Reforming Medicaid

by

James R. Cantwell
U.S. House Committee on the Budget

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National Center for Policy Analysis
12655 N. Central Expwy., Suite 720
Dallas, Texas 75243
(214) 386-6272

Executive Summary

While growth in private-sector health care spending has declined recently, spending on Medicaid, the federal-state health insurance program for the nation's poor, has continued to explode — growing at an average annual rate of 19.1 percent between 1990 and 1994. The Congressional Budget Office estimates that federal outlays for Medicaid will be $89.2 billion in 1995, and states will spend an additional $67.3 billion, for a total of $156.5 billion. Unless Congress reins in the growth of Medicaid, any attempt to balance the federal budget will be futile.

Both the Republican-led Congress and the Clinton administration have proposed budgets that call for reducing the rate of growth of Medicaid spending. The congressional plan, providing for less growth than the administration's plan, calls for giving Medicaid funds to each state in the form of a block grant. Block-granting the funds would allow the federal government to limit the financial exposure of taxpayers while giving states maximum flexibility to design a health care program that meets local needs.

Critics have charged that slowing the rate of growth of Medicaid spending would force states to reduce the number of people covered, reduce benefits, reduce payments to providers or some combination of these. However, six constructive steps described in this study could achieve Medicaid savings of $185.4 billion over seven years without any reduction in benefits for needy people.

- Changing incentives for recipients and providers through Medical Savings Accounts and/or managed care would produce $37.2 billion savings in acute care programs and $64 billion in long-term care.
- Enforcing estate recovery provisions would produce savings of $35 billion.
- Redirecting and capping "disproportionate share hospital" payments would produce savings of $13.9 billion.
- Reducing administrative costs would produce savings of $3.7 billion.
- Making Medicaid the payer of last resort would produce savings of $31.5 billion.
- Reducing waste, fraud and abuse through greater state vigilance would produce savings of an unknown but substantial amount.

Introduction

Congress cannot balance the federal budget unless the spiraling costs of Medicaid, the nation's health care financing program for the poor, are brought under control. Without fundamental change, over the next seven years the federal government will spend nearly $1 trillion on this one program. Additionally, the states will spend more than $400 million on their share of Medicaid.

The U.S. House of Representatives and the U.S. Senate have agreed on the need to restructure Medicaid, and the key feature of their approach is to provide federal Medicaid funds in block grants to the states. Block-granting Medicaid would allow the federal government to limit the financial exposure of federal taxpayers while, at the same time, giving states maximum flexibility to design a health care program tailored to meet local needs.

"Unless Congress reins in the growth of Medicaid, any attempt to balance the federal budget will be futile."

Critics have charged that slowing the rate of growth of Medicaid spending, as required by the 1996 Budget Resolution Conference Report,[1] would force states to (1) reduce the number of people covered by Medicaid, (2) reduce the benefits enjoyed by those who continue to be covered, (3) reduce payments to doctors, hospitals and other providers, or (4) some combination of the above. These criticisms are wrong. The purpose of this paper is to show that by adopting sensible reforms Congress can not only meet its budget target but, at the same time, the states can more effectively meet the needs of low-income families.

Medicaid's Financial Crisis

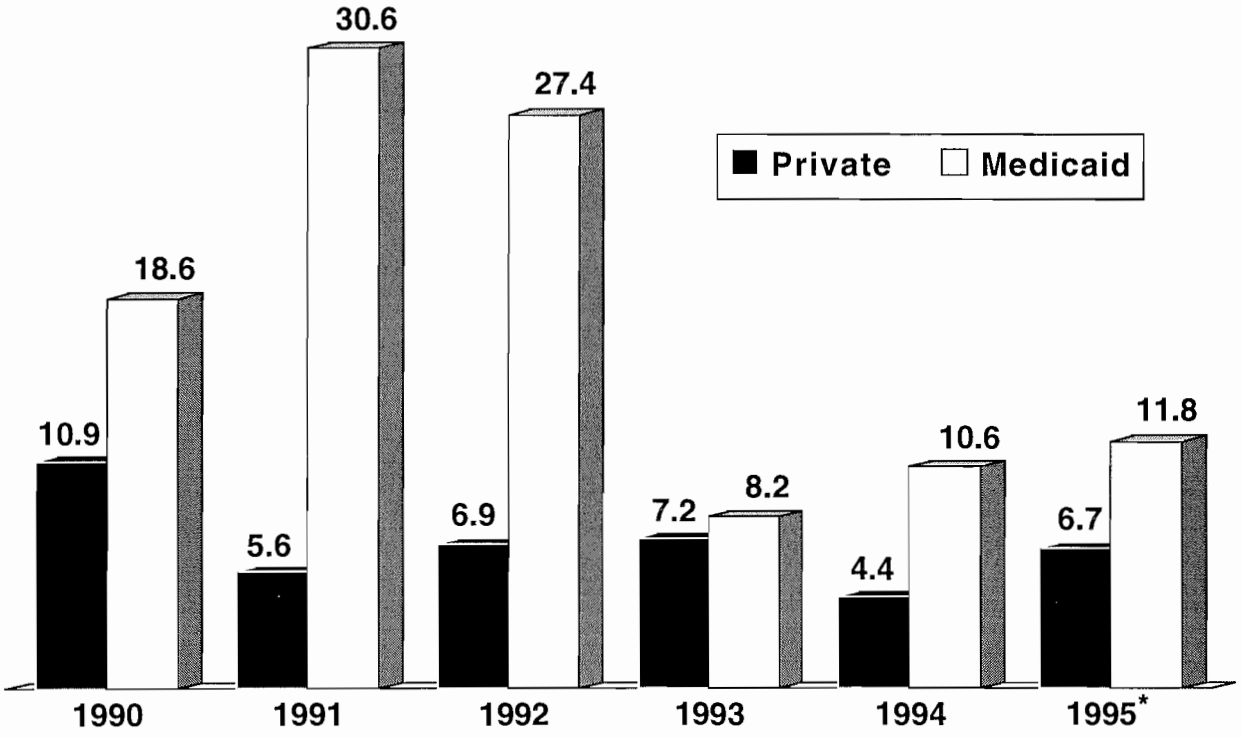
Medicaid is the federal-state health insurance program for the nation's poor. It was created in 1965 as part of the Johnson administration's initiative to expand health insurance to the poor (Medicaid) and elderly (Medicare). Both the federal and state governments provide funds for Medicaid, which is administered by the states under federal guidelines. States match federal funds based on a formula, ranging from as little as 21 cents for each dollar spent in low-income states to 50 cents in high-income states.

Among those entitled to receive Medicaid benefits are recipients of Aid to Families With Dependent Children (AFDC); the aged, blind and disabled receiving Supplemental Security Income (SSI) cash assistance; and pregnant women and children up to age 6 with family incomes less than 133 percent of the poverty level. As a result, the program touches the lives of a great many people:

FIGURE I

Health Care Spending

(Average annual percent change)



*Projected

Source: Health Care Financing Administration, Office of the Actuary (includes administrative costs).

- Medicaid finances the health care of one out of four American children, and pays for one-third of all U.S. births.
- About 60 percent of those living in poverty are receiving assistance from Medicaid, including 10 percent of the elderly or disabled on Medicare.
- Medicaid pays for about half of all nursing home care.

"Medicaid spending grew at an average annual rate of 19.1 percent between 1990 and 1994."

Medicaid is facing a financial crisis. Even without reform at the federal level, state legislators are already looking for ways to reduce costs. The reason is that Medicaid spending is out of control:

- While growth in private-sector health care spending has declined recently, Medicaid spending has continued to explode — growing at an average annual rate of 19.1 percent between 1990 and 1994.[2] [See Figure I.]
- The Congressional Budget Office (CBO) estimates that federal outlays for Medicaid will be $89.2 billion in 1995, and states will spend an additional $67.3 billion, for a total of $156.5 billion.

Unless Congress reins in the growth of Medicaid, any attempt to balance the federal budget will be futile. The first step in controlling Medicaid spending is to return Medicaid money to the states. The next step is to allow the states to implement some important reforms.

"By adopting sensible reforms Congress can not only meet its budget target but, at the same time, the states can more effectively meet the needs of low-income families."

Returning Medicaid to the States

As Figure II shows, if the approach proposed by the Republican-led Congress were adopted, the growth in expected Medicaid spending would be significantly lower than has been projected by the CBO and the Office of Management and Budget (OMB). [See Table I.] The Clinton administration's recent "balanced budget" also calls for somewhat lower Medicaid outlays.

Block Grants. As part of Congress' most recent budget plan (the 1996 Budget Resolution Conference Report), Medicaid funds would be given to each state in the form of a block grant:

- Over the seven-year period from 1996 through 2002, total outlays would be $773 billion.[3]
- This would be $329 billion *more* than the $444 billion spent during the previous seven years (1989-95).[4]

FIGURE II

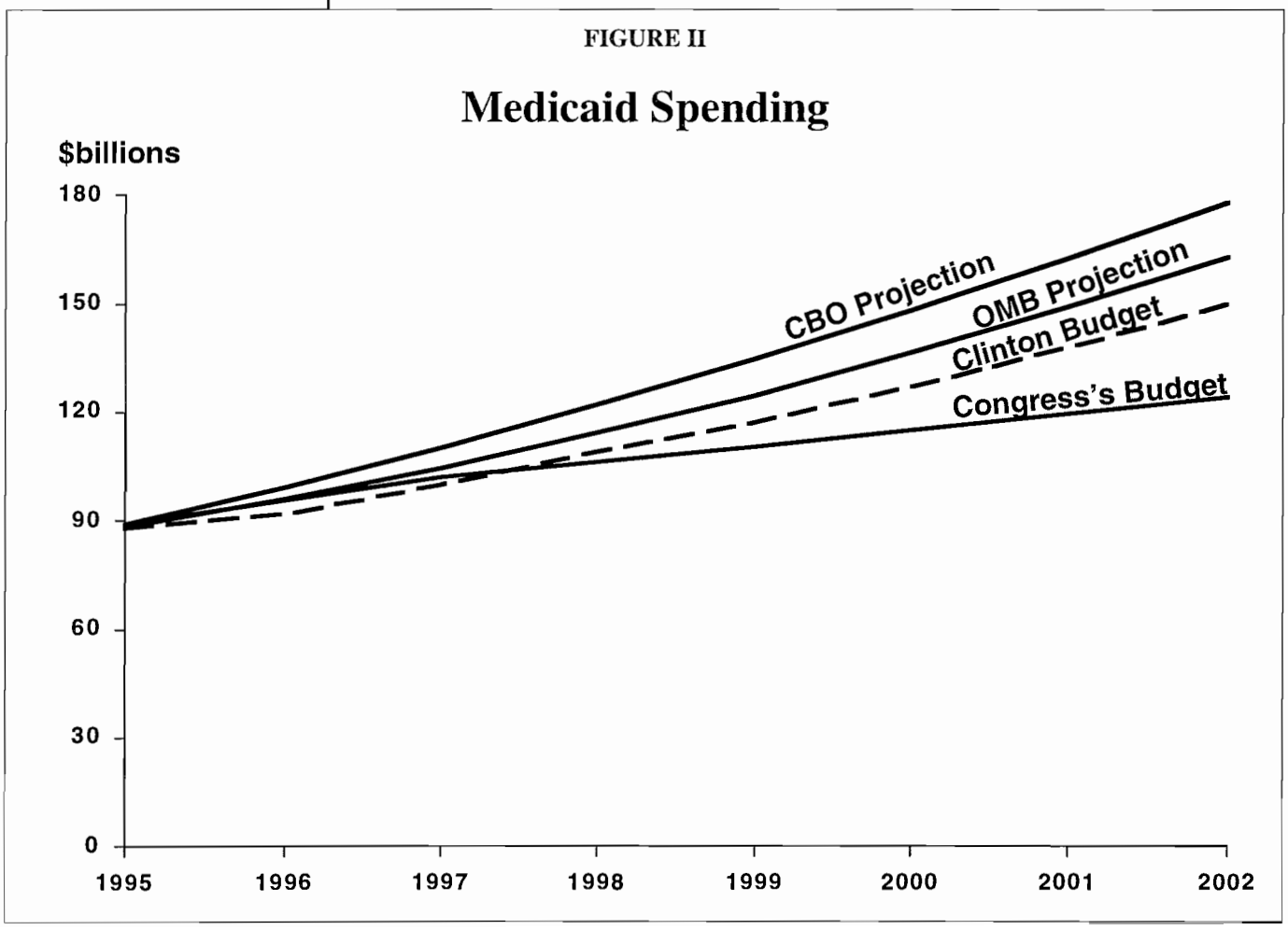


TABLE I

Medicaid Outlays, 1995 - 2002

($billions)

	1995	1996	1997	1998	1999	2000	2001	2002
CBO	89.2	99.3	110.0	122.1	134.8	148.1	162.1	177.8
OMB	88.4	95.9	104.6	114.4	124.5	136.5	149.0	163.0
Clinton	88.4	92.0	100.0	109.0	117.0	127.0	138.0	150.0
Congress	89.2	95.7	102.1	106.2	110.5	114.9	119.5	124.3

- But it would be $181.6 billion *less* than the CBO's projection of spending under current law.[5] [See Figure III.]

The Impact of Block Grants. How Medicaid recipients are affected by the block grants will depend upon how the states use the funds. Opponents of reform are predicting dire consequences. According to a recent article in the *Wall Street Journal*:

> [E]xperts on all sides of the issue agree that a 4 percent cap on Medicaid spending won't be enough to cover the expected growth in population in the program. And they say the situation can only result in one or a combination of three things: fewer benefits for Medicaid beneficiaries; lower payments to doctors, hospitals and other medical care providers who treat patients in the program; or reduced eligibility.[6]

"One of the merits of block grants is that they encourage states to innovate."

Such criticisms ignore the fact that one of the merits of block grants is that they encourage states to innovate and to improve the way Medicaid operates. In fact, Medicaid savings can be achieved without reductions in benefits for needy people. How? By doing the following:

- Change incentives for recipients and providers through Medical Savings Accounts and/or managed care.
- Enforce estate recovery provisions.
- Redirect "disproportionate share hospital" payments.
- Reduce administrative costs.
- Make Medicaid the payer of last resort.
- Reduce waste, fraud and abuse through greater state vigilance.

Implementing these reforms in the ways explained below would allow states to provide better health care for the poor — with less money.

Reform No. 1: Change Incentives

Changing patient and provider incentives is the primary key to reform. Under the current system, Medicaid recipients pay little or nothing for the care they receive. As a result, they have an incentive to consider only the benefits of medical services and ignore the costs. This encourages overconsumption. In addition, since the income of doctors, hospital personnel and other suppliers is based on the level of service they provide, they have a financial incentive to overprovide. To counteract these incentives, state legislators are looking at managed care and Medical Savings Accounts (MSAs).

Managed Care for Medicaid. Nearly every state has sought Medicaid waivers to experiment with new ways of delivering health care to the poor. Many of the experiments place Medicaid recipients in managed care programs operated by health maintenance organization (HMOs):

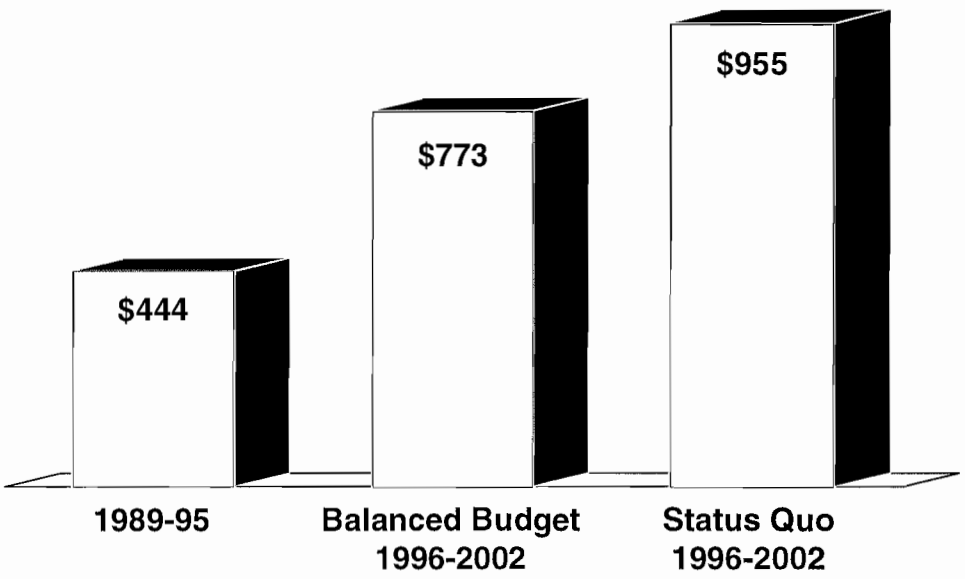
- As recently as 1991, only 2.7 million (9.5 percent) of Medicaid's 28.3 million enrollees were in managed care, according to the Health Care Financing Administration (HCFA).
- In recent years, Medicaid HMO membership has soared and now is 7.8 million (about 22 percent).
- HCFA's director of managed care estimates that by the end of the decade 75 percent of Medicaid recipients will be enrolled in managed care programs.

"The congressional proposal would spend $329 billion more on Medicaid than was spent during the previous seven years, but $182 billion less than under current law."

FIGURE III

Medicaid Spending: The Last Seven Years and the Next

($billions)



Source: Congressional Budget Office.

Although only about one-fifth of Medicaid recipients are currently enrolled in a managed care plan, about 93 percent of Medicaid payments are for fee-for-service patients, according to a recent report by Lewin-VHI.[7] As a result, the potential savings from managed care are even greater than the above statistics would suggest.

Because most of Medicaid's managed care waivers were granted in the last few years, the programs' costs have not been fully evaluated. An exception is Arizona, which is discussed below. Where evaluations have been completed, ample evidence shows that managed care *can* reduce Medicaid costs, especially for acute care services — physician and hospital visits (both inpatient and outpatient) and prescription drugs.

A General Accounting Office (GAO) report states that "a 1991 analysis of previous evaluations of 25 managed care programs in 17 states concluded that managed care programs...were able to achieve modest cost savings." The report also said that for the most reliable evaluations, "approximately 80 percent of the (13) programs reported cost savings ranging from 5 to 15 percent."[8] In addition, the CBO has reported that, for the general population (not just Medicaid), "group/staff HMOs reduce use of medical services by an estimated average of 19.6 percent."[9]

"Managing acute care could save an estimated $37.2 billion over the next seven years."

Some argue that managed care costs are lower only because it is primarily the healthy people who move into managed care, leaving sicker and more expensive patients in the fee-for-service pool. But an analysis of 1992 Health Interview Survey data concluded that "the most striking finding is how little HMOs and indemnity plans differ in the prevalence of chronic conditions."[10]

Case Study: Arizona. Until recently, state efforts to enroll Medicaid recipients in managed care programs have targeted the AFDC population. The Arizona Health Care Cost Containment System (AHCCCS) is an exception in that all recipients are in managed care. Compared with the costs if Arizona were running a typical fee-for-service Medicaid program, the savings are substantial. In the acute care portion of the program, managed care saved about 3.6 percent per year from 1984 through 1988 and 8.3 percent per year from 1989 through 1993.[11]

Potential Savings. As shown in Table II, the CBO estimates that over the next seven years (1996 through 2002), spending on Medicaid acute care benefits will total $511.7 billion. Since 93 percent of Medicaid program payments are made on a fee-for-service basis, we can multiply 93 percent of each year's acute care outlays by the savings rate achieved in Arizona to estimate the potential savings to Medicaid. Assuming that the potential savings are achieved from the first year of the Medicaid block grant, our estimate of Medicaid savings for the next seven-year period from managing acute care is $37.2 billion. [See Table II.]

TABLE II

Acute Care Savings Estimate

($billions)

Year	1996	1997	1998	1999	2000	2001	2002	Total
Acute Care Benefits (CBO)	**51.2**	**57.6**	**64.7**	**72.1**	**80.2**	**88.6**	**97.3**	**511.7**
O.93 x Row 1	**47.6**	**53.6**	**60.2**	**67.1**	**74.6**	**82.4**	**90.5**	**457.9**
Savings rate*	**.036**	**.083**	**.083**	**.083**	**.083**	**.083**	**.083**	
Acute Care	**1.7**	**4.4**	**5.0**	**5.6**	**6.2**	**6.8**	**7.5**	**37.2**

* Based on the savings achieved in Arizona's AHCCCS, 1988-93.

"Savings from managing long-term care could total $64 billion from 1996 through 2002."

Managed care also can yield substantial savings in long-term care. The Arizona Long-Term Care System (ALTCS), begun in December 1988, serves the elderly, the physically and developmentally disabled and the mentally retarded. According to the evaluation report cited above, ALTCS achieved savings of 8 percent in 1990, 15 percent in 1991, 22 percent in 1992 and 21 percent in 1993 over the costs of a traditional Medicaid program. Applying these savings percentages to the long-term care outlays projected by the CBO results in total expected savings of $64 billion from 1996 through 2002. [See Table III.]

Summing up:

- The expected savings from managed care are $37.2 billion for acute care plus $64.0 billion for long-term care.
- The total savings would be $101.2 billion over the next seven years.

Medical Savings Accounts. Medical Savings Accounts can create incentives for patients to help control rising Medicaid costs. A typical Medical Savings Account option gives people the opportunity to move from a conventional, low-deductible health insurance plan to one with a high deductible (say $2,000 to $3,000) and to put the premium savings in a personal account. Beneficiaries pay all medical bills up to the deductible from their MSAs and out-of-pocket funds. Catastrophic insurance pays all expenses above the deductible.

Providing MSAs to Medicaid participants would permit beneficiaries to use the funds in their accounts to pay for small and routine health care expenditures, relying on catastrophic health insurance to pay the major bills. Under this approach, Medicaid beneficiaries would control a portion of their own health care dollars and would have incentives to use these dollars wisely.[12]

Recently, legislation introduced in five states (Indiana, Louisiana, Ohio, Oregon and West Virginia), working from a model proposed by the American Legislative Exchange Council, would have provided vouchers to Medicaid recipients. Beneficiaries would have been able to choose among competing health care plans and MSAs would have been one of the options. In addition, Texas has enacted a pilot project to use MSAs for a limited number of Medicaid recipients.[13]

The political difficulty with MSA proposals has been to construct a program in which Medicaid recipients benefit from being prudent health care shoppers, but use remaining funds for constructive purposes. For example, under a 1994 Indiana proposal (which passed in the state's Senate but not the House) Medicaid beneficiaries who incurred less than $3,250 of medical expenses would have been able to use 10 percent of what they did not spend for services such as day care and job training.

Could MSAs for Medicaid recipients save the states money? That is unclear. While there is evidence that adopting MSAs in the private sector has enabled many businesses to reduce their health care costs significantly, there are no operational Medicaid MSAs to be evaluated. However, a new study of Medicare by Mark Litow (Milliman & Robertson) indicates that MSAs combined with managed care can save as much money as managed care alone, or more.[14]

"Medical Savings Accounts combined with managed care can save as much money as managed care alone, or more."

Reform No. 2: Enforce Estate Recovery

Long-term care is one of the fastest-growing segments of the Medicaid budget, increasing about 15 percent per year since 1990. Although the elderly have more assets than any other segment of the population, nearly half of those who enter a nursing home get Medicaid assistance. One reason is that many

TABLE III

Long-Term Care Savings Estimate

($billions)

Year	1996	1997	1998	1999	2000	2001	2002	Total
Long-Term Care (CBO)	35.4	38.8	42.8	47.2	51.7	57.0	62.7	335.6
Savings rate*	.08	.15	.22	.21	.21	.21	.21	
LTC Savings	2.8	5.8	9.4	9.9	10.9	12.0	13.2	64.0

* Based on the savings achieved in Arizona's ALTCS, 1990-93.

people either "spend down" or hide their assets in order to qualify for Medicaid's means-tested benefits. The Omnibus Budget Reconciliation Act of 1993 (OBRA) requires each state to look back three years when determining eligibility for long-term care services to see if a Medicaid recipient has transferred money or other assets to other persons, such as their children. Furthermore, when a Medicaid recipient dies, the state is expected to recover some of the past cost of providing long-term care.

"One source has estimated $25 billion in savings over five years if estate recovery provisions were enforced."

Many states have been lax in enforcing these provisions. The result has been that Medicaid-financed nursing home services intended for the elderly poor are sometimes channeled to those with substantial assets. Indeed, books giving instructions on how to qualify for benefits by transferring assets are widely available.[15] Medicaid-covered nursing home services would cost much less if the states enforced the law.[16] Specifically:

- One source has estimated that if the OBRA 1993 provisions were enforced, $25 billion could be saved over five years.[17]
- Extrapolating from that estimate gives a seven-year saving from estate recovery of $35 billion.

Note that the estimated savings from managed care ($101.2 billion) and estate recovery ($35 billion) add up to $136.2 billion. This is equal to about 75 percent of the aggregate reduction in outlays from the CBO baseline needed to meet Congress's budget goal ($181.6 billion).

Reform No. 3: Redirect "Disproportionate Share Hospital" Payments

As noted above, federal spending on Medicaid is growing at an unacceptably high rate. One reason for this rapid growth (totaling 28 percent in 1991 and 29 percent in 1992) was the shifting of states' Medicaid costs to the federal government. According to the *New York Times*:

> The program has become a giant slush fund that governors use to balance budgets or to free up money for other programs. Although Medicaid costs are supposed to be shared, many states have found ways to get more Federal dollars at little or no cost to local taxpayers. One approach used in the past is for a state to enact a new tax on hospitals, add the revenue to its Medicaid budget, demand Federal matching funds and then reimburse the hospitals for the tax by paying them higher Medicaid rates. "We're funding our judicial system, our highway program and everything else out of a Medicaid loophole," said ... a legislator.[18]

TABLE IV

CBO Medicaid Projections

($billions)

Year	1996	1997	1998	1999	2000	2001	2002	Total
Acute Care Benefits	51.2	57.6	64.7	72.1	80.2	88.6	97.3	511.7
Long-Term Care Benefits	35.4	38.8	42.8	47.2	51.7	57.0	62.7	335.6
DSH*	8.9	9.4	9.8	10.3	10.5	10.8	11.0	70.7
Administration	3.8	4.2	4.7	5.2	5.7	6.3	6.8	36.7
Total	99.3	110.0	122.1	134.8	148.1	162.6	177.8	954.7

* Disproportionate share hospital (DSH) payments.

Although the Omnibus Budget Reconciliation Acts of 1991 and 1993 restricted such practices, problems persist. Tax loopholes that allow states to manipulate federal matching funds remain.

Another problem involves disproportionate share hospital (DSH) payments. DSH payments refer to a supplemental payment Medicaid makes to hospitals with a disproportionate share of patients who are low-income, either on Medicaid or indigent. Federal DSH payments grew from $547 million in 1990 to $9.9 billion in 1992 and then declined to $8.5 billion in 1995. The CBO estimates that over the next seven years DSH payments will total $70.7 billion. [See Table IV.]

"Freezing 'disproportionate share hospital' payments at 1995 levels would save $13.9 billion."

The Senate budget resolution assumes that DSH payments will be frozen at 1995 levels. This assumption allows the Senate to achieve savings of about $13.9 billion over seven years. Even if frozen, DSH payments would still be sufficient to meet legitimate needs, making payments to those hospitals that provide a disproportionate share of care to low-income populations.

Reform No. 4: Reduce Administrative Costs

According to the CBO, Medicaid's 1995 administrative costs will be $3.4 billion. This annual cost will double over the next seven years and reach a seven-year total of $36.7 billion. Administrative savings can be achieved by eliminating requirements that states develop a state plan and receive approval from the Secretary of the Department of Health and Human Services for any changes to the plan. We estimate this change could result in at least a 10 percent savings in administrative costs, amounting to about $3.7 billion.

"Eliminating required federal administrative work could save about $3.7 billion."

Reform No. 5: Make Medicaid the Payer of Last Resort

"Recovering payments from third parties could save $31.5 billion."

As a public assistance program, Medicaid is intended to pay for health care services only after a Medicaid recipient's private health insurance has been exhausted. Indeed, according to the 1990 Census, more than 13 percent of Medicaid recipients had some health insurance, either an individual policy or coverage provided by an employer. Medicaid also is suppose to pay only after workers' compensation or liability insurers have paid. But state Medicaid programs generally are not recovering such payments from third-party insurers. Finally, noncustodial parents of Medicaid children are to provide health insurance when it is available through their employment. Yet, again states have not vigorously enforced these requirements.

A series of General Accounting Office (GAO) reports suggests that the amount of funds not being collected by the states is substantial. One recent report estimated that funds owed but not collected were between $500 million and more than $1 billion in 1985.[19] Since total federal Medicaid outlays were $22.7 billion that year, between 2.2 and 4.4 percent of total Medicaid outlays by the states should have been paid by someone else. With total federal Medicaid outlays projected to be $955 billion over the next seven years, a rough estimate of the future savings from this reform would be $21 billion to $42 billion. We will use the midpoint ($31.5 billion) as our seven-year savings estimate.

Reform No. 6: Reduce Waste, Fraud and Abuse

"After block grants, a state will gain a dollar for each dollar of waste eliminated."

The GAO estimates that the level of waste, fraud and abuse in health care may be as high as 10 percent. Medicaid Fraud Control Units, the FBI and the Health and Human Services Inspector General's office investigate health care fraud, but the investigative resources of all are stretched thin. Further, states may have had a reduced incentive to eliminate waste, fraud and abuse aggressively. The reason is that Medicaid funding is unlimited. Since the states supply as little as 21 cents of each dollar spent, their benefit from eliminating one dollar of waste is as low as 21 cents.

By capping the level of federal funding through a block grant, each state's incentive to eliminate waste, fraud and abuse will change. After the block grant, states will gain a dollar for each dollar of waste eliminated. However, reliable estimates of potential savings under this reform are not available.

Conclusion

The six factors discussed above can substantially reduce the cost of Medicaid without adversely affecting Medicaid recipients. As Table V shows, the expected total savings over the seven-year period are $185.4 billion.

"Six reforms would meet Congress's budget goals without any reduction in health care benefits for Medicaid beneficiaries."

TABLE V

Summary of Savings[1]

Factor	Savings ($billions)
1. System Reform:	
Acute Care	**37.2**
Long-Term Care	**64.0**
2. Estate Recovery	**35.0**
3. DSH	**13.9**
4. Administrative Costs	**3.7**
5. Third-Party Collections	**31.5**
6. Reduce Waste, Fraud and Abuse	**?**
Total	**185.3**

[1] Effects of interaction are not included.

Block-granting would allow the federal government to limit federal taxpayer exposure for Medicaid costs. This is essential if the federal budget is to be balanced by 2002. Allowing the federal grant to the states to grow at about half of the currently projected rate would provide the states with enough resources to meet the immediate and long-term care needs of the poor, disabled and elderly.

The mechanisms for cost reduction are available now but — absent rigorous federal spending restraints — the states lack incentives to use them. Federal block grants will provide those incentives.

Notes

[1] All references to a particular year of the federal budget refer to the government's fiscal year, which runs from October 1 through September 30.

[2] Federal Medicaid outlays grew by27.8 percent in 1991 and by another 29.1 percent in 1992.

[3] The plan assumes Medicaid outlays of $89.2 billion in 1995, with increases held to 7.2 percent in 1996, 6.8 percent in 1997 and 4 percent per year thereafter. The level of proposed spending is compatible with higher growth rates for benefits and administration if disproportionate share hospital payments, which are explained later in this paper, are frozen at 1995 levels.

[4] If the block grant spending were compared with Office of Management and Budget (OMB) projections, substantially smallerseven-year Medicaid savings would result from the block grant because the administrationassumes slower Medicaid growth. Over the period 1996 through 2002, OMB Medicaid projections are $66.8 billion less (cumulatively) than the CBO projections. Seven-year Medicaid savings from OMB projections would total $114.8 billion under the Budget Resolution Conference Report block-grant assumptions.

[5] Based on which projection is used, the block grant proposal promoted by Congress could result in savings of between $114.8 billion and $181.6 billion over the seven-year period between 1996 and 2002.

[6] Hilary Stout, "Contrasting Reactions to GOP Proposals to Cut Medicare, Medicaid Reflect Voting Blocs' Power," *Wall Street Journal*, May 30, 1995. The same theme is developed in a Families USA report titled "Hurting Real People: The HumanImpact of Medicaid Cuts," Washington, DC, June 1995.

[7] Lewin-VHI, "States as Payers: Managed Care for Medicaid Populations," National Institute for Health Care Management, Washington, DC, February 1995.

[8] U.S. General Accounting Office, "Medicaid: States Turn to Managed Care to Improve Access and Control Costs," GAO/HRD-93-46, March 1993, p. 39.

[9] Based on its analysis of the 1992 National Health Interview Survey, "The Effects of Managed Care and Managed Competition," CBO Staff Memorandum, February 1995, p. 2.

[10] Teresa Fama, Peter D. Fox and Leigh Ann White, "Do HMOs Care for the Chronically Ill?" *Health Affairs*, Spring 1995, p. 237.

[11] Nelda McCall, et al., "Evaluation of Arizona's Health Care Cost Containment System Demonstration," Draft Fourth Outcome Report, submitted to HCFA April 1995.

[12] See Brant S. Mittler and Merrill Matthews Jr., "Can Managed Care Solve the Medicaid Crisis?" National Center for Policy Analysis, NCPA Brief Analysis No. 155, April 10, 1995.

[13] Molly Hering Bordonaro, "Medical Savings Accounts and the States: Growth From the Grassroots," National Center for Policy Analysis, NCPA Brief Analysis No. 170, August 3, 1995.

[14] Mark E. Litow, "Reform Options for Medicare," National Center for Policy Analysis, NCPA Policy Report, forthcoming, August 1995.

[15] See, for example, Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Cost of Nursing Home Care,* 3rd Ed. (New York: H. Holt, 1995).

[16] U.S. General Accounting Office, "Medicaid Estate Planning," GAO/HRD-93-29R, July 20, 1993; and "Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs," GAO/HEHS-94-133, August 1, 1994.

[17] Marrilyn Serafini, "Plugging a Drain on Medicaid," *National Journal,* March 3, 1995, p. 687.

[18] Paul Offner, "Medicaid Games," *New York Times,* May 19, 1995, p. A 31. Also see GAO, "Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government," GAO/HEHS-94-133, August 1, 1994.

[19] U.S. General Accounting Office, "HCFA Needs Authority to Enforce Third-Party Requirements on States," GAO/HRD-91-60, April 1991. Also see GAO, "Medicaid: Millions of Dollars Not Recovered From Michigan Blue Cross/Blue Shield," GAO/HRD-91-12, November 1990.

About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute, funded exclusively by private contributions. The NCPA developed the concept of Medical Savings Accounts, the health care reform that has wide bipartisan support in Congress and in a growing number of states. Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. Its forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free enterprise health care task force report, written by 40 representatives of think tanks and research institutes, and a first-of-its-kind, pro-free enterprise environmental task force report, written by 76 representatives of think tanks and research institutes.

The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.

What Others Say About the NCPA

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