwise. If the special payment rules for SCHs were eliminated, total PPS payments would be \$220 million less in 1996 and \$1.3 billion less for the 1996-2000 period.

A primary objective of the SCH rules is to assist hospitals in locations where closings would threaten access to hospital care, but the support is not well aimed at essential providers. The group of hospitals qualifying for SCH payments includes, for example, some hospitals located in areas where there are other providers nearby. Moreover, whether an SCH actually receives higher payments under the special rules that permit payments to be based on a hospital-specific amount depends on whether its costs in either of the specified base years (1982 or 1987) were relatively high, not on its current financial condition.

If the special payment rules were eliminated, however, revenues of many sole community hospitals would be lower, which might cause financial distress for some of them. Because many SCHs are the sole providers of hospital services in their geographic areas, quality or access to care might be reduced in some rural locations.

ENT-38 REDUCE MEDICARE'S PAYMENTS FOR HOSPITALS' INPATIENT CAPITAL-RELATED COSTS

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Rebase Federal and Hospital-Specific Rates for Capital Payments						
Outlays	245	290	295	305	315	1,450
Rebase the Rates for Capital and Freeze Them for One Year						
Outlays	290	340	350	360	375	1,715
Reduce Capital Payments for PPS-Excluded Hospitals and Units by 15 Percent						
Outlays	125	160	185	215	250	935

In 1992, Medicare revised its method of paying hospitals for their inpatient capital-related costs by replacing cost-based reimbursement with a prospective payment method. Under the prospective system, hospitals receive a predetermined amount for each Medicare patient to pay for capital-related costs, which include depreciation, interest, taxes, insurance, and similar expenses for buildings and fixed and movable equipment. The prospective system applies to hospitals paid under Medicare's prospective payment system (PPS) for operating costs. For hospitals and certain units that are excluded from the PPS, such as psychiatric and rehabilitation hospitals and units, Medicare continues to pay for capital-related expenses on the basis of reasonable costs.

A fully prospective federal payment rate for capital costs is being phased in over 10 years. During the transition period, payments are determined by a complicated method based on a number of factors, including federal and hospital-specific payment rates. The federal and hospital-specific rates are increased annually. By 2001, all hospitals will receive the federal rate, adjusted for the hospital's mix of patients and certain other characteristics.

Recent data suggest that the initial federal and hospital-specific rates were overestimated. The 1992 rates were based on actual 1989 and 1990 data (for the federal rate and hospital-specific rates, respec-

tively) projected to 1992, but more recent data indicate that the rate of growth of capital costs between 1989 and 1992 was slower than expected. Although the federal rate was reduced by 7.4 percent in the Omnibus Budget Reconciliation Act of 1993, the Health Care Financing Administration (HCFA) estimates that a further reduction of 5.62 percent in the federal rate and a reduction of 7.13 percent in the hospital-specific rates would be consistent with current data. Those reductions would yield savings of \$245 million in 1996 and \$1.5 billion for the 1996-2000 period.

If, in addition, capital-related payment rates were frozen for one year, total savings would rise to \$290 million in 1996 and \$1.7 billion over the 1996-2000 period. A justification for this version is that past capital costs and their growth rate might have been higher than warranted. In particular, HCFA estimates that the growth rate of per-case capital costs during the 1985-1992 period was greater than can be explained by changes in capital prices, the mix of patients treated by hospitals, and the "intensity" of hospital services.

A third option--which could be combined with either of the first two--would be to reduce capital-related payments to PPS-excluded hospitals and units. If payments to these facilities were lowered by 15 percent, savings would be \$125 million in 1996

and \$945 million over the five-year period. This approach would provide a greater incentive than under full reasonable-cost reimbursement for these hospitals and units to use capital efficiently.

Most hospitals would probably be able to adjust to these reductions by lowering their capital costs or partially covering them with other sources of revenue because Medicare's payments for capital costs are a

small share of hospitals' revenues. Payments for inpatient capital-related costs constitute about 10 percent of Medicare's total payments for inpatient care, and less than 5 percent of hospitals' total revenues from all sources. Hospitals that are in poor financial condition, however, might have difficulty absorbing the reductions. As a result, their quality of care might decline, and they might provide fewer services to people without insurance.