



State Medicare Impact Profile



MAYO CLINIC
Health Policy Center

Final Report
October 2006

State Medicare Impact Profile

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Executive Summary

Introduction

In 2004, Medicare provided health insurance coverage to over 42 million elderly and disabled Americans and accounted for \$295 billion, representing almost one fifth of the \$1.9 trillion spent on health care in the U.S. The new prescription drug benefit, passed as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), will add additional costs to the program – \$724 billion between 2006 and 2015.¹

Growth in health care costs, increasing numbers of older people, fewer workers to support the Medicare and Social Security programs, and an increasing federal deficit all point to ongoing reform of the Medicare program. And while these decisions will be made in the U.S. Congress, the incidence of these changes is felt more directly and more significantly at the state and local levels. Surprisingly, there is little information available that assesses these impacts at the state level, and there has been limited discussion about state impacts at the national level.

In this report on the pilot State Medicare Impact Profile project, we present a unique contribution to discussions about Medicare reform policy from a state policy perspective. We provide comparative data across five states (Florida, Minnesota, North Dakota, Pennsylvania, and Washington) on key policy issues to assess the impact that Medicare policy has on each state. Given the comprehensive changes to the Medicare program included in the MMA, the growth in the numbers of Medicare beneficiaries, and increasing health care costs, the time is critical to better understand the state and local impact of these important national decisions. The State Medicare Impact Profile, which was prepared by the State Health Access Data Assistance Center (SHADAC) for the Mayo Clinic Health Policy Center, is the first systematic look at the impact of Medicare reform from a state policy and local market perspective.

We assess four recent Medicare reform topics: 1) the transition of low-income Medicare beneficiaries enrolled in Medicaid to the new Medicare prescription drug program; 2) the introduction of high-income means testing for Part B premiums; 3) the introduction of regional preferred provider organization (PPO) plans under Medicare; and 4) the reallocation of physician resident caps under Medicare’s financing of Graduate Medical Education (GME). The four topics were selected to examine and highlight policy reform impacts from multiple perspectives. While each policy area has both short- and long-term implications for a variety of important stakeholders (including beneficiaries, providers, pharmacists, health insurance carriers, and state governments), this pilot report focuses on the potential *immediate* impacts of each reform area on a specific stakeholder group. Specifically, the chart book focuses on the immediate impact on *states* by the transition of low-income Medicare beneficiaries enrolled in the Medicaid program to the new Medicare prescription drug program; impact on *beneficiaries* by the introduction of high-income means testing for part B premiums; impact on the *health insurance market* by the establishment of regional PPOs; and impact on *providers* by the reallocation of physician resident slots across hospitals on which Medicare GME payments are based.

¹ Kaiser Family Foundation (2005). “Medicare Spending and Financing.” Medicare Fact Sheet, April 2005. Washington, DC: The Henry J. Kaiser Family Foundation.

Overall Findings

- *There is significant and consistent variation in Medicare impact at the state level:* We found significant variation in the impact of Medicare policy across the five states studied. The variation was consistent across the four key policy areas analyzed.
- *Variation is driven by the number of beneficiaries but other factors as well:* While Medicare is a federal program with relatively uniform benefits across the country, Medicare policy and its impact at the state level are driven by the number of Medicare beneficiaries in each state but also by other factors such as health care costs and efficiency, practice patterns, and distribution of providers.
- *Assessing Medicare from a state policy perspective raises questions about states' role in Medicare policy deliberations:* Our analysis shows that Medicare policy changes can have an impact at the state level from several perspectives: state infrastructure for public programs, state Medicare beneficiaries, providers and health markets, and teaching hospitals and levels of physician training. This information should be used to inform state Congressional delegations and also engage the National Governors' Association and other groups to provide input to Medicare policy debates.

Specific Findings on Key Medicare Reform Topics

Transition of Dual Eligible Prescription Drug Coverage to Medicare – State Impacts

- We found significant variation in the amount that states have to pay to the federal government for Medicare prescription drug coverage for Medicare/Medicaid dual eligibles (ranging from \$4.9 million for North Dakota to \$433.6 million for Florida). The amount is based not only on a state's number of beneficiaries but also on drug prices, negotiated discounts, and physician prescribing practices. Using a national prescription drug price index in states' payment calculations masks the variation in drug prices and price increases by different state market areas. Our estimates indicate that the payments the states included in this report will make for dual eligible drug coverage under Medicare will be lower than what their costs would have been under Medicaid.
- Reduction in the market share for prescription drug purchases could reduce a state's ability to negotiate discounts for other Medicaid populations. As a result of the transition of dual eligibles to the Medicare prescription drug program, state Medicaid programs on average will lose an estimated 11% of Medicaid beneficiaries, and dual eligibles in general have been estimated to be responsible for as much as half of Medicaid drug spending. Both a reduction in volume and shifts in composition will have implications for states' share of the market and their ability to negotiate rebates with manufacturers.

- There is also significant reduction in the state infrastructure costs as the amount of federal match received for Medicaid program outlays may be significantly reduced, particularly for those states with large number of dual eligibles and for those with significantly high prescription drug expenditures for dual eligibles. We estimate that states on average will lose approximately 20% of their total federal match dollars for their dual eligible spending. Florida and Washington are estimated to experience the largest loss in federal dual eligible dollars (32% and 38%, respectively). In contrast, we estimate that North Dakota will lose only 11% of the federal match dollars the state receives for their total dual eligible population.

High-Income Means Testing of Medicare Part B Premiums – Beneficiary Impacts

- We estimate that the high-income threshold will translate into higher Part B premiums for 2.9% of the population aged 65 and above in states on average. Smaller percentages of elderly in Minnesota (2.6%), North Dakota (1.6%) and Pennsylvania (2.3%) meet the income threshold, while a slightly higher percentage in Florida (4.2%) will be required to pay a larger share of their Part B premiums
- All but one of the states included in this report have more high-income elderly compared to the U.S. state average. The number of high-income elderly in Florida (over 116,000) is over nine times the state average, and over 40,000 high-income elderly reside in Pennsylvania. In contrast, significantly fewer elderly in North Dakota (approximately 1,300) will meet the means testing income threshold.
- Medicare beneficiaries with high earnings from either employment or from income-generating assets unsheltered from taxes will be more likely to fall above the income threshold. Employed elderly will be disproportionately impacted by the implementation of high-income means testing. Across all states, approximately 7.5% of employed elderly, in comparison to 2% of unemployed elderly, have incomes that meet or exceed the high income limit.

Introduction of Regional Managed Care Plans under Medicare – Market Impacts

- States vary in the extent to which their Medicare beneficiary population is enrolled in Medicare Advantage, and this will have an impact on enrollment in the new regional PPO plans. Urban states, states with higher payment rate areas, states with a major national/regional health insurance carrier presence, and states with past Medicare managed care demonstration contracts have had greater Medicare Advantage plan availability and enrollment.

- For the five states included in this report, the percent of Medicare beneficiaries enrolled in Medicare Advantage (as of 2004) ranged from as low as 1.0% (North Dakota) to as high as 24.4% (Pennsylvania). With the exception of North Dakota, the states in this report exceeded the national state median of 5.5%.
- The new Medicare Advantage regions differ in their number of regional plans established to date. As of June 2006, the number of regional plans in each of the five states ranged from zero (Washington) to five (North Dakota, Minnesota). Humana offers plans in both Florida and Pennsylvania; United has a regional plan in Florida; and Blue Cross Blue Shield is currently the only regional plan provider in Minnesota and North Dakota.

Redistribution of Graduate Medical Education (GME) Physician Resident Caps

- In 2002, the median level of GME payments per state was \$62.1 million. Of our five pilot states, Pennsylvania received the highest amount in GME payments (\$727.1 million), and North Dakota hospitals received the lowest (\$7.4 million). Payments received by hospitals in Florida and Minnesota also noticeably exceeded the state median.
- In states overall, 27.8% of teaching hospitals gained direct medical education (DME) and indirect medical education (IME) resident slots as part of the redistribution. North Dakota, in particular, exceeded this state median, with 60% of its hospitals (3 hospitals) gaining DME resident slots and 40% (2 hospitals) gaining IME resident slots. Pennsylvania was the only other state to be above the state median in the percent of hospitals gaining slots. Florida, Minnesota, and Washington were all at or below the median, with Florida falling well below the median.
- In states overall, 29.2% of teaching hospitals lost some of their DME resident slots, and 36.9% lost some of their IME resident slots. Relative to the U.S. state median, fewer hospitals in Washington lost both DME and IME resident slots yet more hospitals in Minnesota lost both DME and IME slots. North Dakota is the only state among our five pilot states to have lost no DME resident slots, but similar to hospitals in Minnesota, 60% of the hospitals in North Dakota lost IME resident slots.

Summary

As part of Mayo's interest in developing informed decision making for health policy, the State Medicare Impact Profile was a pilot project designed to test the assumption that Medicare matters from a state policy perspective. The goal of this project was to translate existing relevant state level data into information that can be used to assess the capacity of states to respond to changes in the Medicare program. The data and information are presented in an accessible way to encourage discussion of Medicare reform at the state and local level and to highlight local implementation issues that might be addressed by Congress to improve the quality and efficacy of the Medicare program. Another key objective of this project was to stimulate the use and interpretation of available state-level data to assess changes in the Medicare program at the state and local level. While Congress is ultimately responsible for Medicare reform legislation, the impact of such reform has the most impact at the state and local level. Surprisingly, little information is available to assess the impact of Medicare reform from this perspective.

We recommend that additional analysis be conducted for all 50 states and the District of Columbia. Our primary project objectives were to educate the public and elevate the awareness of important issues relating to the Medicare program and how they relate to a state's health care system at a general level and to *patients* in particular; help those creating public health care policy better understand how the intended and unintended consequences of change might impact local, regional, and state healthcare delivery; help those working at the local, regional, and state levels anticipate the consequences they would need to address when Medicare policy changes are implemented; and develop support for pursuing viable reform of the Medicare system and position the Mayo Clinic as a trusted source of *patient-centered* information on major health issues.

As the federal government looks for savings to reduce the growing federal deficit, Medicare will certainly be a target. State policymakers must be engaged to understand the impact that these changes may have on their own health care delivery system in terms of assuring access to efficiently delivered quality of care for patients. We hope the pilot State Medicare Impact Profile will begin to fill the gap for needed data and information.

Introduction

Background

This pilot version of the State Medicare Impact Profile was prepared by research staff at the State Health Access Data Assistance Center (SHADAC), housed in the School of Public Health at the University of Minnesota. The Profile is a systematic compilation and analysis of existing state-level data to examine the impact of Medicare policy and policy reform in individual states within the United States and how impacts may vary by state context. Impact across states is assessed from four key state-level perspectives: state governments, Medicare beneficiaries, health care markets, and health care providers. The pilot project, which targets five states—Florida, Pennsylvania, Minnesota, North Dakota, and Washington—was conducted to assess the feasibility of conducting a full-scale (50-state) Profile in the future.

Purpose

Recent federal legislation including the Balanced Budget Act (BBA) of 1997, the Balanced Budget Refinement Act (BBRA) of 1999, the Benefits Improvement and Protection Act (BIPA) of 2000, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, and the Deficit Reduction Act of 2005 have all brought about important changes to the Medicare Program. While Medicare is typically examined as a national program and Congress is responsible for crafting its reform, policy decisions related to Medicare have important and varying ramifications at the state level. Given recent changes to the Medicare program, the anticipated growth in the numbers of Medicare beneficiaries, and increasing health care costs, the time is critical to better understand the state and local impact of this national program.

The primary objectives of the State Medicare Impact Profile are to:

- Elevate awareness of important issues related to the Medicare program and their ramifications at the state level;
- Assist those creating public health care policy at the federal level to better understand the intended and unintended consequences of change at local, regional, and state levels; and
- Facilitate those working at the local and state levels to anticipate consequences of changes to the Medicare program.

Introduction

Approach

The State Medicare Impact Profile is a chart book designed to be useful for national and state policy makers, policy analysts, health delivery systems, and patients. The pilot chart book presents data on four recent Medicare reform topics:

1. The impact on states by the transition of certain low-income beneficiaries (i.e., “dual eligibles,” or individuals eligible for both Medicare and Medicaid) from state Medicaid programs to the new prescription drug coverage under Medicare.
2. The impact on beneficiaries by the increase in the share of Medicare Part B premiums through high-income means testing provisions.
3. The impact on state managed care markets by the introduction of regional managed care plans under Medicare.
4. The impact on providers, namely teaching hospitals, by the redistribution of physician resident limits under Medicare’s financing of general medical education (GME).

The four topics were selected to examine and highlight policy reform impacts from multiple perspectives. While each policy area has both short- and long-term implications for a variety of important stakeholders (including beneficiaries, providers, pharmacists, health insurance carriers, and state governments), this pilot report focuses on the potential *immediate* impacts of each reform area on a specific stakeholder group. Specifically, the chart book focuses on the immediate impact on *states* by the transition of low-income Medicare beneficiaries enrolled in the Medicaid program to the new Medicare prescription drug program; impact on *beneficiaries* by the introduction of high-income means testing for part B premiums; impact on the *health insurance market* by the establishment of regional preferred provider organizations (PPOs); and impact on *providers* by the reallocation of physician resident slots across hospitals on which Medicare GME payments are based.

For each reform area, SHADAC staff conducted a review of current Medicare program documentation and policy literature, conceptualized and outlined potential reform impacts, identified existing data sources for relevant contextual information and impact indicators, and compiled and conducted analyses.

Introduction

About the Data

This project focuses on current Medicare reform issues. New information and data concerning the implementation and impact of policy changes are available on an ongoing basis. The data in this report come from a variety of secondary sources accessed between December 2005 and July 2006. We used several types of data available from the Centers for Medicare and Medicaid Services (CMS), including summary enrollment and spending tables provided on the CMS website, Hospital Cost Report data, managed care plan enrollment files, and correspondence materials. Other data exhibited come from analyses that were conducted by other research centers and have been previously presented by the Kaiser Commission on Medicaid and the Uninsured. Finally, some analyses were conducted at SHADAC using national survey data. Adjustments have been made to some of the data to produce current estimates. More information about our sources and calculations can be found in the Technical Report.

State Selection

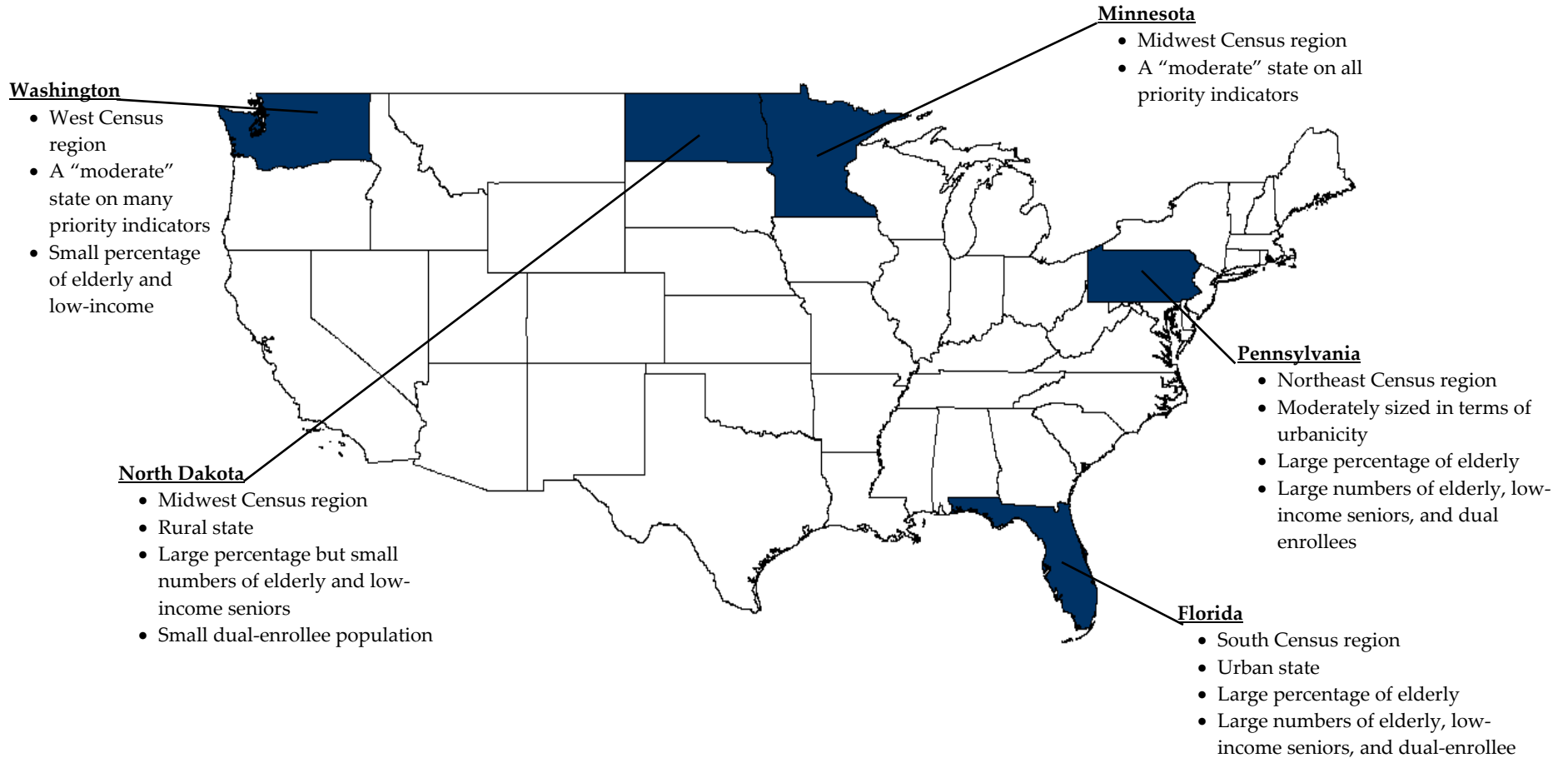
Our primary goal in the selection of states for this pilot version of the State Medicare Impact Profile was to capture important geographic and demographic variation across the states. States were considered based on a number of priority characteristics, including

- Census Region representation,
- Number of elderly residing in the state,
- Proportion of elderly as a percent of the state's population,
- Number of low-income elderly/Medicaid and Medicare dual enrollees,
- Proportion of low-income elderly/Medicaid and Medicare dual enrollees, and
- Degree of urbanicity (proportion of population living in urban areas).

SHADAC and Mayo selected the five states featured in this Profile — Florida, Minnesota, North Dakota, Pennsylvania, and Washington — based on the diversity they offered across these key indicators. The final states rank high, low, as well as moderate on a number of these indicators, and two of the states, Florida and Pennsylvania, represent a significant percentage of Medicare beneficiaries in the country. SHADAC and Mayo Clinic's familiarity with Minnesota and its data sources was an additional motivation for the inclusion of this state. A separate Technical Report provides more information on the state rankings across our priority statistics. The key features of each state are summarized in the figure below.

Introduction

Key Features of Selected States



Introduction

Overview of Content

The Profile is organized into four sections, one for each of the key state impact perspectives and Medicare policy reform topics introduced earlier. These are:

Section 1: State Impacts: Examining the impact on states by the transition of dual eligible prescription drug coverage from Medicaid to Medicare. We look at three specific areas of impact: A) the impact on states' dual eligible prescription drug spending; B) the impact on states' Medicaid prescription drug purchasing power; and C) the impact on the federal Medicaid funding received by states.

Section 2: Beneficiary Impacts: Examining the impact of high-income means testing of Medicare Part B premiums on beneficiaries. We estimate how many Medicare enrollees will be affected in each state and how the impact varies by age and employment status.

Section 3: Market Impacts: Examining the impact on state managed care markets by the introduction of regional managed care plans under Medicare. We consider the history of Medicare managed care in states and the role of each state in its broader regional context. We also provide information about the regional plans that have been established to date.

Section 4: Provider Impacts: Examining the impact of Medicare financing of General Medical Education (GME) by looking at the new provisions to redistribute the formerly-universal number of resident physician slots across teaching hospitals. We show to what extent states have gained and lost resident slots as a result of the reallocation.

Each section begins with background information on the reform topic, provides a discussion of the potential impacts of the policy change, and introduces the data indicators compiled for the topic. Within each report section, cross-state analyses are graphically shown for key indicators. Individual state profiles, containing all data items collected for each state, are located in Appendix A at the end of the Profile.

All data sources and methodologies used are summarized in a separate Technical Report.

Section 1: State Impacts

Reform Topic: Transition of Dual Eligible Prescription Drug Coverage from Medicaid to Medicare

Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provided for new coverage of prescription drugs not previously included in the Medicare program. The new drug benefit, or Part D of Medicare, represents the single largest expansion of benefits in the Medicare program since the program's inception. The new prescription drug benefit is financed by the federal Medicare program but administered by new private Part D Drug Plans. The MMA included provisions for significant subsidies to help low-income beneficiaries pay for the costs of the program. In addition, the new Medicare prescription drug program transfers prescription drug coverage for low-income Medicare beneficiaries currently provided through state Medicaid programs to the federal Medicare Part D prescription drug program.

There are an estimated 14 million low-income Medicare beneficiaries receiving health benefits through state Medicaid programs – these beneficiaries are often referred to as “dual eligibles” as they are eligible for both the Medicare and Medicaid programs. To qualify for state Medicaid programs, Medicare beneficiaries must meet state income and asset qualifications. Depending on the state program, Medicaid covers many of Medicare out-of-pocket costs including Medicare Part B premiums, co-payments, and deductibles. In addition, Medicaid has covered services and benefits not covered by Medicare, including coverage for prescription drugs. The estimated costs of the Medicaid prescription drug benefit for low-income Medicare beneficiaries across states was \$15.2 billion in 2003.

Effective January 2006, the low-income dual eligible prescription drug benefit, provided by state Medicaid programs, is now being provided by the Medicare program under the new Part D prescription drug program.² These dual eligibles were automatically assigned to a private Medicare Part D drug program in the fall of 2005, unless they signed up for a Medicare prescription drug plan on their own. A key provision in this transfer is that states must continue to pay a share of the costs of the prescription drug program. How these payments are determined and implemented is the topic of this section of the State Medicare Impact Profile.

In addition to the impact on state Medicaid programs, it is anticipated that beneficiaries will experience significant changes to their current drug coverage under Medicare Part D. Prescription drug benefits provided under the Medicaid program have been comprehensive. The private drug plans offered under Medicare Part D are likely to cover fewer drugs, have more restrictive formularies and additional prior authorization requirements, and involve new co-payments for full dual eligibles. The new Part D program will be a significant change for Medicare beneficiaries currently enrolled in state Medicaid programs.

² These provisions are for “full” dual eligibles who qualify for full Medicaid benefits.
State Medicare Impact Profile

Section 1: State Impacts

Role of State in Financing Medicare Part D Coverage

The new Medicare prescription drug program requires states to continue to pay for low-income beneficiaries enrolled in state Medicaid programs. States are required to continue to finance the cost of prescription drugs for those currently eligible for both Medicare and state Medicaid. This type of financing is virtually unprecedented, whereby states transfer funds to the federal government for a new federally administered program.

To maintain states' role in the financing of prescription drug coverage, states are required to make monthly payments to the federal government to cover the costs of Medicaid-eligible Medicare beneficiaries. The federal government has assured states that they would not pay more than their current obligation, but how this payment is calculated and administered has become a contentious issue. The state payment to the federal government has been called the Medicaid "clawback" – as the federal government has given the states authority to provide prescription drug benefits through the Medicaid program but then has "clawed back" the financing to pay for the new Medicare Part D for these same beneficiaries.

Each state must pay an amount equal to a state-specific per capita Medicaid prescription drug expenditure amount multiplied by the number of full dual eligible beneficiaries in the state. The amount a state pays is phased down over time such that the state's contribution is set at 90% for 2006 and will be reduced to 75% by 2015. Key features of the payment formula are the following:

- The state-specific per capita Medicaid prescription drug expenditure amount is based on a state's expenditures for dual eligibles in 2003 and then trended forward to 2006.
- The 2003 expenditure amount for a state includes only claims for drugs covered under Part D for full dual eligibles. The amount also takes into account prescription expenditures under both fee-for-service and managed care arrangements. Additionally, the base expenditure amount is adjusted by a state's rebate collection rate.
- While the 2003 expenditure amount is state specific, the multiplier applied to trend costs to 2006 is based on an average annual increase in *national* per capita spending, including not only Medicaid spending but also expenditures for other payers and populations.
- The number of full dual eligibles in each state is based on state enrollment reports. States are required to submit monthly data on full dual eligibles to CMS.

Section 1: State Impacts

Policy stakeholders and analysts have raised a number of issues about the state clawback payment, ranging from philosophical to methodological concerns. These include:

- The MMA shifts responsibility for dual eligible drug coverage to the federal government yet requires states to participate in the financing of the federal program through a “maintenance of effort” arrangement. All states prior to 2006 had offered prescription drug coverage under their Medicaid programs; however, it is important to emphasize that such coverage had been and is optional. The clawback payment is unprecedented in that it represents the first time since the initiation of Medicare that a specific benefit under the national program will be partially supported by state dollars.
- Basing the per capita dual eligible drug expenditures on only one year (2003) has generated concerns about the representativeness of that year in terms of a state’s recent drug expenditure pattern. In any given year, state spending may be high or low depending on enrollment and utilization and the cost-containment mechanisms in place. Some analysts believe that many states had higher drug costs and had increased drug volume between 2000 and 2003 and that many states were on the verge of implementing costs savings mechanisms around 2003. In fact, the MMA and the anticipation of the clawback itself may have led to cost savings since 2003. Many argue that the base per capita amount should have been averaged over multiple years.
- On a related note, trending a state’s 2003 expenditures based on *national* drug cost growth data may not reflect an individual state’s cost growth during the same period. Depending on a state’s actual expenditures between 2003 and 2006, using a national rate could insert advantages and disadvantages into the formula for different states.
- Finally, the only component of the clawback formula states have control over in their payment calculation is their number of full dual eligibles. This is seen by some policy makers and analysts as having a potentially unfortunate result by providing incentives to states to reduce this component of the formula.

In response to concerns, CMS has already modified their estimated state payment amounts once and more revisions are possible. Some states have initiated a law suit regarding their clawback payments.

Section 1: State Impacts

Impacts on States by the Transition of Dual Eligible Prescription Drug Coverage from Medicaid to Medicare

The impact of the transitioning of Medicaid prescription drug coverage for dual eligibles from state Medicaid programs to the new Medicare prescription drug program has implications for a variety of important stakeholders including beneficiaries, providers, pharmacists, health plans, and state Medicaid budgets and programs. In this section, we look at three specific impacts of the new Medicare Prescription Drug Program on states:

- A. *Impact on States' Dual Eligible Prescription Drug Spending:*** The impact of the federal clawback formula on a state's dual eligible drug spending depends on each state's "actual" drug spending in the base year (2003), increases in drug prices, and drug utilization patterns. The 2006 state contribution to the new Medicare prescription drug program may be higher than what a state would have paid in 2006 under its existing Medicaid drug coverage program, or the new program may actually cost less. While the design of the state Part D payment is to reduce state costs over time (via the phased-down factor), some analysts believe that the state contribution sets precedence for the federal government to call on states for increased payments to cover unanticipated costs of the program in the future. This section of the Profile reports data showing variability in the estimated annual clawback payment states will pay to the federal government in 2006 and in the difference between states' estimated clawback payment and the costs states would have expended had dual eligible drug spending continued under Medicaid in 2006.
- B. *Impact on States' Medicaid Prescription Drug Bargaining Power:*** Medicaid is a major buyer of prescription drugs in the U.S. As a result of the transition of dual eligibles to the Medicare prescription drug program, state Medicaid programs overall will lose an estimated 14% of Medicaid beneficiaries who are responsible for as much as half of Medicaid drug spending. Not only will the volume of drugs purchased under Medicaid change, but so will the composition of drugs purchased. Both a reduction in volume and shifts in composition will have implications for states' share of the market and their ability to negotiate rebates with manufacturers. The impact on states will differ depending on a state's drug utilization and costs for its full dual eligible and other Medicaid populations. Data on the estimated percent reduction in the number of Medicaid prescription drug users in states and in the number of Medicaid prescription drugs purchased by states are shown in this section of the report.

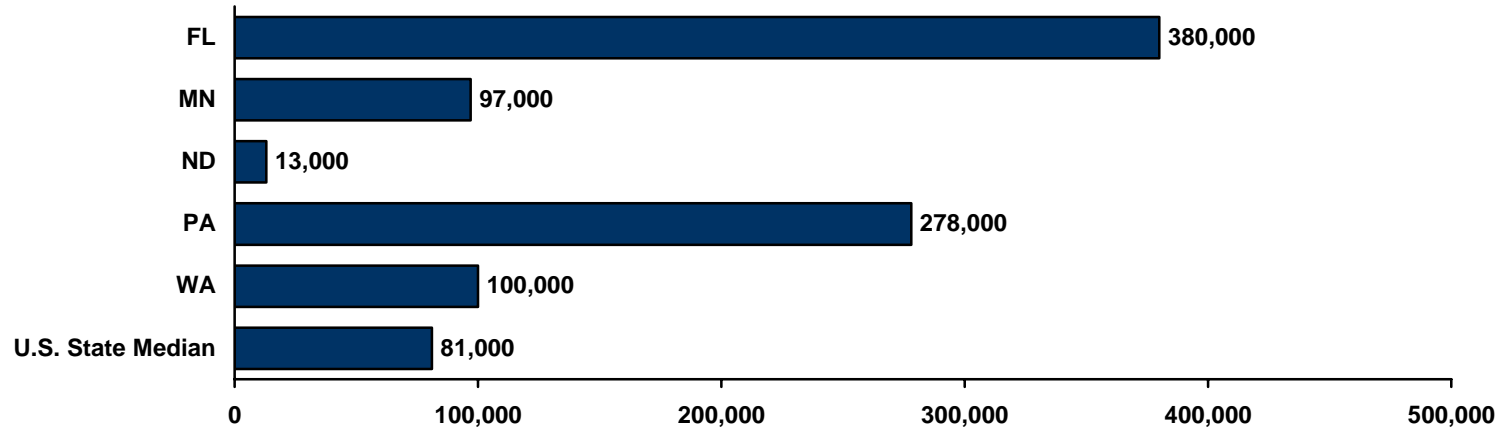
Section 1: State Impacts

C. Impact on Federal Medicaid Funding Received by States: The federal government provides matching funds to state outlays for Medicaid program costs. Currently, the average federal match is 60%, ranging from 50% to 76%. That is, for every \$1 a state spends, the federal government reimburses a state \$0.60 on average. One concern with the transfer of dual eligibles from Medicaid to the federal Medicare prescription drug program is the reduction in total federal matching dollars state Medicaid programs will receive. Given that state Medicaid programs will continue to provide other Medicaid-covered health services to dual eligibles, including Medicare Part B cost sharing, the reduction in federal match dollars may be viewed as a loss in “infrastructure” dollars for state Medicaid programs in general. This will especially be the case for states with dual eligible drug costs representing a particularly large proportion of overall Medicaid spending. It is estimated that the costs of prescription drugs for full dual eligibles represents, on average, up to 50% of all state Medicaid prescription drug spending. This section of the Profile provides data on the percent reduction in the dual eligible and overall federal Medicaid dollars received by a state.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

States' Dual Eligible Populations

Figure 1-1. Number of Full Dual Eligibles in Each State, 2003



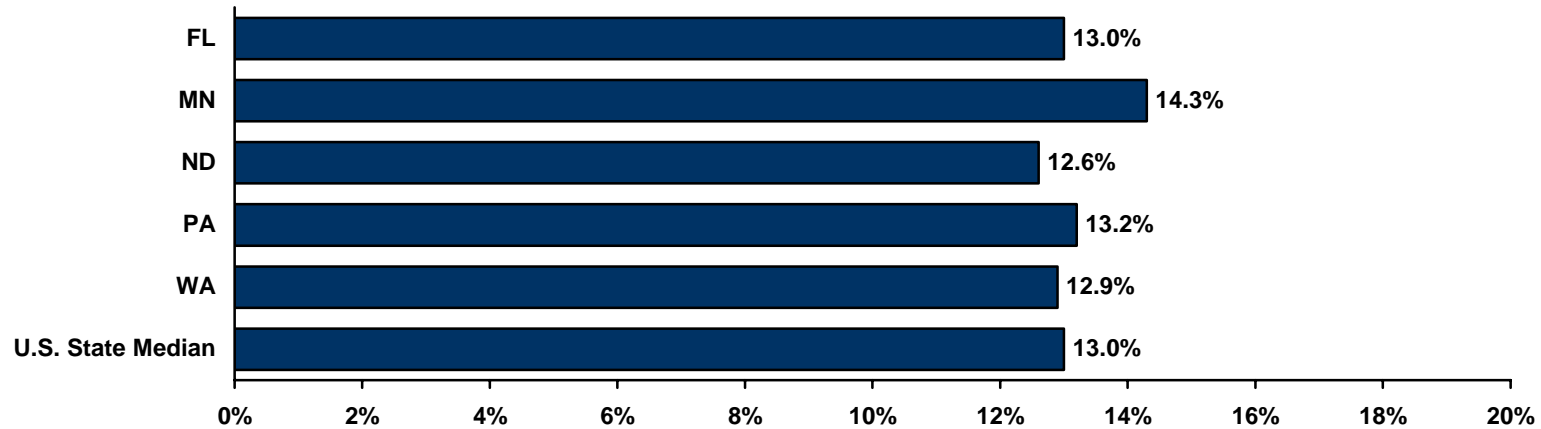
Source: Urban Institute estimates of data from the Medicaid Statistical Information System (MSIS) presented by the Kaiser Family Foundation. See Technical Report for more information on data sources and calculations.

- The transition of dual eligible prescription drug coverage from Medicaid to Medicare Part D only pertains to “full dual eligibles,” those enrolled in Medicare who are also eligible for complete Medicaid benefits.
- States vary significantly in their number of residents affected by the transition: Florida and Pennsylvania have the largest number of full dual eligibles among the states included in this report. With only 13,000, North Dakota has significantly fewer full dual eligibles than the U.S. state median of 81,000.
- The distribution of full dual eligibles across the country is largely a reflection of the distribution of the elderly population. Over 10% of all dual eligibles in the country reside in Florida and Pennsylvania (6.1% and 4.5%, respectively). Minnesota and Washington’s share of full dual eligibles (each 1.6%) is comparable to the overall U.S. state median of 1.3%. North Dakota has a relatively small percentage (0.2%) of the country’s full dual eligible population (data not shown in graph).

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

States' Dual Eligible Populations

Figure 1-2. Estimated Percent of State Medicare Beneficiaries who are Full Dual Eligibles, 2003



Source: Urban Institute estimates of data from the Medicaid Statistical Information System (MSIS) presented by the Kaiser Family Foundation and CMS Medicare Enrollment Reports

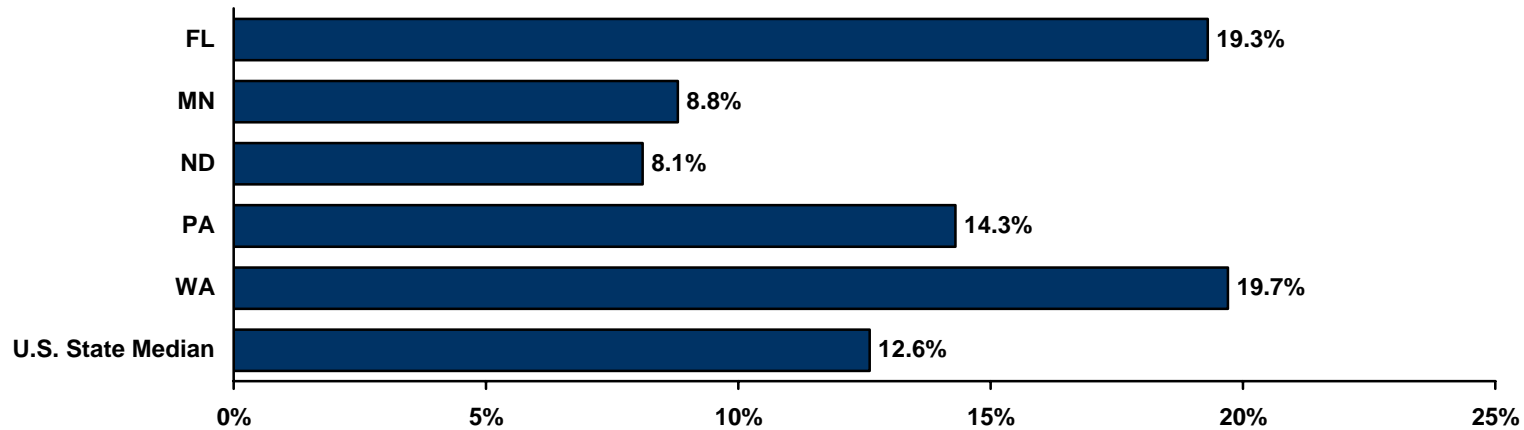
See Technical Report for more information on data sources and calculations.

- Low-income Medicare beneficiaries who are eligible for full Medicaid benefits represent a relatively small share of the total Medicare population in states, although costs of these dual eligibles are roughly twice the costs of other Medicare beneficiaries.
- On average, 13% of Medicare beneficiaries are full dual eligibles and therefore impacted by the transition of dual eligible drug coverage to Medicare from Medicaid.
- The proportion of Medicare beneficiaries who are eligible for full Medicaid benefits does not vary dramatically across the five states included in this report.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

States' Dual Eligible Populations

Figure 1-3. Estimated Percent of All Dual Eligible Medicaid Spending in State on Prescription Drugs for Full Dual Eligibles, 2003



Source: CMS estimates in letters from CMS to State Medicaid Officials, October 2005, and Urban Institute estimates based on the Medicaid Statistical Information Systems (MSIS) presented by the Kaiser Family Foundation.

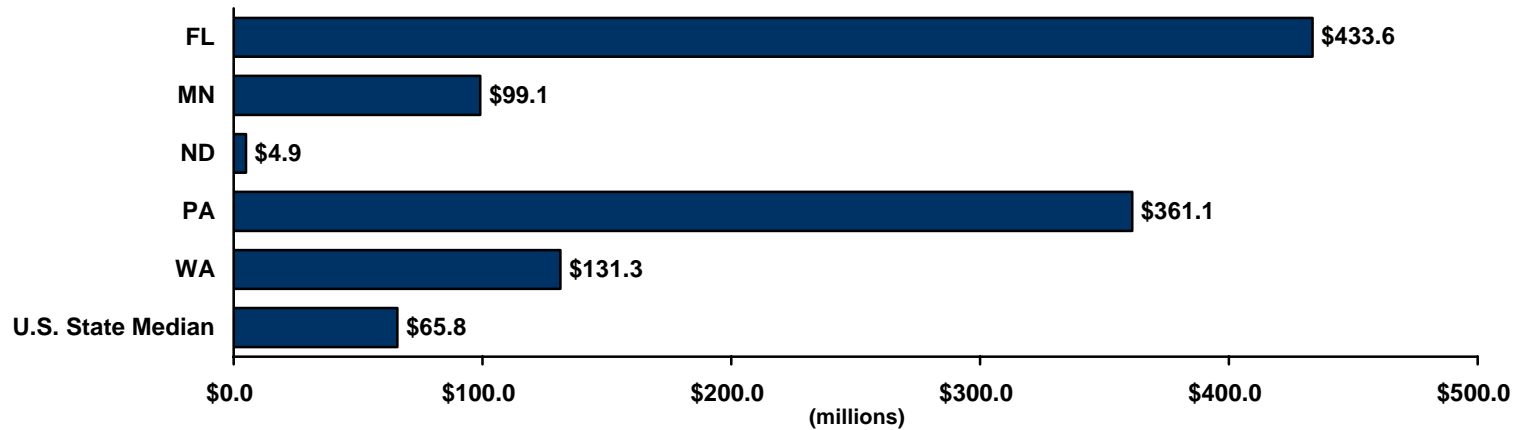
See Technical Report for more information on data sources and calculations.

- Prescription drugs for full dual eligibles make up an important proportion of total dual eligible spending by state Medicaid programs.
- On average, full dual eligible drug spending represented 12.6% of states' total Medicaid spending on all dual eligibles in 2003.
- The significance of full dual eligible drug spending stands out in Florida and Washington, where over 19% of all dual eligible Medicaid costs were attributable to prescription drugs for full dual eligibles. In contrast, less than 9% of dual eligible Medicaid spending in Minnesota and North Dakota was from prescription drugs for their full dual eligible populations.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

A1. Impact on States' Dual Eligible Prescription Drug Spending

Figure 1-4. Estimated State Annual "Clawback" Payment to Federal Government, 2006



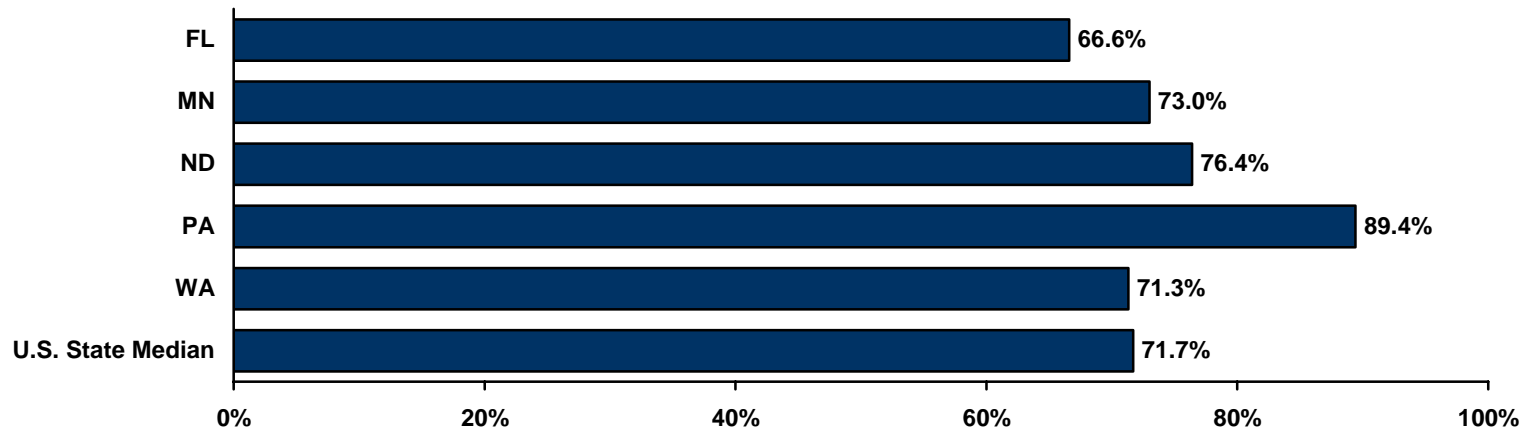
Source: CMS estimates in letters from CMS to State Medicaid Officials, February 2006
See Technical Report for more information on data sources and calculations.

- To maintain states' role in the financing of prescription drug coverage for full dual eligibles, states are required to make a monthly phase-down state contribution, also known as the "clawback" payment, to the Medicare Part D program. This payment is billed to states by the federal government on a monthly, per-dual eligible basis. The formula used by the federal government to calculate states' payments takes into consideration a state's full dual eligible drug spending, a state's federal Medicaid match rate (which ranges from 50 to 76% across the states), and the size of a state's full dual eligible population.
- On average, a state will pay over \$65.8 million to the federal government for dual eligible drug coverage under Medicare in 2006, totaling more than \$6.6 billion across all states.
- Among the five states highlighted in this report, Florida and Pennsylvania will be required to pay the highest amounts, \$433.6 and \$361.1 million, respectively. North Dakota's annual payment to Medicare, on the other hand, will be significantly lower. Variations in states' clawback amounts reflect the features of the formula used by the federal government to determine states' contributions.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

A2. Impact on States' Dual Eligible Prescription Drug Spending

Figure 1-5. State Annual "Clawback" Payment as Percent of Estimated Annual Full Dual Eligible Drug Spending Under Medicaid, 2006



Source: CMS estimates in letters from CMS to State Medicaid Officials, February 2006, and Medicaid Statistical Information System (MSIS) state summary files

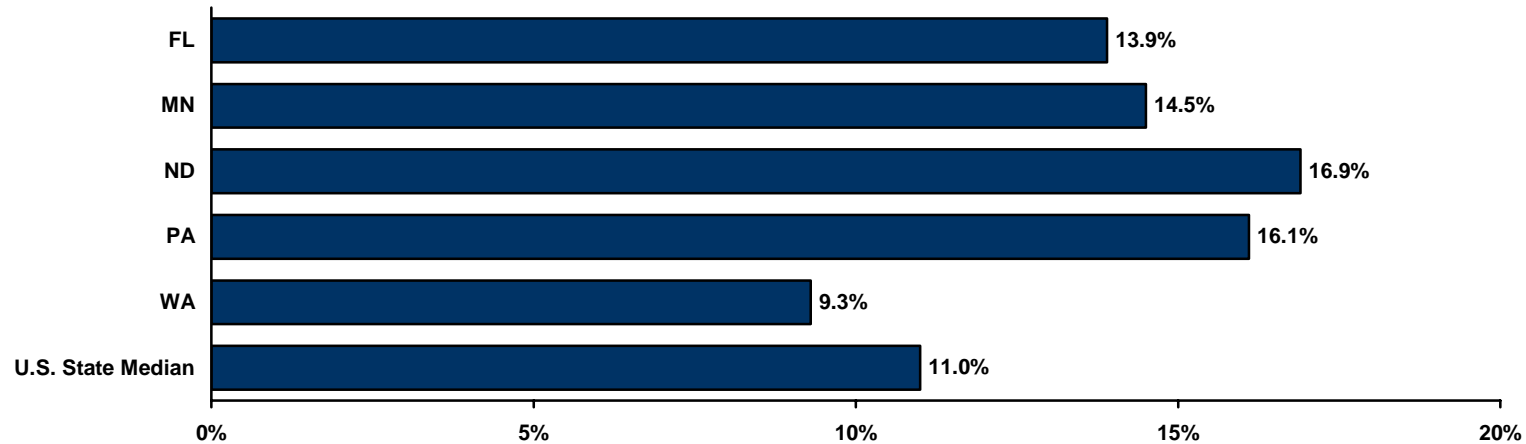
See Technical Report for more information on data sources and calculations.

- The intention of state clawback payments to Medicare Part D was that states would not spend more on dual eligible drug spending than what they would under Medicaid. In fact, the reduction factor included in the payment formula explicitly lowers state payments. However, there is significant variation in how much less a state will pay due to the other aspects of the formula used by the federal government to calculate states' payments.
- Overall, states' annual clawback contributions to Medicare are estimated to be approximately 72% of what they would have spent for full dual eligible drug coverage under their state Medicaid programs in 2006.
- Among the five states included in this report, Florida's estimated clawback contribution for 2006 is only 67% of what their Medicaid costs are estimated to have been for their full dual eligible population. In contrast, Pennsylvania's total payment amounts to almost 90% of their estimated Medicaid drug spending for full dual eligibles.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

B1. Reduction in States' Medicaid Prescription Drug Purchasing Power

Figure 1-6. Estimated Percent Reduction in Number of Potential Medicaid Prescription Drug Consumers in State, 2003



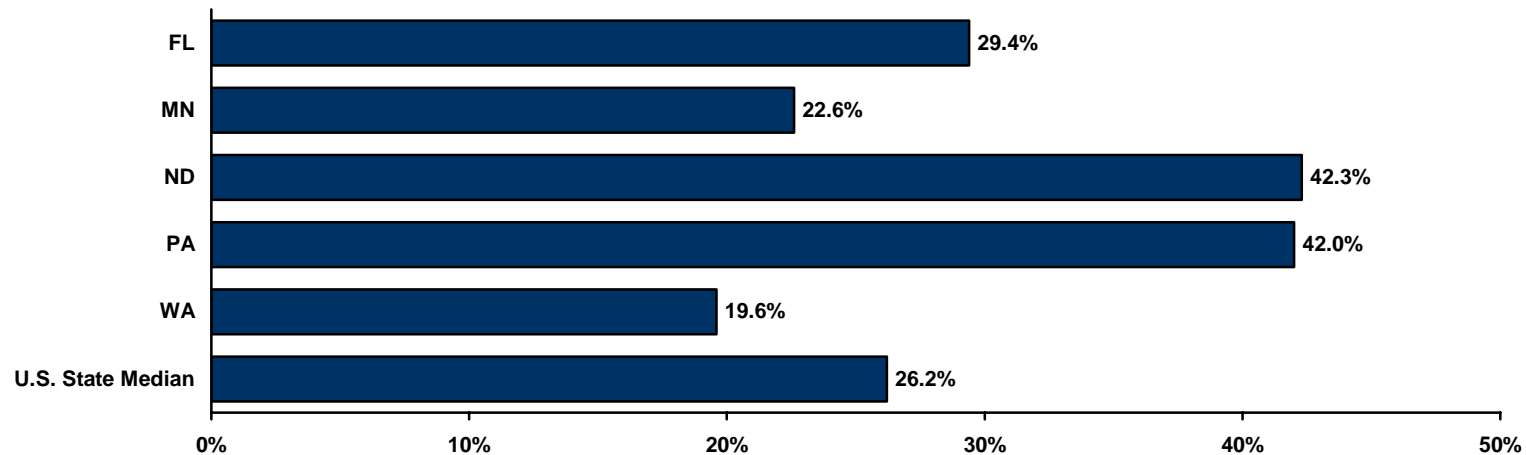
Source: Urban Institute estimates based on the Medicaid Statistical Information Systems (MSIS) presented by the Kaiser Family Foundation and MSIS State Summary Files
See Technical Report for more information on data sources and calculations.

- The transition of full dual eligible drug coverage to Medicare Part D will result in a reduction in the number of Medicaid prescription drug consumers in states, having implications for states' share of the prescription drug market and their ability to negotiate lower prices with manufacturers. The magnitude of the effect will differ for states, depending on the drug utilization and costs for a state's full dual eligible and other Medicaid populations.
- The transition of full dual eligible Medicaid drug coverage to Medicare Part D will result in an average of 11% fewer Medicaid drug consumers in states.
- Compared to this U.S. state median, all but one of the states included in this report (Washington) are losing a higher percentage of their Medicaid population to the Medicare Part D program. This is especially the case for North Dakota and Pennsylvania, with approximately 16% of their Medicaid populations being shifted to Medicare for drug coverage. In contrast, Washington is estimated to lose a slightly smaller percentage (9.3%) of their potential Medicaid drug consumers.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

B2. Reduction in States' Medicaid Prescription Drug Purchasing Power

Figure 1-7. Estimated Percent Reduction in Number of Medicaid Prescription Drugs Purchased in State, 2003



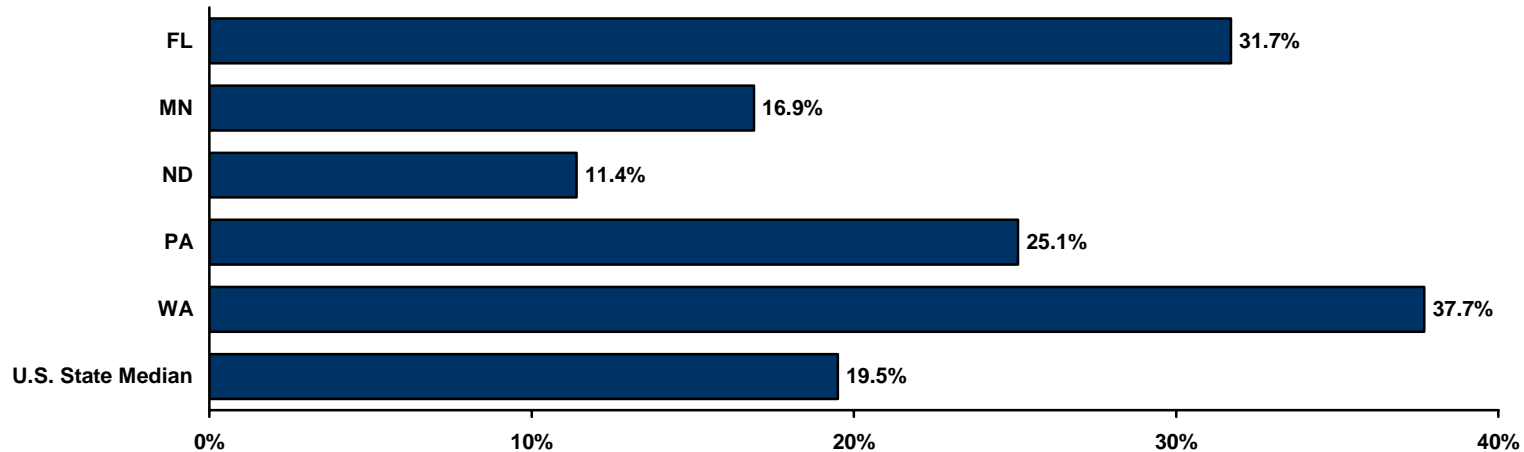
Source: Urban Institute estimates based on MSIS presented by the Kaiser Family Foundation, MSIS State Summary File, and Mathematica Policy Institute analysis of Medicaid Analytic eXtract (MAX) presented by CMS
See Technical Report for more information on data sources and calculations.

- Full dual eligibles tend to be chronically ill beneficiaries and represent a disproportionate share of prescription drugs purchased under Medicaid. The transition of full dual eligibles to Medicare, therefore, has implications for the number (and type) of drugs purchased by state Medicaid programs. Again, the magnitude of the change will differ for states depending on the drug utilization and costs for a state's full dual eligible and other Medicaid populations.
- On average, states will experience an estimated 26% drop in the number of prescription drugs purchased under Medicaid. The percent reduction is more pronounced in both North Dakota and Pennsylvania (42% in each state). It is estimated that Minnesota and Washington, however, will experience a smaller drop in their volume of drugs purchased (23% and 20%, respectively).

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

C1. Reduction in Federal Medicaid Funding Received by States

Figure 1-8. Estimated Federal Prescription Drug Spending for Medicaid Full Dual Eligibles as Share of Total Federal Medicaid Spending on Dual Eligibles, 2003



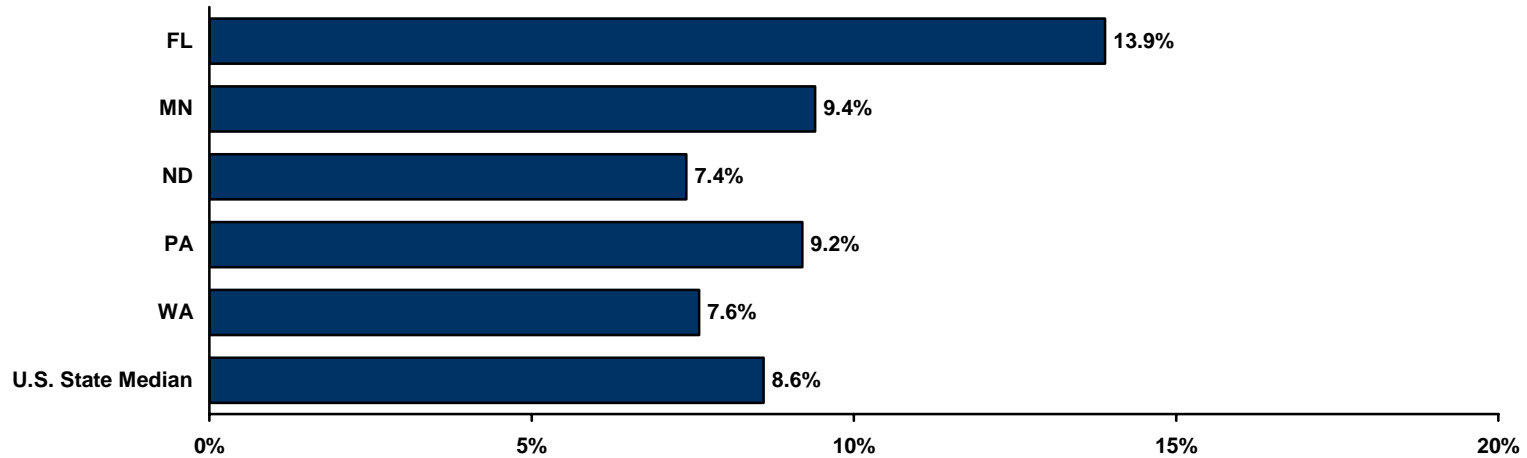
Source: Urban Institute estimates based on Medicaid Statistical Information System (MSIS) and Medicaid Financial Management Report data presented by the Kaiser Commission on Medicaid and the Uninsured and National Association of State Budget Officers. See Technical Report for more information on data sources and calculations.

- With the transition of prescription drug coverage for full dual eligibles from Medicaid to Medicare Part D, states' overall Medicaid expenditures are reduced, leading to a loss in federal Medicaid matching dollars received by states. Given that state Medicaid programs will continue to provide other Medicaid-covered health services to full and other dual eligibles, the reduction in federal match dollars may be viewed as a loss in "infrastructure" dollars for state programs in general. The drop in federal Medicaid dollars states will receive depends on a state's federal match percentage (which currently ranges from 50 to 76%) and its drug spending on full dual eligibles. The role full dual eligible drug spending plays in a state's overall and dual eligible Medicaid spending varies by state.
- On average, 19.5% of the federal dollars received by states for their dual eligible population in 2003 was for prescription drug use by full dual eligibles. In other words, states overall will lose 20% of their total federal match dollars for their dual eligible spending.
- Among the states in this Profile, Florida and Washington are estimated to experience the largest loss in federal dual eligible dollars (32% and 38%, respectively). In contrast, North Dakota will lose only 11% of the federal match dollars the state receives for their total dual eligible population.

State Impacts: Transition of Dual Eligible Prescription Drug Coverage

C2. Reduction in Federal Medicaid Funding Received by States

Figure 1-9. Estimated Percent of Total Federal Medicaid Spending in State Attributed to Prescription Drugs for Full Dual Eligibles, 2003



Source: CMS estimates in letters from CMS to State Medicaid Officials and National Association of State Budget Officers
See Technical Report for more information on data sources and calculations.

- The loss in federal Medicaid match dollars due to transitioning dual eligibles to prescription drug coverage under Medicare will impact states differently, depending on the role full dual eligible drug spending plays in each state’s overall Medicaid budget.
- On average, prescription drug spending for full duals represents approximately 9% of all federal Medicaid dollars states received in 2003.
- Florida is estimated to lose a slightly larger proportion (13.9%) of their total federal Medicaid dollars than the U.S. state median. North Dakota and Washington will lose slightly smaller proportions (approximately 7.5% each) of the federal share of their total Medicaid budget.

Section 1: State Impacts

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Section 2: Beneficiary Impacts

Reform Topic: High-Income Means Testing of Medicare Part B Premiums

Introduction

Part B (Supplementary Medical Insurance) of the Medicare program provides insurance coverage for physician services and hospital outpatient care as well as other services such as emergency room visits, tests, medical equipment and supplies, and limited preventive care. Part B is intended to supplement Part A (Hospital Insurance), which offers insurance coverage for hospital and skilled nursing facility inpatient care as well as hospice and some home health services. Generally, Medicare Part A does not involve beneficiary premiums, but Part B requires monthly premium payments from most beneficiaries. Part B premiums are largely subsidized by the federal government, however, and are considered to be cost-efficient for beneficiaries relative to what individuals would pay for the same coverage on the private market. Roughly 94% of Part A Medicare beneficiaries also are on Part B. Beneficiaries enrolled in Medicare managed care automatically receive both Part A and B benefits.

Each month Part B beneficiaries pay a premium to support part of the costs of the program. Historically, monthly premium costs have been uniform across all beneficiaries and are currently capped at 25% of program costs, with the federal program subsidizing the remaining 75%. While the 25/75 split has been in effect for most years since 1983, overall Part B program costs fluctuate each year and the resulting premium costs for beneficiaries fluctuate as well. As of 2006, the monthly premium cost for beneficiaries is \$88.50, a 13.2% increase from 2005. For Medicare beneficiaries also eligible for Medicaid (full dual eligibles), Medicaid may pay the Medicare Part B premium costs.³

Provisions in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 brought about unprecedented changes to the federal subsidy of the Part B premium. Effective in 2007, Medicare beneficiaries with higher incomes will be responsible for paying a higher proportion of their Part B premiums. Single beneficiaries earning \$80,000 or more annually (and couples earning \$160,000 and above) will see an increase in their Part B premium contribution. The resulting increase in beneficiary premiums will vary by income, with higher-income beneficiaries above the initial \$80,000 threshold responsible for a greater share of Part B costs (see Table 2-1). Beneficiaries earning more than the equivalent of \$200,000 (or \$400,000 for couples) in 2007 will incur the largest increase, with their contribution increasing from 25% to 80% of the premium cost. The income levels to be used will be adjusted annually for inflation based on the Consumer Price Index. The federal government plans to make these income threshold amounts available in September of every

³ The only dual eligible exception is the Qualified Disabled and Working Individuals (QDWI) group. These beneficiaries receive Medicaid coverage for the Part A premium but not the Part B premium.

year (for the following calendar year) and will generally use a beneficiary's modified adjusted gross income⁴ (from two prior tax years) to determine which individuals will fall into each income group.

Table 2-1. Changes to Beneficiary Premium Contributions towards Medicare Part B, by Income Level

Beneficiary Income Level*	Pre-MMA Part B Premium Contribution (%)	New Part B Premium Contribution (%)
≤\$80,000	25%	25%
>\$80,000-\$100,000	25%	35%
>\$100,000-\$150,000	25%	50%
>\$150,000-\$200,000	25%	65%
>\$200,000	25%	80%

Source: Medicare Modernization Act of 2003.

* Incomes indicated are for 2007 and for single beneficiaries. For couples, the 2007 income levels are doubled. Income levels will change annually with inflation.

Initially, the implementation of the high-income means testing was scheduled to be phased in over a five-year period between 2007 and 2011 to ease the transition to higher premium costs for those beneficiaries who face additional Part B payments. Legislative changes included in the more recent Deficit Reduction Act of 2005 accelerated this phase-in schedule to a three-year process, beginning in 2007 and now ending in 2009. The revised schedule for the phase-in is outlined below in Table 2-2.

Table 2-2. Revised Phase-In Schedule for the Increases in Part B Premium Contributions for Beneficiaries with Incomes above the Minimum Threshold

Year	Percent of Increase in Beneficiary Part B Premium Contribution
2007	33%
2008	67%
2009	100%

Source: Deficit Reduction Act of 2005.

⁴ Modified Adjusted Gross Income is a person's adjusted gross income (from tax form 1040), modified to also include other sources of income (e.g., foreign income, deductions claimed for a regular contribution to a traditional IRA).

Section 2: Beneficiary Impacts

Table 2-3 shows the difference in estimated premium costs for beneficiaries in the different income groups, assuming full implementation of the high-income means testing adjustment.

Table 2-3. Differences in Beneficiary Part B Premium Costs, by Income Level (Assuming Full Implementation of Part B High-Income Means Testing)

Beneficiary Income Level*	New Part B Premium Contribution (%)	Estimated New Premium Costs**	% Increase in Premium from Baseline
≤\$80,000	25%	\$93.50	0%
>\$80,000-\$100,000	35%	\$130.90	40%
>\$100,000-\$150,000	50%	\$187.00	100%
>\$150,000-\$200,000	65%	\$243.10	160%
>\$200,000	80%	\$299.20	220%

* Incomes indicated are for 2007 and for single beneficiaries. For couples, the income levels are doubled. Income levels will change annually with inflation.

** Monthly premium costs are based on the 2007 Part B premium cost for beneficiaries.

Impact of Part B Premium Means Testing on High-Income Beneficiaries

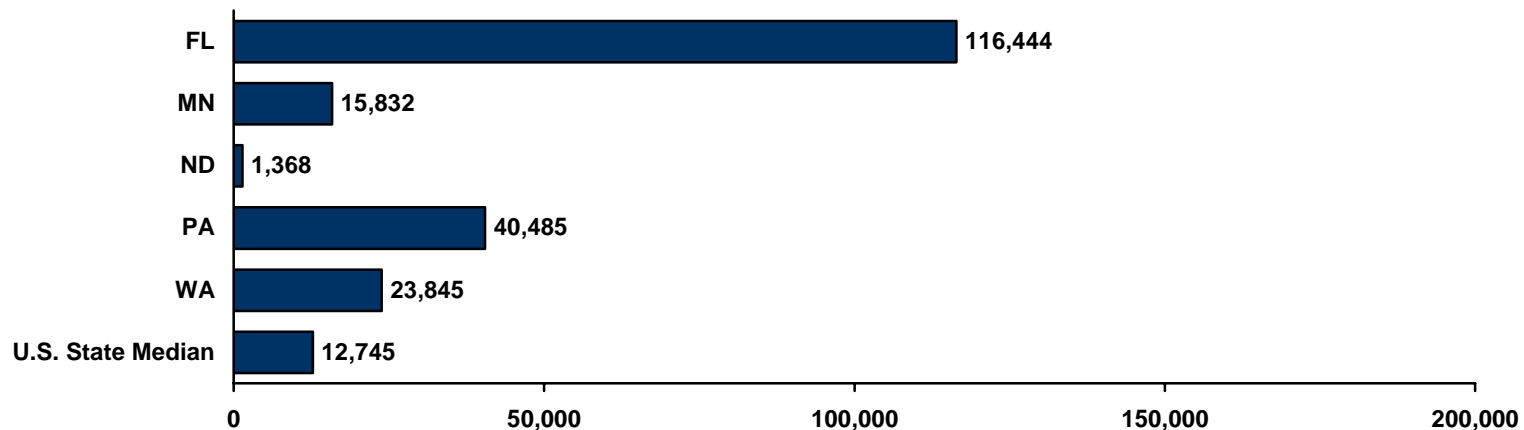
There are two basic reasons for implementing increased cost-sharing for high-income beneficiaries under Part B. First, Medicare Part B is a supplemental voluntary program that the federal government offers as a benefit to Medicare beneficiaries. Unlike Medicare Part A, it is not a part of the formal Medicare entitlement. The new policy is intended to increase contributions of higher-income beneficiaries who are able to pay and more adequately target the federal subsidy of the Part B premium to lower-income beneficiaries. In addition, there was and is interest in increasing beneficiary contributions to the Medicare program to assist in the solvency of the program in the future. However, policy makers and analysts have debated whether the new means testing approach will contribute significantly to the livelihood of the Medicare program. Pauly (2004), for example, makes the case that means testing in Medicare (both in terms of higher Part B premiums for high-income individuals and greater Part D benefits for low-income individuals) will positively contribute to the program's financial standing. Moon (2004), on the other hand, has argued that there are not enough Part B beneficiaries who fall or will fall above the prescribed income limits to help offset the growing costs of the program overall. Some policy stakeholders also feel that means testing of Part B premiums establishes a risky precedent because it opens the door for means testing thresholds to be lowered, thereby impacting more beneficiaries in future years.

Section 2: Beneficiary Impacts

The methodology for assessing beneficiary incomes dictates which individuals (and states) will be impacted by Part B premium means testing. Using modified adjusted gross income means that Medicare beneficiaries with high earnings from either employment or from income-generating assets unsheltered from taxes will be more likely to fall above the income thresholds. Employed elderly may be disproportionately impacted by the implementation of means testing. States' economic differences are likely be related to state variations in the proportion and characteristics of beneficiaries affected by Part B premium means testing. In this section of the Profile, data are shown on the percent of individuals in states likely to be impacted by the high-income means testing, including breakouts by age and employment status.

Beneficiary Impacts: High-Income Means Testing of Part B Premiums

Figure 2-1. Estimated Number of Individuals Aged 65 and Older with Income above the High-Income Means Test Threshold, 2002-2004

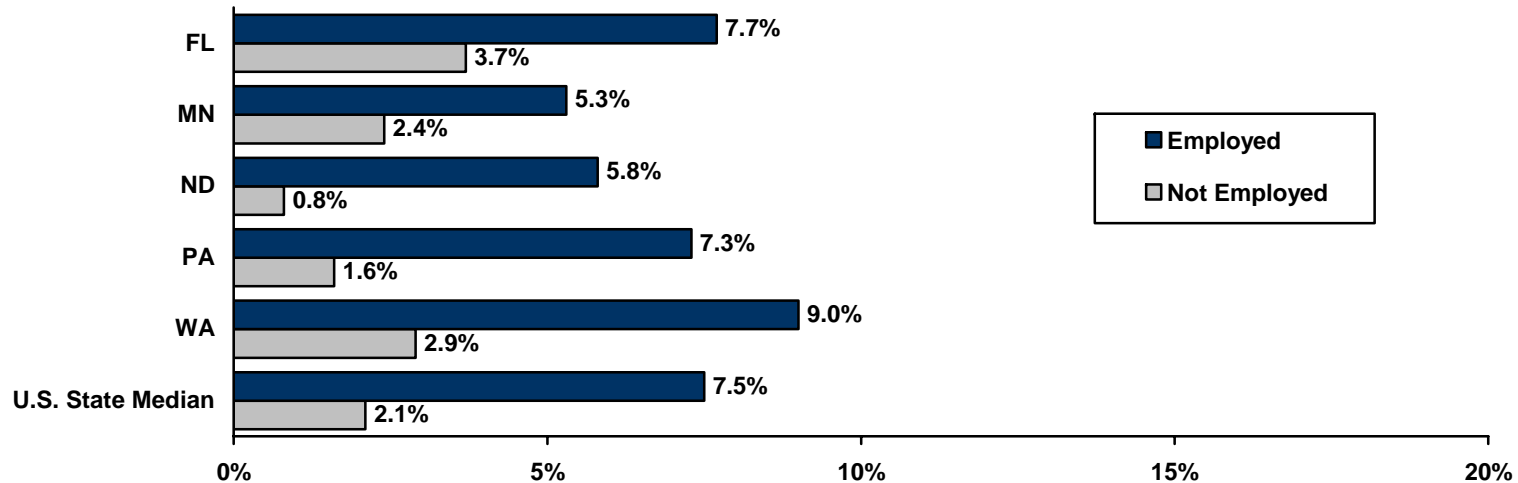


Source: SHADAC analysis of American Community Survey (2002-2004) microdata
See Technical Report for more information on data sources and calculations.

- Means testing of Part B premiums increases the share of Part B premium costs for Medicare beneficiaries with relatively high incomes (at least \$80,000 for a single person). The proportion of the Medicare population to be impacted by this change is relatively small. States' economic conditions and beneficiary incomes will factor into state variations in the proportion and characteristics of affected beneficiaries.
- On the average, just under 12,750 residents aged 65 and older in each state are estimated to meet the income threshold and will therefore need to pay more for their Part B premiums. All but one of the states included in this report have more high-income elderly. In fact, the number of high-income elderly in Florida is over nine times the U.S. state median, and over 40,000 high-income elderly reside in Pennsylvania. In contrast, significantly fewer elderly in North Dakota (only 1,368) will meet the income threshold.
- On average, the high income threshold will affect 2.9% of the U.S. population aged 65 and above (data not shown in graph). Smaller percentages of elderly in Minnesota (2.6%), North Dakota (1.6%) and Pennsylvania (2.3%) meet the income threshold, while slightly higher percentages in Florida (4.2%) and Washington (3.6%) will be required to pay a larger share of their Part B premiums.

Beneficiary Impacts: High-Income Means Testing of Part B Premiums

Figure 2-2. Estimated Percent of Population Aged 65 and Older with Income above the High-Income Means Test Threshold, by Employment Status, 2002-2004

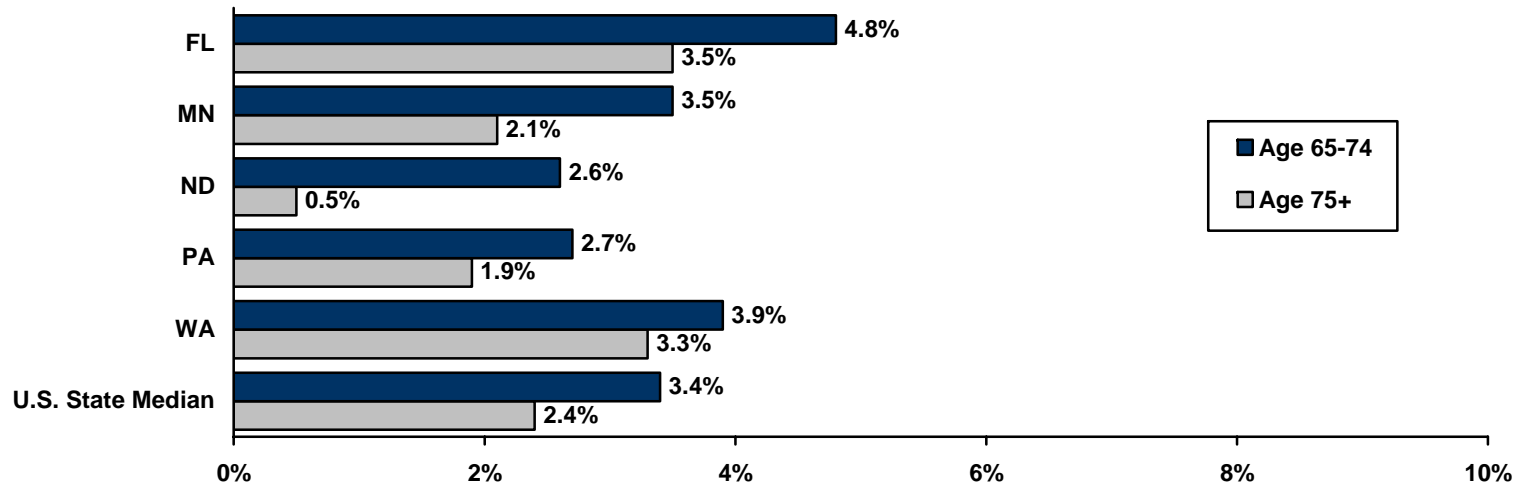


Source: SHADAC analysis of American Community Survey (2002-2004) microdata
See Technical Report for more information on data sources and calculations.

- Medicare beneficiaries with high earnings from either employment or from income-generating assets unsheltered from taxes will be more likely to fall above the income thresholds and therefore will be required to pay a larger share of their Part B premium starting in 2007. Again, states' economic conditions will factor into state variations in the proportion and characteristics of beneficiaries affected.
- Employed elderly will be disproportionately impacted by the implementation of high-income means testing. In states overall, approximately 7.5% of employed elderly, in comparison to 2.1% of unemployed elderly, have incomes that meet or exceed the high income limit.
- The larger percentage of employed elderly impacted by the high-income means test is the case across all states included in this report.

Beneficiary Impacts: High-Income Means Testing of Part B Premiums

Figure 2-3. Estimated Percent of Population with Income above the High-Income Means Test Threshold, by Age, 2002-2004



Source: SHADAC analysis of American Community Survey (2002-2004) microdata
See Technical Report for more information on data sources and calculations.

- Income levels from either employment or income-generating assets may vary by age. For example, young elderly may continue to work past the age of 65, while older elderly are more likely to have spent assets.
- In the U.S. overall, the percent of elderly individuals with incomes high enough for Part B premium share increases does not differ dramatically for the young elderly (aged 65 -74 years) versus older elderly (aged 75 years and older), except in North Dakota, where the rate of meeting the high-income threshold in the young elderly is five-fold the rate of meeting the high-income threshold in the older elderly.
- The states included in this Profile do not show dramatic variation from the overall U.S. average.. In all of the states in this report, the younger elderly are slightly more likely to meet the high-income threshold and therefore experience an increase in Part B premium contribution.

Section 2: Beneficiary Impacts

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Section 3: Market Impacts

Reform Topic: Introduction of Regional Managed Care Plans under Medicare

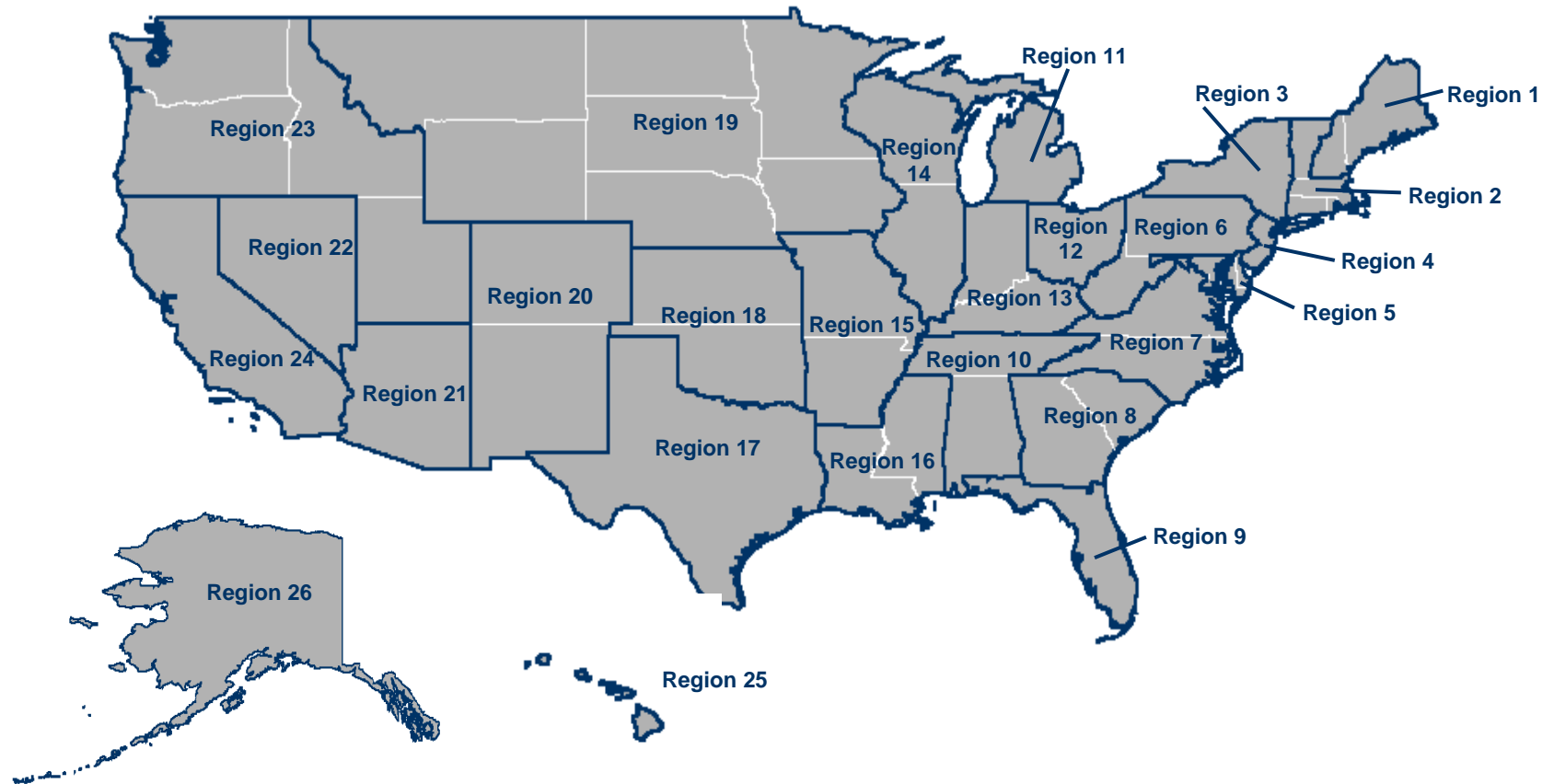
Background

Local (i.e., county-level) managed care plan options have been available under Medicare since the 1980s. Prior to the Balanced Budget Act (BBA) of 1997, Medicare contracted with health maintenance organizations (HMOs) and similar private plans. Through its implementation of the Medicare+Choice (M+C) program, the BBA widened the range of authorized local private plans to include preferred provider organizations (PPOs), provider sponsored organizations (PSOs), private fee-for-service (PFFS), and medical savings accounts (MSAs). The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 renamed the M+C program to Medicare Advantage (MA) and further augmented private plan options. The ongoing expansion of private plans under Medicare is an attempt to increase consumer choice and the role of managed care under the national Medicare program.

A key feature of the new Medicare Advantage program was the introduction of *regional* private plans – specifically, regional PPOs – in 2006. Similar to local Medicare Advantage plans, regional plans are required to provide both Medicare Part A and Part B Medicare benefits (excluding hospice) and now must offer an option including the new Medicare prescription drug benefit (Part D). Regional plans must have a combined Parts A and B deductible and include some out-of-network services. Unlike the local plans (which have operated mostly at the county level), regional plans are required to serve a larger geographic region and to provide the same benefit across the entire region. Congress established 26 Medicare Advantage regions throughout the country (see map on the following page). Eleven of the regions are single-state regions, and the remaining 15 regions are made up of two to seven states. Regions vary significantly in terms of the number of beneficiaries who reside within them, the urban/rural composition of their beneficiary populations, and their history with Medicare private plans.

Section 3: Market Impacts

Medicare Advantage Regions



Section 3: Market Impacts

The MMA instituted several economic incentives to encourage health carriers to offer regional plans: These incentives include:

- Government financial back-up in the event a regional plan's actual costs are more than estimated: During 2006 and 2007, plans that surpass plan-specific spending targets will receive additional payments from the federal government. At the same time, regional plans with expenditures below the target will be required to return excess funds to the government. This arrangement is referred to as "symmetrical" risk-sharing between the government and regional health plans.
- Potential access to additional government support: The Centers for Medicare and Medicaid Services (CMS) will have authorization to tap a "regional stabilization fund," initially set at \$10 billion, to increase short-term payments to carriers in order to encourage and maintain regional plans as necessary during 2007-2013.
- Controls on competition: The establishment of new local PPO plans as well as any growth in service areas of existing local PPOs are restricted through a moratorium of such plans during 2006 and 2007.
- Assistance with establishing a provider network: Regions that have difficulty contracting with a hospital may acquire an "essential hospital payment" for a hospital, as long as the hospital is deemed necessary for an adequate regional network. Further, compared to local plans, regional plans benefit from more flexibility in terms of the overall network adequacy requirements Medicare has set for them.

Payments for Regional Medicare Advantage Plans

How well regional PPO plans are paid, especially compared to local plans, will have an impact on the establishment and viability of regional plans over time. The MMA brought about important changes in payments for all Medicare Advantage private plans. Prior to MMA, Medicare Advantage payments for local plans equaled 95% of fee-for-service costs in each county. In 2004 and 2005, MMA increased payments to local plans overall and took into consideration several payment calculations, awarding each plan the highest amount across them. In 2006, further revisions to local Medicare Advantage plan payments became effective, along with the start-up of regional PPO plans. Current payments to local and regional plans are separate but similarly calculated. Both involve a bidding process and take into consideration: 1) the plan bids received by Medicare and 2) a benchmark or targeted plan payment amount. An additional MMA-related change pertains to the risk adjustment of plan payments. As of 2006, 75% of plan payments is now being adjusted based on health risk factors and 25% for demographic factors. By 2007, payments will be 100% risk-factor adjusted.

Section 3: Market Impacts

Impacts on States' Health Insurance Markets by the Introduction of Regional Medicare Advantage Plans

Regional Medicare Advantage plans will have important implications for both the insurance industry and Medicare beneficiaries. In this section, we focus on the impacts of the new regional plans on states' insurance markets, taking into consideration carriers that develop regional plans as well as the Medicare Advantage provider industry overall.

Whether carriers take to establishing regional plans is of significant policy interest, and policy stakeholders and analysts have raised several issues about the attractiveness of these plans. On the one hand, there are several reasons to believe regional plans will be an appealing option for insurance carriers to expand their business. The possible advantages include:

- The benefits introduced by the short-term federal incentives discussed above.
- A reduced-risk opportunity to test the Medicare Advantage waters for firms that historically have not had a local Medicare Advantage presence.
- The ability to produce products rapidly among firms with Medicare Advantage experience.
- The prospect of a larger market share due to broader geographic presence: Carriers will be interested in the cost effectiveness of increased plan enrollment.
- The prospect of a larger market share due to advantages for beneficiaries: Although how beneficiaries will perceive regional plans over local Medicare Advantage plans is not clear, there are several reasons to think that the uniform plan choice and the required out-of-network services associated with a regional plan may be important to some. Further, and perhaps more importantly, some analysts believe that Medicare Advantage participation in general (both regional and local) will increase due to the initiation of Medicare Part D. Gold (2005), for example, makes the strong argument that the role of private drug plans under Part D will require many beneficiaries to interact with a private plan for the first time and that the coordination of Part A, Part B, Part D and any supplemental benefits under the umbrella of a single private plan will attract additional Medicare Advantage enrollees.

Section 3: Market Impacts

Regional plans also introduce increased complexity and inflexibility in product development and implementation as well as financial uncertainty for carriers. The possible disadvantages include:

- The elimination of control over the geographic size and location of a plan's market.
- The need to develop products that are conducive to rural areas: Targeting rural areas can be expensive. Further, there is increased risk in developing products in areas that have lacked Medicare Advantage experience.
- The need to establish provider networks across large geographic areas.
- State regulatory structures: In some regions, states' varying regulations may pose some obstacles.
- Increased dependence on Medicare for revenue: Service utilization is high among Medicare beneficiaries so expanding Medicare enrollment means increasing the share of profits that comes from this national program.
- The financial and market uncertainty over the long haul: In the future, there may be challenges in maintaining a regional product, especially with any changes in and the planned elimination of federal incentives. Some believe that in order to sustain regional plans in the future, costly government incentives will need to be maintained.

Over time, the introduction of regional plans may have significant impacts on the availability of Medicare Advantage plans, the composition of the Medicare Advantage market, and changes in Medicare Advantage competition within a state. Differences between local and regional payments will be an important factor in these concerns in both the short-term and long-term. While some analysts believe local and regional payments are not likely to be comparable, others are not clear whether local and regional Medicare Advantage payments in a given county will differ significantly.

Important to this report, the fate of regional plans and their impacts are likely to evolve differently across regions. Analysts have suggested that how regional plans fare and how they will impact the markets of individual regions and states will vary depending on a number of factors, including the prior penetration of Medicare Advantage in states, the historical composition of the Medicare Advantage market in states, the prior/current presence of major national health insurance carriers within a region, and the degree of overlap between prior Blue Cross Blue Shield service areas and regional boundaries. Gold and Harris (2005) also have convincingly argued that the regional context to which states have been assigned will play a crucial role in the ultimate success and impacts of regional plans. For example, some regions include states with dramatically different Medicare Advantage histories and plan choices. How within-region variability and other factors will steer the cost/benefit analysis among insurance firms is yet to be known.

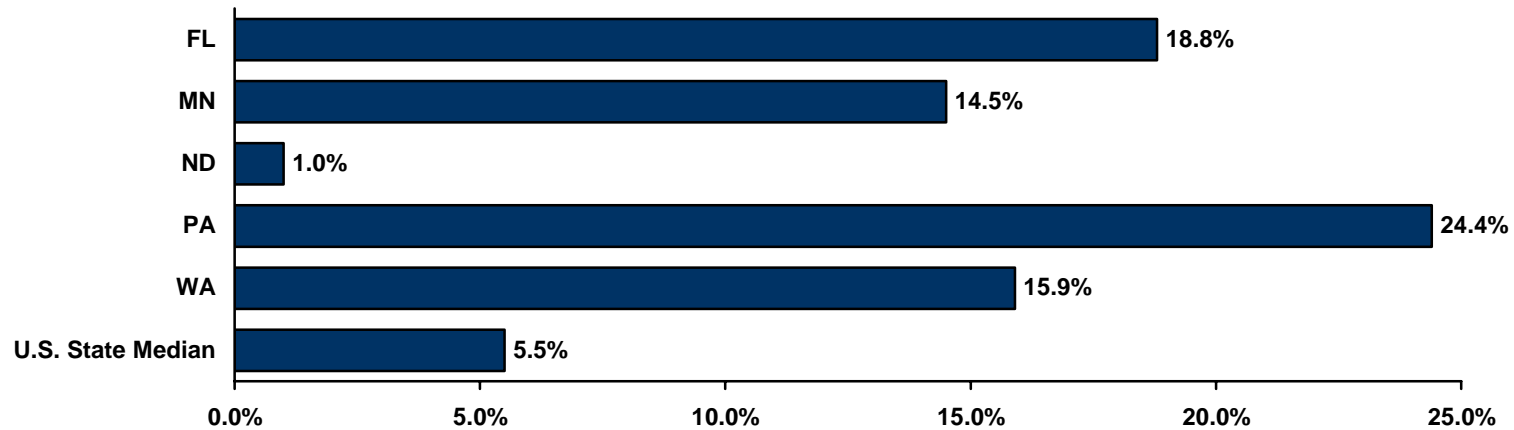
Section 3: Market Impacts

In this pilot, we show data on the different state Medicare Advantage market contexts into which regional plans are being introduced. For example, we present the market penetration levels of managed care in each state and the composition of Medicare Advantage enrollment by plan type across the states. Further, we highlight within-region, cross-state variations in Medicare Advantage enrollment and provide current information about the regional plans that have been established in the regions to which our five pilot states belong. It will take some time to understand the popularity of regional plans among providers and beneficiaries, their market impacts, and how these outcomes vary by region.

Market Impacts: Introduction of Regional Managed Care Plans

Market Share of Medicare Advantage Plans in States

Figure 3-1. Percent of Medicare Beneficiaries in Each State Enrolled in Medicare Advantage, Last Quarter 2004

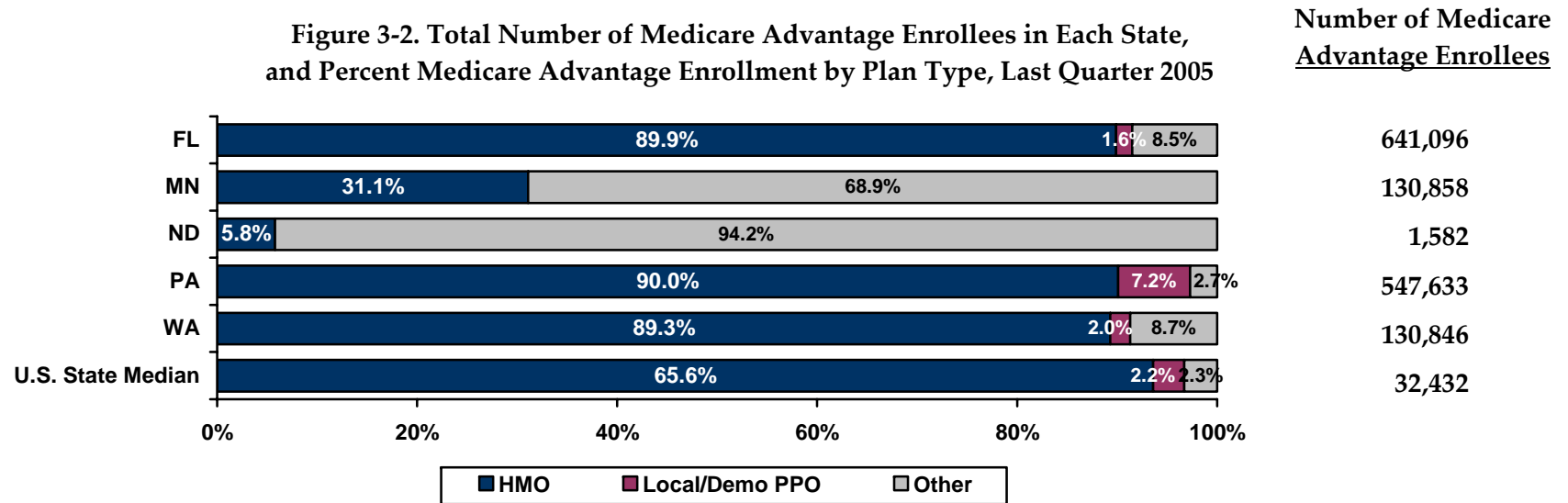


Source: CMS Medicare Enrollment Report and SHADAC analysis of State County Plan market penetration file, 2004
See Technical Report for more information on data sources and calculations.

- Historically, enrollment in Medicare managed care (now called Medicare Advantage) has been relatively low compared to traditional fee-for-service Medicare. Recent legislative efforts (including the MMA) have attempted to expand private plan choice under Medicare and to shift more Medicare beneficiaries into this type of plan.
- States vary in the extent to which their Medicare beneficiary population is enrolled in Medicare Advantage. For example, urban states, states with higher payment rate areas, states with a major national/regional health insurance carrier presence, and states with past Medicare managed care demonstration contracts have had greater Medicare Advantage plan availability and enrollment. For the five states included in this report, the percent of Medicare beneficiaries enrolled in Medicare Advantage (as of 2004) ranged from as low as 1.0% (North Dakota) to as high as 24.4% (Pennsylvania). With the exception of North Dakota, the states in this report exceeded the national state median of 5.5%.

Market Impacts: Introduction of Regional Managed Care Plans

Composition of Medicare Managed Care Enrollment in States



Source: SHADAC analysis of CMS State County Plan market penetration file, 2005

Notes: Other MA plans include cost, private fee-for-service, provider sponsored organization or another type of demonstration plan. The overall U.S. state percentages do not total 100% because they represent the median state value, not mean, for each category.

See Technical Report for more information on data sources and calculations.

- The types of local Medicare Advantage plans available in a state have varied due to a number of factors, including the presence of key health insurance carriers and the population density of states. Private fee-for-service plans, for example, have been largely responsible for improving beneficiary access to Medicare Advantage in general because, unlike HMOs, they do not require provider networks and have been more conducive for rural areas. However, HMOs prevailed on average in 2005, with 65.6% of Medicare Advantage beneficiaries in states enrolled in a HMO plan, 2.2% enrolled in a local or local demonstration PPO plan, and 2.3% participating in another private plan, such as a cost, private fee-for-service, PSO, or other demonstration plan.
- The market dominance of HMOs is particularly evident in Florida, Pennsylvania, and Washington, where the percent of Medicare Advantage beneficiaries enrolled in this type of plan has been much higher, at or close to 90%. In contrast, in 2005, fewer than a third of Medicare Advantage enrollees in Minnesota participated in HMOs and, in North Dakota, only 5.8% were enrolled in an HMO.
- Pennsylvania is noticeable for its higher percentage of PPO enrollees, and both North Dakota and Minnesota stand out for the share of Medicare Advantage beneficiaries in these states who participated in a private plan *other* than an HMO or PPO.

Market Impacts: Introduction of Regional Managed Care Plans

Regional PPO Plans

Figure 3-3. Number and Carriers of Regional Plans Established in Each State, June 2006

	Number of Regional Plans	Carriers
Florida	4	Humana (3 plans); United (1 plan)
Minnesota	5	Blue Cross Blue Shield
North Dakota	5	Blue Cross Blue Shield
Pennsylvania	3	Humana
Washington	0	N/A

Source: Medicare Personal Plan Finder available from the Centers for Medicare and Medicaid Services (CMS), 2006

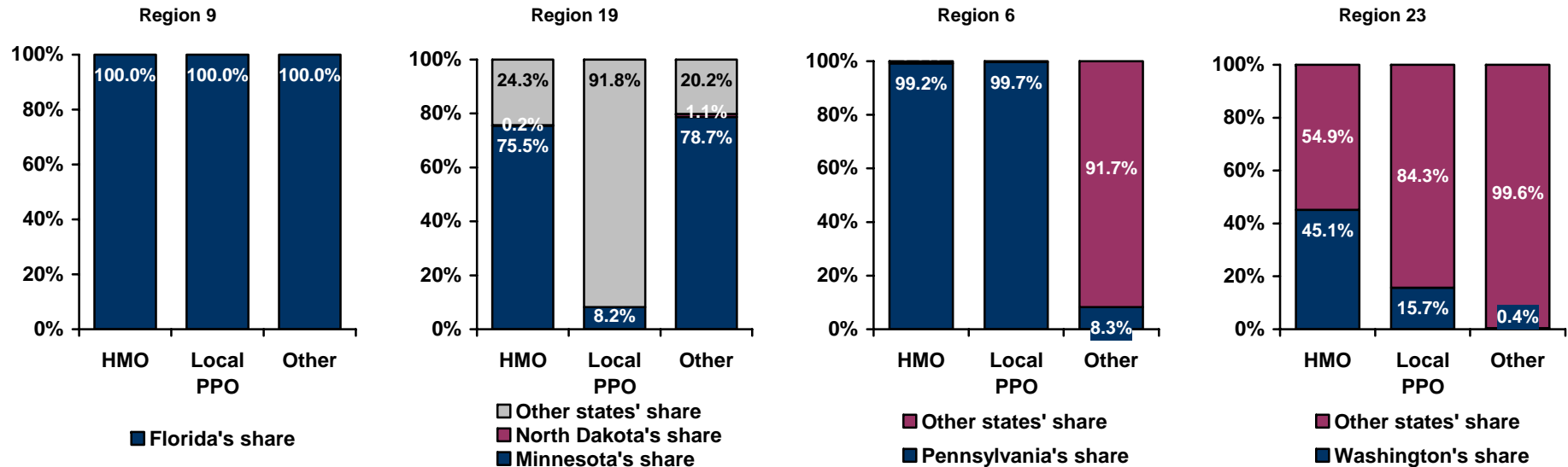
See Technical Report for more information on data sources and calculations.

- The new Medicare Advantage regions differ in their number of regional plans established to date. As of June 2006, the number of regional plans in each of the five states included in this report ranges from zero (Washington) to five (North Dakota, Minnesota). Humana offers plans in both Florida and Pennsylvania; United has a regional plan in Florida; and Blue Cross Blue Shield is currently the only regional plan provider in Minnesota and North Dakota.
- More regional plans are anticipated to surface in the remainder of 2006 and during 2007, while some of the federal incentives encouraging carriers to initiate regional plan remain in effect.

Market Impacts: Introduction of Regional Managed Care Plans

States' Regional Medicare Advantage Context

Figure 3-4. State Share of Total Medicare Advantage Enrollment in Region by Plan Type, Last Quarter 2005



Source: SHADAC analysis of CMS State County Plan market penetration file, 2005

Notes: Other MA plans include cost, private fee-for-service, provider sponsored organization or another type of demonstration plan.

See Technical Report for more information on data sources and calculations.

- Regions are comprised of states with varying Medicare beneficiary populations and Medicare managed care enrollment histories. Carriers may find it more risky and challenging to establish plans in regions that include states with dramatically different Medicare Advantage experiences and those that include one or more states with a historically weak Medicare Advantage presence.
- The states addressed in this report are situated in very different regional contexts. The five states differentially contributed to the presence of Medicare Advantage within their region as of 2005. For example, in Region 19, Minnesota represents 75.5% of Medicare Advantage HMO enrollment and “other enrollment” in the region, while North Dakota contributes around 1% or less to both HMO and “other” plan types. Washington has just under one-half of Medicare Advantage HMO enrollment in its region. Pennsylvania, in contrast, represents the overwhelming majority (99.2%) of Medicare Advantage HMO enrollment in Region 6 while contributing relatively little to enrollment in “other” plans in the region. Florida’s share is 100% across all plan types because it is a single-state region.

Section 3: Market Impacts

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Section 4: Provider Impacts

Reform Topic: Redistribution of Graduate Medical Education (GME) Resident Caps

Introduction

The label “Graduate Medical Education,” or GME, describes the training physicians receive after medical school. At the minimum, physicians complete a three-year residency program; however, residency program length varies by specialty, and post-residency training may be needed as well. GME usually takes place in hospitals but can also occur in community settings. Medicare has included financing for GME since the program inception in 1965, and since 1983, Medicare has been the largest source of funding for GME in the United States.

Medicare GME provides funds to individual teaching hospitals based on the number of residents being trained at each hospital. To qualify for Medicare GME payments, a teaching hospital needs to have an approved residency program. Teaching hospitals may or may not be attached to a medical school or academic health center and may be public or privately owned. In 1997, the Balanced Budget Act (BBA) capped the total number of residents that Medicare would fund at each institution, and hospitals seeking to expand their residency programs have had to do so without financing from the federal government or have been forced to cutback one residency program to expand another.

The number of residents funded at each institution was revisited in 2003, in the Medicare Prescription, Drug Improvement, and Modernization Act (MMA). The MMA maintained the current cap on the total number of resident slots funded; however, it provided an opportunity for some hospitals to increase their number of slots by redistributing existing slots not being used by other hospitals. Some policy analysts consider this redistribution of resident caps to be the most significant change in Medicare GME financing since the BBA. The policy change will cause a shift in GME funding across institutions across the country. While the redistribution of resident caps has implications for institutions, it is also important to consider the impact at the state level.

Section 4: Provider Impacts

History of Medicare Financing of GME

As Medicare moved to the prospective payment system (PPS) in 1983, a distinction was drawn between direct payments (DME) and indirect payments (IME). DME is intended to cover costs of teaching, including the salaries and fringe benefits of residents, interns, and faculty and overhead costs and is based on reported costs in 1984 or 1985, adjusting for inflation for each subsequent year. DME payments to hospitals are calculated using the number of resident full-time equivalents (FTEs), the proportion of inpatient days used by Medicare beneficiaries, and a predetermined, hospital-specific amount for salaries, fringe benefits and teaching costs. IME was introduced to cover the increased costs of caring for patients in a teaching hospital setting—that is, to account for the fact that patients in teaching facilities are generally more complex and new residents are less efficient than already trained physicians. IME payments are added on to the Diagnosis Related Group (DRG) charge for each discharge and are calculated based on the ratio of residents and interns to patient beds and a multiplier set by Congress.

The resident limit for a teaching hospital may be different for DME and IME. For example, a resident that is working in ambulatory care is often not included in the intern/resident to bed ratio because they are not working in an inpatient setting (for which DRGs are paid). The resident may be counted in the number of residents for the DME calculation in order for the provider to receive Medicare funding for their resident salary.

Congress has revisited Medicare payments to GME multiple times in an effort to restrain the growth in Medicare spending. Reductions in the IME multiplier (from the original 11.4%) occurred in 1986, 1987, and 1997, the last of which was slated to take place over a period of five years. The IME multiplier was then frozen at 6.5% in 1999 and remained at that level until the MMA of 2003, which authorized further decreases in the multiplier after a short period of increase. The other method of controlling GME payments was to institute a cap on the total number of residents funded at each teaching institution under the BBA. As mentioned above, this cap was revisited under the MMA, and, as a result, resident slots were redistributed in June 2005.

Section 4: Provider Impacts

State Impacts of the Redistribution of GME Resident Caps in the MMA

There is variation among states (and even among institutions within the same state) in the amount of Medicare GME dollars received. Factors that contribute to this variation: number of teaching programs (and number of residents), proportion of Medicare beneficiaries living in an area, and the amount paid to the hospital for salary, fringe benefits, and teaching costs per resident. Also, the variation in the amount Medicare pays for hospital procedures affects the indirect payments. The number of teaching programs in each state and the size of those programs varies as well, and this has important implications for the amount of GME funding that each state receives.

The specifics of the resident redistribution program in the MMA determine the impact on states. While the total number of residents allotted by Medicare remains unchanged from the level set in 1997, the MMA has reallocated resident slots on the basis of use—those hospitals which had been training fewer residents than their cap are seeing a reduction in their number of resident slots reimbursed. Exceptions to this reduction are:

1. Rural hospitals with fewer than 250 beds, and
2. Teaching hospitals that had participated in the Voluntary Resident Reduction Program (as allowed by the BBA or CMS's New York demonstration project).

The “extra” slots are now redistributed to hospitals seeking to expand their residency programs up to 25 FTEs per hospital. Hospitals were expected to show that the slots would be filled by providing information on their success in filling residency positions in the past. The Centers for Medicare and Medicaid Services (CMS) determined which hospitals would receive the slots using the following order of priority:

1. Rural hospitals defined by Metropolitan Statistical Area status (no urban center with more than 50,000 population),
2. Small urban hospitals (hospitals in an urban area with less than one million population), and
3. Large urban hospitals.

Section 4: Provider Impacts

Within each category, hospitals requesting slots for a program which is the only specialty of its kind in the state were prioritized over others. There were enough slots available for redistribution so that slots were distributed to large urban hospitals, but there also were hospitals that did not receive the slots that they requested.

Redistributed resident slots have non-institution specific payments attached to them—this differs from the payment for slots existing before the reallocation. DME payments are based on a locally adjusted national average, and all IME payments have an add-on of 2.7%.

The redistributive nature of the resident cap program creates winners and losers. If a hospital loses resident slots, it does not lose funding directly, as it is only losing resident slots it is not using; however, the hospital does lose the opportunity to expand its existing programs or create new programs. If a hospital gains slots, it gains the potential to add residents and therefore additional Medicare GME funding. The likelihood of losing slots depends upon the likelihood of an institution not using all of the slots and whether or not the institution meets the exclusion criteria above. The likelihood of gaining slots depends upon need, ability to prove need, and where the institution fell on the priority list. Some general conclusions can be drawn:

- Rural hospitals and small urban hospitals which are operating at or above their resident limit had the potential to benefit from this legislation.
- Small rural hospitals were protected from losing resident slots and were prioritized for redistribution of extra slots if they could prove need; however, they may be less likely to have a need for more resident slots.
- Hospitals in small urban areas operating at or above their caps did not lose resident slots and were prioritized to receive redistributed slots; however, they were not protected from losing slots if they were operating below their 1997 cap.
- Large, urban hospitals were not protected from losing caps nor prioritized for receiving redistributed caps. This contributed to a net loss for some large hospitals; however, some large hospitals with thriving residency programs also have more ability to expand their programs above the 1997 cap and were therefore able to make successful bids for the redistributed slots.

At the state level, the impact is determined by the number of teaching hospitals in the state, the proportion of those which are located in rural or small urban areas, and the ability to compete for residency cap slots. The relative impact of the loss or gain in resident slots is less for states that train a large number of residents and have a large number of teaching hospitals. However, states that have trained few residents historically could face a large impact from a relatively small gain or loss.

Section 4: Provider Impacts

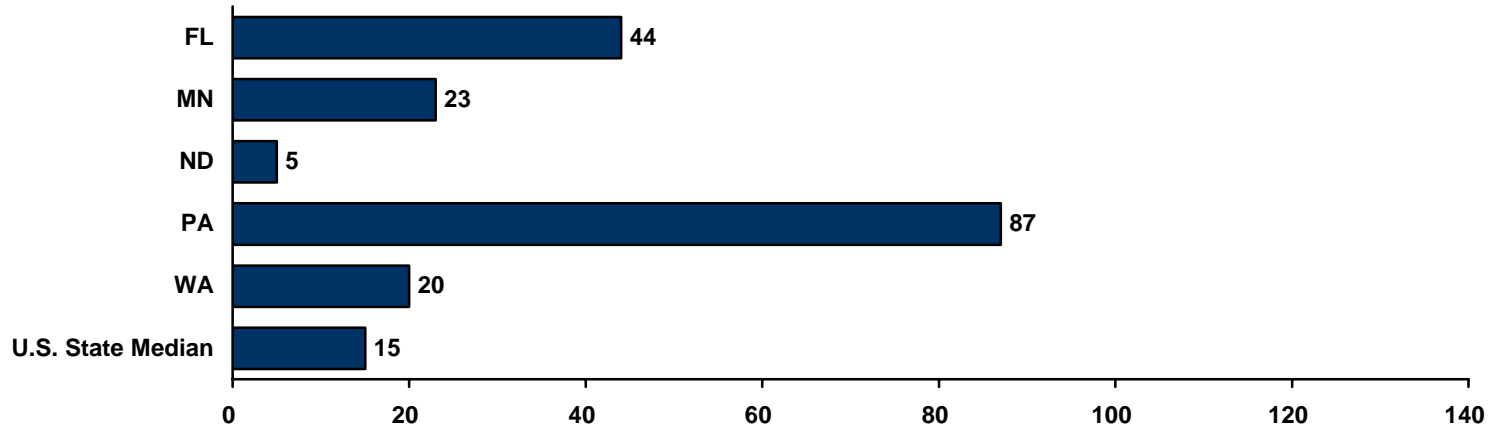
It is important to note that Medicare is not the only financing mechanism for graduate medical education. The effects of the variation of Medicare GME payments on total graduate medical education dollars in each state are mediated by state policies regarding graduate medical education, including trust fund arrangements, Medicaid GME payments, and the ability of institutions to capitalize on other forms of support, such as other third-party payers. This report focuses on the variation in Medicare GME payments and the impact of the MMA on this variation, keeping in mind that these changes may force a change in the landscape of GME funding in different states.

Below we present a cross-state comparison of background data regarding Medicare's GME payments to each of our five pilot states, including the number of teaching hospitals and residents trained in each state prior to the redistribution. We then present the amount of Medicare GME funding that each state received in 2002, prior to the redistribution of resident slots. Finally, we show how each of the five pilot states are affected following the redistribution of Medicare GME resident caps.

Provider Impacts: Redistribution of Graduate Medical Education Resident Caps

Teaching Hospitals in States

Figure 4-1. Number of Teaching Hospitals Receiving Medicare Graduate Medical Education Payments in Each State, 2002



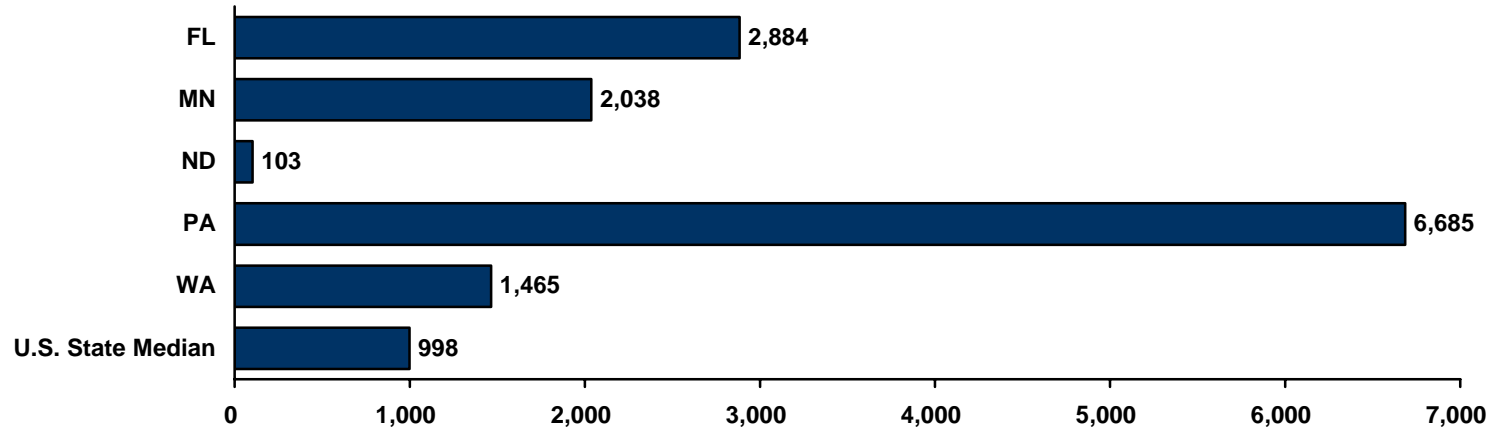
Source: SHADAC analysis of Medicare Hospital Cost Reports extract, CMS, 2002
See Technical Report for more information on data sources and calculations.

- There is substantial variation in the number of teaching hospitals in each state. In 2002, Pennsylvania had almost four times the national state median of 15 hospitals, while North Dakota had only a third. Florida, Minnesota, and Washington also had a relatively high number of teaching hospitals.
- To qualify for Medicare GME funding, a provider must have an approved residency program. The distribution of teaching hospitals across states was not formally planned but grew out of a number of factors: population, hospital volume, and the culture of the hospital tending towards teaching.

Provider Impacts: Redistribution of Graduate Medical Education Resident Caps

States' Medical Resident Populations

Figure 4-2. Number of Resident Physicians in Accredited Residency Programs in Each State Prior to Redistribution, 2003



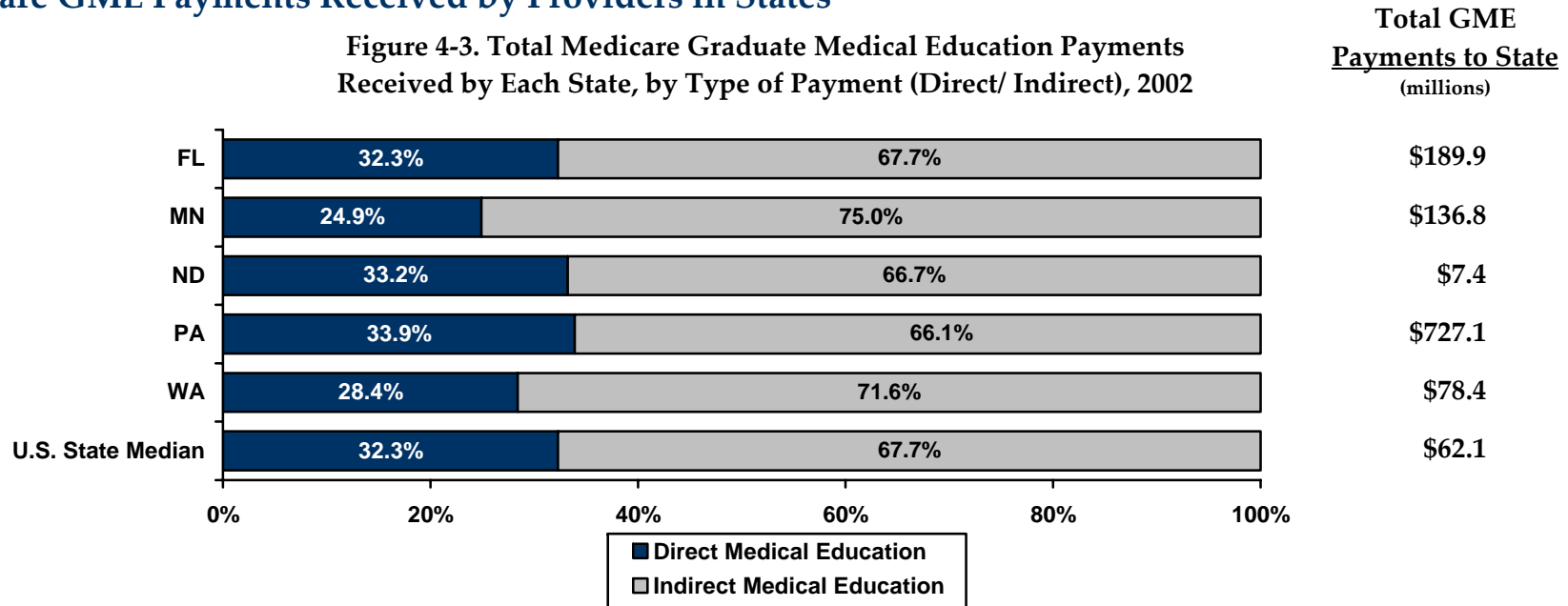
Source: Data from the National GME Census, 2003, presented in JAMA 2004.
See Technical Report for more information on data sources and calculations.

- Medicare GME funding is tied to the number of residents directly and indirectly. The amount of GME funding provided to hospitals in each state is impacted by the number of residents trained in that state.
- There is significant variation in the number of resident physicians in each state prior to the redistribution, and the redistribution of resident slots does not attempt to reduce the variation among states. The variation in residents is a reflection of the number of teaching hospitals, the number of residency programs, and, to a lesser extent, the size of the population in each state.
- The state median is just under 1,000 resident physicians. Among the five states highlighted in this project, Pennsylvania stands out with over 6,600 residents trained in 2003, while North Dakota only trained 103.
- Expressed differently, Pennsylvania had 54 residents per 100,000 population in 2003, while North Dakota had 16 residents per 100,000 population. Florida, Minnesota, and Washington had 17, 40 and 24 residents per 100,000 population, respectively. (Data not shown in figure)

Provider Impacts: Redistribution of Graduate Medical Education Resident Caps

Medicare GME Payments Received by Providers in States

Figure 4-3. Total Medicare Graduate Medical Education Payments Received by Each State, by Type of Payment (Direct/ Indirect), 2002



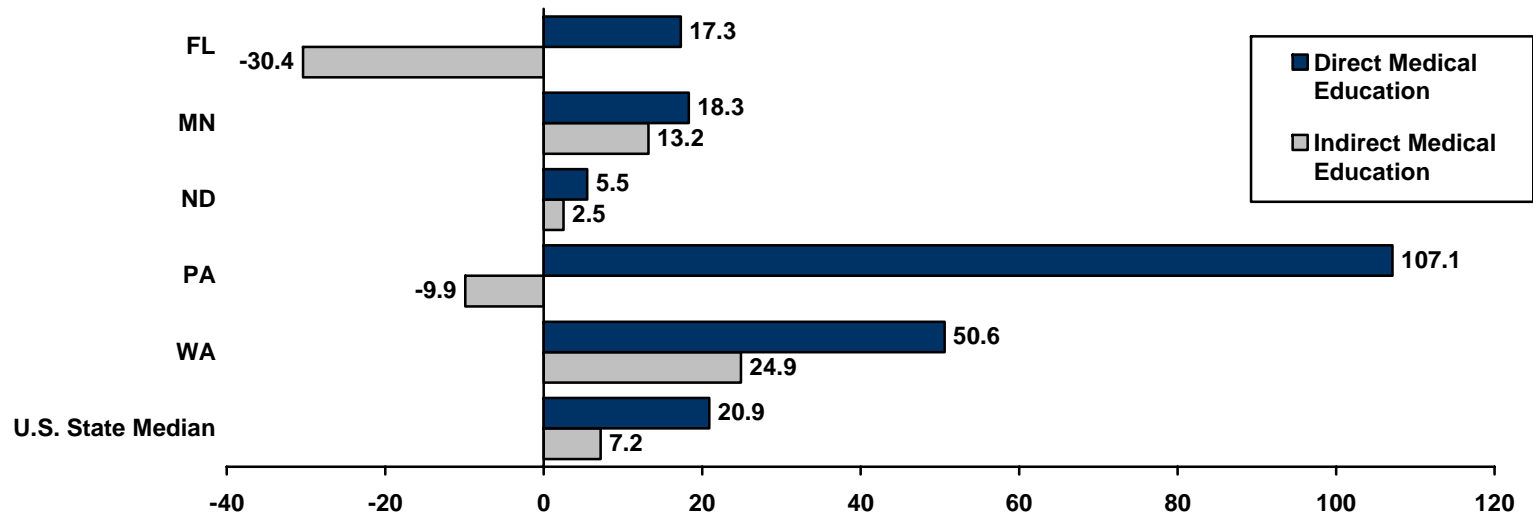
Source: SHADAC analysis of Medicare Hospital Cost Reports extract, CMS, 2002
See Technical Report for more information on data sources and calculations.

- Medicare GME funding varies by state for multiple reasons. The number of residents in each state is the most important contributor; however, this does not explain all of the variation. There also is substantial variation in the amount of DME paid per resident, which is based on costs reported in the 1980s and adjusted for inflation as well as variation in the number of Medicare beneficiaries served in a state. The median level of GME payments per state was \$62.1 million. Not surprisingly, of our five pilot states, Pennsylvania received the highest amount in GME payments (\$727.1 million), and North Dakota hospitals received the lowest (\$7.4 million). Payments received by hospitals in Florida and Minnesota also noticeably exceeded the state median.
- The composition of IME and DME in each state is roughly one-third DME and two-thirds IME. Among the five states highlighted in this report, Minnesota and Washington are different, both with greater proportions of IME, which may reflect the relatively lower proportions of Medicare beneficiaries in both states.
- Resident caps have the potential to increase funding in states that receive resident slots. There should be no reduction in funding in states that lose resident slots, as they only lost unused resident slots.

Provider Impacts: Redistribution of Graduate Medical Education Resident Caps

Overall Change in Resident Slots in States

Figure 4-4. Net Gain/Loss in Number of Full-Time Equivalent Resident Slots in Each State, 2005



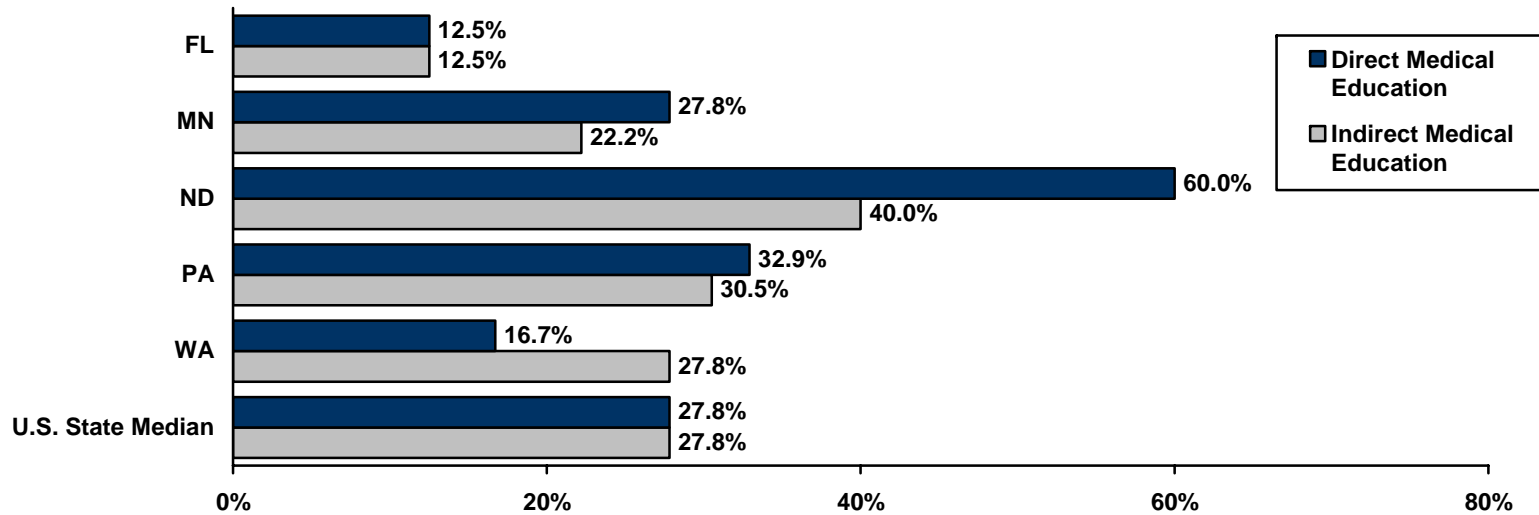
Source: SHADAC analysis of cap increase and reduction determinations by CMS, 2005
See Technical Report for more information on data sources and calculations.

- Overall, most states (34) have experienced a net gain in resident slots with the new redistribution of GME resident caps. It appears that states with large numbers of residency training programs (e.g., California and New York) lost many slots that were then reallocated to other states. The intent of the redistribution was to give resident slots to providers that had plans to use them.
- Among the five states in this report, Florida and Pennsylvania were the only states to have a net reduction in their overall number of IME resident slots, and none of the five states saw a net reduction in their number of DME slots. The reduction in IME slots could be related to an increase in residents in ambulatory care programs in Pennsylvania and Florida, resulting in IME slots that were not being used.
- While rural hospitals were prioritized, providers in North Dakota, a mostly rural state, had less need or could prove less demand for new resident slots. Pennsylvania, on the other hand, with many teaching programs and hospitals in large urban areas, received a significant number of additional slots.

Provider Impacts: Redistribution of Graduate Medical Education Resident Caps

Overall Gain in Resident Slots in States

Figure 4-5. Percent of Teaching Hospitals with Gain of Full-Time Equivalent Resident Slots in Each State, 2005



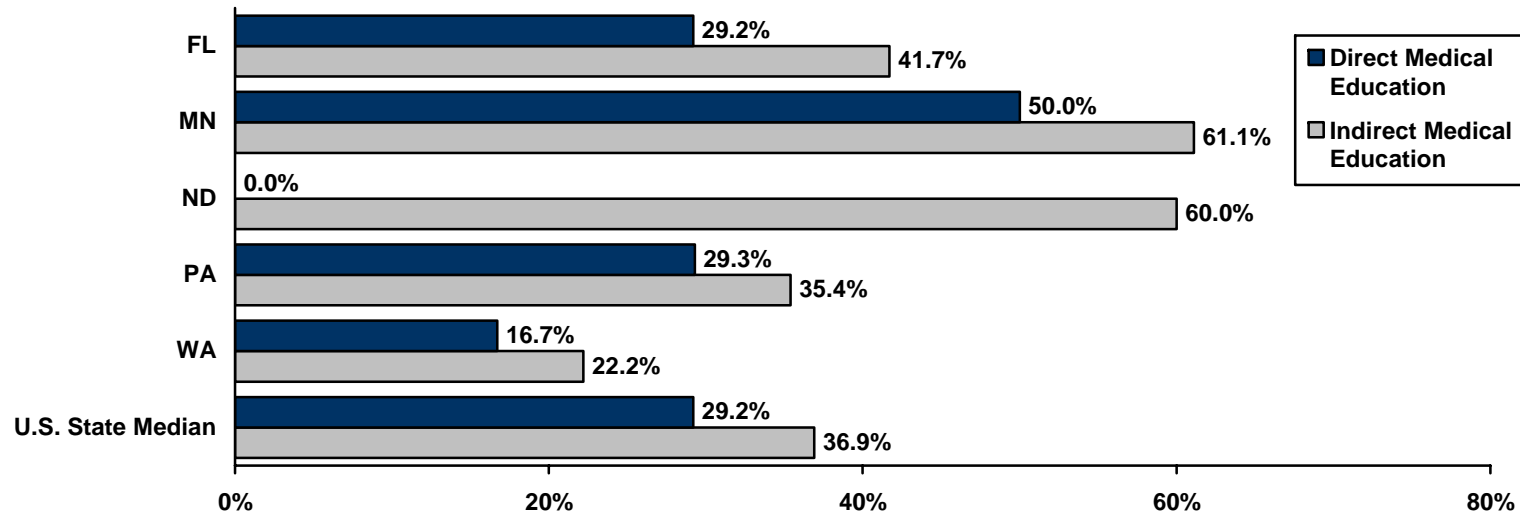
Source: SHADAC analysis of cap increase and reduction determinations by CMS, 2005
See Technical Report for more information on data sources and calculations.

- Teaching hospitals could gain resident slots if they could demonstrate that the slots would be used. Rural hospitals had highest priority for new resident slots, with hospitals in small urban areas prioritized next. Hospitals with the only residency program of its kind in the state also were prioritized.
- 60% of North Dakota hospitals (3 hospitals) gained DME resident slots, and 40% (2 hospitals) gained IME slots. Pennsylvania was the only other state to be above the state median in the percent of hospitals gaining residents slots. Florida, Minnesota, and Washington were all at or below the median, with Florida falling well below the median. Teaching hospitals with a net gain in resident slots obtain the ability to qualify for more Medicare GME funding as they train more residents.

Provider Impacts: Redistribution of Graduate Medical Education Resident Caps

Overall Loss in Resident Slots in States

Figure 4-6. Percent of Teaching Hospitals with Loss in Number of Full-Time Equivalent Resident Slots in Each State, 2005



Source: SHADAC analysis of cap increase and reduction determinations by CMS, 2005
See Technical Report for more information on data sources and calculations.

- Teaching hospitals stood to lose resident slots if in 2003 they were not using the full number of resident FTEs allotted to them when the caps first went into effect in 1997. Hospitals protected from losing slots were small rural hospitals and hospitals that had voluntarily redistributed their resident slots. Hospitals did not lose all of their unused spots; they lost 75% of the difference between the caps allotted to them and the number of residents trained at their hospital.
- Teaching hospitals with a net loss in resident slots lose the ability to expand their residency program. These hospitals will not experience a decrease in GME funding, as they were not receiving funding for the unused slots; however, they will not receive Medicare funding if they choose to expand their residency programs.
- On average, 29.2% of teaching hospitals in a state have lost some of their DME resident slots and 36.9% have lost some of their IME resident slots. Relative to the U.S. state median, fewer hospitals in Washington have lost both DME and IME resident slots yet more hospitals in Minnesota have lost both DME and IME slots. North Dakota is the only state among our five pilot states to have lost no DME resident slots, but similar to hospitals in Minnesota, 60% of the hospitals in North Dakota have lost IME resident slots.

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Appendix A

Section 1: State Impact Tables

Transition of Dual Eligible Prescription Drug Coverage

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Transition of Dual Eligible Prescription Drug Coverage

State Profile: Florida

	Florida	U.S. State Median
State Full Dual Eligible Population		
Total # of Full Dual Eligibles, 2003	380,000	81,000
% of Full Dual Eligibles Enrolled in Managed Care, 2003	7.0%	0.0%
Full Dual Eligibles as an Estimated % of State Medicare Beneficiaries, 2003	13.0%	13.0%
Full Dual Eligibles as an Estimated % of State Medicaid Beneficiaries, 2003	13.9%	12.6%
% of U.S. Medicare Population in State, July 2003	7.3%	1.3%
% of U.S. Medicaid Population in State, FY 2003	5.3%	1.3%
% of U.S. Full Dual Eligible Population in State, 2003	6.1%	1.3%
Estimated % of All Dual Eligible Medicaid Spending in State on Prescription Drugs for Full Dual Eligibles, 2003	19.3%	12.6%
Impact on State Full Dual Eligible Prescription Drug Spending		
Total Annual Medicaid Full Dual Eligible Drug Spending, 2003 (millions)	\$345.6	\$50.0
Estimated Average % Change in Annual Per Capita Overall Medicaid Drug Spending, FY 1999-2003	14.9%	11.1%
Estimated Annual Full Dual Eligible Drug Spending under Medicaid, 2006 (millions)	\$651.3	\$91.9
Estimated State Annual "Clawback" Payment to Federal Government, 2006 (millions)	\$433.6	\$65.8
State Annual "Clawback" Payment as % of Estimated Annual Full Dual Eligible Spending under Medicaid, 2006	66.6%	71.7%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: Florida, continued

	Florida	U.S. State Median
Reduction in Federal Medicaid Funding Received by State		
Federal Medical Assistance Percentage (FMAP), 2003	61.1%	62.5%
Federal Medicaid Full Dual Eligible Drug Spending in State, 2003 (millions)	\$542.1	\$91.1
Federal Medicaid Full Dual Eligible Drug Spending per Dual Eligible in State, 2003	\$136	\$127
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Spending in State, 2003	13.9%	8.6%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Dual Eligible Spending in State, 2003	31.7%	19.5%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Combined Federal/State Total Medicaid Spending in State, 2003	8.2%	5.2%

Reduction in State Medicaid Prescription Drug Purchasing Power

# of Potential Medicaid Drug Consumers (Total Medicaid Enrollment), FY 2003	2,743,368	702,064
# of Drugs Used per Medicaid Beneficiary, 1999	1.6	1.6
# of Drugs Used per Medicaid Dual Eligible Beneficiary, 1999	3.4	3.8
Reduction in # of Medicaid Drug Consumers (Full Dual Eligibles), 2003	380,000	81,000
Estimated Reduction in # of Medicaid Drugs Purchased, 2003	1,292,000	307,800
Estimated % Reduction in # of Potential Medicaid Drug Consumers, 2003	13.9%	11.0%
Estimated % Reduction in # of Medicaid Drugs Purchased, 2003	29.4%	26.2%

See Technical Report for information on data sources and calculation.

Transition of Dual-Eligible Prescription Drug Coverage

State Profile: Minnesota

	Minnesota	U.S. State Median
State Full Dual Eligible Population		
Total # of Full Dual Eligibles, 2003	97,000	81,000
% of Full Dual Eligibles Enrolled in Managed Care, 2003	40.3%	0.0%
Full Dual Eligibles as an Estimated % of State Medicare Beneficiaries, 2003	14.3%	13.0%
Full Dual Eligibles as an Estimated % of State Medicaid Beneficiaries, 2003	14.5%	12.6%
% of U.S. Medicare Population in State, July 2003	1.7%	1.3%
% of U.S. Medicaid Population in State, FY 2003	1.3%	1.3%
% of U.S. Full Dual Eligible Population in State, 2003	1.6%	1.3%
Estimated % of All Dual Eligible Medicaid Spending in State on Prescription Drugs for Full Dual Eligibles, 2003	8.8%	12.6%
Impact on State Full Dual Eligible Prescription Drug Spending		
Total Annual Medicaid Full Dual Eligible Drug Spending, 2003 (millions)	\$111.6	\$50.0
Estimated Average % Change in Annual Per Capita Overall Medicaid Drug Spending, FY 1999-2003	11.4%	11.1%
Estimated Annual Full Dual Eligible Drug Spending under Medicaid, 2006 (millions)	\$135.8	\$91.9
Estimated State Annual "Clawback" Payment to Federal Government, 2006 (millions)	\$99.1	\$65.8
State Annual "Clawback" Payment as % of Estimated Annual Full Dual Eligible Spending under Medicaid, 2006	73.0%	71.7%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: Minnesota, continued

	Minnesota	U.S. State Median
Reduction in Federal Medicaid Funding Received by State		
Federal Medical Assistance Percentage (FMAP), 2003	52.2%	62.5%
Federal Medicaid Full Dual Eligible Drug Spending in State, 2003 (millions)	\$121.9	\$91.1
Federal Medicaid Full Dual Eligible Drug Spending per Dual Eligible in State, 2003	\$110	\$127
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Spending in State, 2003	9.4%	8.6%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Dual Eligible Spending in State, 2003	16.9%	19.5%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Combined Federal/State Total Medicaid Spending in State, 2003	4.9%	5.2%
Reduction in State Medicaid Prescription Drug Purchasing Power		
# of Potential Medicaid Drug Consumers (Total Medicaid Enrollment), FY 2003	667,500	702,064
# of Drugs Used per Medicaid Beneficiary, 1999	1.8	1.6
# of Drugs Used per Medicaid Dual Eligible Beneficiary, 1999	3.7	3.8
Reduction in # of Medicaid Drug Consumers (Full Dual Eligibles), 2003	97,000	81,000
Estimated Reduction in # of Medicaid Drugs Purchased, 2003	358,900	307,800
Estimated % Reduction in # of Potential Medicaid Drug Consumers, 2003	14.5%	11.0%
Estimated % Reduction in # of Medicaid Drugs Purchased, 2003	22.6%	26.2%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: North Dakota

	North Dakota	U.S. State Median
State Full Dual Eligible Population		
Total # of Full Dual Eligibles, 2003	13,000	81,000
% of Full Dual Eligibles Enrolled in Managed Care, 2003	0.0%	0.0%
Full Dual Eligibles as an Estimated % of State Medicare Beneficiaries, 2003	12.6%	13.0%
Full Dual Eligibles as an Estimated % of State Medicaid Beneficiaries, 2003	16.9%	12.6%
% of U.S. Medicare Population in State, July 2003	0.3%	1.3%
% of U.S. Medicaid Population in State, FY 2003	0.1%	1.3%
% of U.S. Full Dual Eligible Population in State, 2003	0.2%	1.3%
Estimated % of All Dual Eligible Medicaid Spending in State on Prescription Drugs for Full Dual Eligibles, 2003	8.1%	12.6%
Impact on State Full Dual Eligible Prescription Drug Spending		
Total Annual Medicaid Full Dual Eligible Drug Spending, 2003 (millions)	\$7.1	\$50.0
Estimated Average % Change in Annual Per Capita Overall Medicaid Drug Spending, FY 1999-2003	9.8%	11.1%
Estimated Annual Full Dual Eligible Drug Spending under Medicaid, 2006 (millions)	\$6.5	\$91.9
Estimated State Annual "Clawback" Payment to Federal Government, 2006 (millions)	\$4.9	\$65.8
State Annual "Clawback" Payment as % of Estimated Annual Full Dual Eligible Spending under Medicaid, 2006	76.4%	71.7%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: North Dakota, continued

	North Dakota	U.S. State Median
Reduction in Federal Medicaid Funding Received by State		
Federal Medical Assistance Percentage (FMAP), 2003	71.3%	62.5%
Federal Medicaid Full Dual Eligible Drug Spending in State, 2003 (millions)	\$17.7	\$91.1
Federal Medicaid Full Dual Eligible Drug Spending per Dual Eligible in State, 2003	\$131	\$127
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Spending in State, 2003	7.4%	8.6%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Dual Eligible Spending in State, 2003	11.4%	19.5%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Combined Federal/State Total Medicaid Spending in State, 2003	5.2%	5.2%
Reduction in State Medicaid Prescription Drug Purchasing Power		
# of Potential Medicaid Drug Consumers (Total Medicaid Enrollment), FY 2003	76,754	702,064
# of Drugs Used per Medicaid Beneficiary, 1999	1.6	1.6
# of Drugs Used per Medicaid Dual Eligible Beneficiary, 1999	4	3.8
Reduction in # of Medicaid Drug Consumers (Full Dual Eligibles), 2003	13,000	81,000
Estimated Reduction in # of Medicaid Drugs Purchased, 2003	52,000	307,800
Estimated % Reduction in # of Potential Medicaid Drug Consumers, 2003	16.9%	11.0%
Estimated % Reduction in # of Medicaid Drugs Purchased, 2003	42.3%	26.2%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: Pennsylvania

	Pennsylvania	U.S. State Median
State Full Dual Eligible Population		
Total # of Full Dual Eligibles, 2003	278,000	81,000
% of Full Dual Eligibles Enrolled in Managed Care, 2003	52.3%	0.0%
Full Dual Eligibles as an Estimated % of State Medicare Beneficiaries, 2003	13.2%	13.0%
Full Dual Eligibles as an Estimated % of State Medicaid Beneficiaries, 2003	16.1%	12.6%
% of U.S. Medicare Population in State, July 2003	5.3%	1.3%
% of U.S. Medicaid Population in State, FY 2003	3.3%	1.3%
% of U.S. Full Dual Eligible Population in State, 2003	4.5%	1.3%
Estimated % of All Dual Eligible Medicaid Spending in State on Prescription Drugs for Full Dual Eligibles, 2003	14.3%	12.6%
Impact on State Full Dual Eligible Prescription Drug Spending		
Total Annual Medicaid Full Dual Eligible Drug Spending, 2003 (millions)	\$294.0	\$50.0
Estimated Average % Change in Annual Per Capita Overall Medicaid Drug Spending, FY 1999-2003	4.2%	11.1%
Estimated Annual Full Dual Eligible Drug Spending under Medicaid, 2006 (millions)	\$403.7	\$91.9
Estimated State Annual "Clawback" Payment to Federal Government, 2006 (millions)	\$361.1	\$65.8
State Annual "Clawback" Payment as % of Estimated Annual Full Dual Eligible Spending under Medicaid, 2006	89.4%	71.7%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: Pennsylvania, continued

	Pennsylvania	U.S. State Median
Reduction in Federal Medicaid Funding Received by State		
Federal Medical Assistance Percentage (FMAP), 2003	56.9%	62.5%
Federal Medicaid Full Dual Eligible Drug Spending in State, 2003 (millions)	\$388.5	\$91.1
Federal Medicaid Full Dual Eligible Drug Spending per Dual Eligible in State, 2003	\$128	\$127
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Spending in State, 2003	9.2%	8.6%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Dual Eligible Spending in State, 2003	25.1%	19.5%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Combined Federal/State Total Medicaid Spending in State, 2003	5.0%	5.2%
Reduction in State Medicaid Prescription Drug Purchasing Power		
# of Potential Medicaid Drug Consumers (Total Medicaid Enrollment), FY 2003	1,721,707	702,064
# of Drugs Used per Medicaid Beneficiary, 1999	1.5	1.6
# of Drugs Used per Medicaid Dual Eligible Beneficiary, 1999	3.9	3.8
Reduction in # of Medicaid Drug Consumers (Full Dual Eligibles), 2003	278,000	81,000
Estimated Reduction in # of Medicaid Drugs Purchased, 2003	1,084,200	307,800
Estimated % Reduction in # of Potential Medicaid Drug Consumers, 2003	16.1%	11.0%
Estimated % Reduction in # of Medicaid Drugs Purchased, 2003	42.0%	26.2%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: Washington

	Washington	U.S. State Median
State Full Dual Eligible Population		
Total # of Full Dual Eligibles, 2003	100,000	81,000
% of Full Dual Eligibles Enrolled in Managed Care, 2003	0.2%	0.0%
Full Dual Eligibles as an Estimated % of State Medicare Beneficiaries, 2003	12.9%	13.0%
Full Dual Eligibles as an Estimated % of State Medicaid Beneficiaries, 2003	9.3%	12.6%
% of U.S. Medicare Population in State, July 2003	1.9%	1.3%
% of U.S. Medicaid Population in State, FY 2003	2.1%	1.3%
% of U.S. Full Dual Eligible Population in State, 2003	1.6%	1.3%
Estimated % of All Dual Eligible Medicaid Spending in State on Prescription Drugs for Full Dual Eligibles, 2003	19.7%	12.6%
Impact on State Full Dual Eligible Prescription Drug Spending		
Total Annual Medicaid Full Dual Eligible Drug Spending, 2003 (millions)	\$104.4	\$50.0
Estimated Average % Change in Annual Per Capita Overall Medicaid Drug Spending, FY 1999-2003	12.3%	11.1%
Estimated Annual Full Dual Eligible Drug Spending under Medicaid, 2006 (millions)	\$184.0	\$91.9
Estimated State Annual "Clawback" Payment to Federal Government, 2006 (millions)	\$131.3	\$65.8
State Annual "Clawback" Payment as % of Estimated Annual Full Dual Eligible Spending under Medicaid, 2006	71.3%	71.7%

See Technical Report for information on data sources and calculation.

Transition of Dual Eligible Prescription Drug Coverage

State Profile: Washington, continued

	Washington	U.S. State Median
Reduction in Federal Medicaid Funding Received by State		
Federal Medical Assistance Percentage (FMAP), 2003	52.4%	62.5%
Federal Medicaid Full Dual Eligible Drug Spending in State, 2003 (millions)	\$114.9	\$91.1
Federal Medicaid Full Dual Eligible Drug Spending per Dual Eligible in State, 2003	\$109	\$127
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Spending in State, 2003	7.6%	8.6%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Federal Total Medicaid Dual Eligible Spending in State, 2003	37.7%	19.5%
Federal Medicaid Full Dual Eligible Drug Spending as Estimated % of Combined Federal/State Total Medicaid Spending in State, 2003	3.9%	5.2%
Reduction in State Medicaid Prescription Drug Purchasing Power		
# of Potential Medicaid Drug Consumers (Total Medicaid Enrollment), FY 2003	1,077,070	702,064
# of Drugs Used per Medicaid Beneficiary, 1999	1.8	1.6
# of Drugs Used per Medicaid Dual Eligible Beneficiary, 1999	3.8	3.8
Reduction in # of Medicaid Drug Consumers (Full Dual Eligibles), 2003	100,000	81,000
Estimated Reduction in # of Medicaid Drugs Purchased, 2003	380,000	307,800
Estimated % Reduction in # of Potential Medicaid Drug Consumers, 2003	9.3%	11.0%
Estimated % Reduction in # of Medicaid Drugs Purchased, 2003	19.6%	26.2%

See Technical Report for information on data sources and calculation.

Section 2: Beneficiary Impact Tables

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High-Income Means Testing of Part B Premiums

State Profile: Florida

		Florida	U.S. State Median
Beneficiaries Affected: 65+ Population Estimates, 2002-2004			
Above High-Income Means Test Threshold (increase in premium share)	Number	116,444	12,745
	Percent	4.2%	2.9%
Below High-Income Means Test Threshold (no change in premium share)	Number	2,601,427	421,369
	Percent	95.8%	97.1%
Beneficiaries Affected: 65+ Population Estimates by Age, 2002-2004			
65-74 years	% above High-Income Means Test Threshold	4.8%	3.4%
	% below High-Income Means Test Threshold	95.2%	96.6%
75+ years	% above High-Income Means Test Threshold	3.5%	2.4%
	% below High-Income Means Test Threshold	96.5%	97.6%
Beneficiaries Affected: 65+ Population Estimates by Employment Status, 2002-2004			
Employed	% above High-Income Means Test Threshold	7.7%	7.5%
	% below High-Income Means Test Threshold	92.3%	92.5%
Not Employed	% above High-Income Means Test Threshold	3.7%	2.1%
	% below High-Income Means Test Threshold	96.3%	97.9%

See Technical Report for information on data sources and calculation.

High-Income Means Testing of Part B Premiums

State Profile: Minnesota

		Minnesota	U.S. State Median
Beneficiaries Affected: 65+ Population Estimates, 2002-2004			
Above High-Income Means Test Threshold (increase in premium share)	Number	15,832	12,745
	Percent	2.8%	2.9%
Below High-Income Means Test Threshold (no change in premium share)	Number	539,822	421,369
	Percent	97.2%	97.1%
Beneficiaries Affected: 65+ Population Estimates by Age, 2002-2004			
65-74 years	% above High-Income Means Test Threshold	3.5%	3.4%
	% below High-Income Means Test Threshold	96.5%	96.6%
75+ years	% above High-Income Means Test Threshold	2.1%	2.4%
	% below High-Income Means Test Threshold	97.9%	97.6%
Beneficiaries Affected: 65+ Population Estimates by Employment Status, 2002-2004			
Employed	% above High-Income Means Test Threshold	5.3%	7.5%
	% below High-Income Means Test Threshold	94.7%	92.5%
Not Employed	% above High-Income Means Test Threshold	2.4%	2.1%
	% below High-Income Means Test Threshold	97.6%	97.9%

See Technical Report for information on data sources and calculation.

High-Income Means Testing of Part B Premiums

State Profile: North Dakota

		North Dakota	U.S. State Median
Beneficiaries Affected: 65+ Population Estimates, 2002-2004			
Above High-Income Means Test Threshold (increase in premium share)	Number	1,368	12,745
	Percent	1.6%	2.9%
Below High-Income Means Test Threshold (no change in premium share)	Number	83,921	421,369
	Percent	98.4%	97.1%
Beneficiaries Affected: 65+ Population Estimates by Age, 2002-2004			
65-74 years	% above High-Income Means Test Threshold	2.6%	3.4%
	% below High-Income Means Test Threshold	97.4%	96.6%
75+ years	% above High-Income Means Test Threshold	0.5%	2.4%
	% below High-Income Means Test Threshold	99.5%	97.6%
Beneficiaries Affected: 65+ Population Estimates by Employment Status, 2002-2004			
Employed	% above High-Income Means Test Threshold	5.8%	7.5%
	% below High-Income Means Test Threshold	94.2%	92.5%
Not Employed	% above High-Income Means Test Threshold	0.8%	2.1%
	% below High-Income Means Test Threshold	99.2%	97.9%

See Technical Report for information on data sources and calculation.

High-Income Means Testing of Part B Premiums

State Profile: Pennsylvania

		Pennsylvania	U.S. State Median
Beneficiaries Affected: 65+ Population Estimates, 2002-2004			
Above High-Income Means Test Threshold (increase in premium share)	Number	40,485	12,745
	Percent	2.3%	2.9%
Below High-Income Means Test Threshold (no change in premium share)	Number	1,733,806	421,369
	Percent	97.7%	97.1%
Beneficiaries Affected: 65+ Population Estimates by Age, 2002-2004			
65-74 years	% above High-Income Means Test Threshold	2.7%	3.4%
	% below High-Income Means Test Threshold	97.3%	96.6%
75+ years	% above High-Income Means Test Threshold	1.9%	2.4%
	% below High-Income Means Test Threshold	98.1%	97.6%
Beneficiaries Affected: 65+ Population Estimates by Employment Status, 2002-2004			
Employed	% above High-Income Means Test Threshold	7.3%	7.5%
	% below High-Income Means Test Threshold	92.7%	92.5%
Not Employed	% above High-Income Means Test Threshold	1.6%	2.1%
	% below High-Income Means Test Threshold	98.4%	97.9%

See Technical Report for information on data sources and calculation.

High-Income Means Testing of Part B Premiums

State Profile: Washington

		Washington	U.S. State Median
Beneficiaries Affected: 65+ Population Estimates, 2002-2004			
Above High-Income Means Test Threshold (increase in premium share)	Number	23,845	12,745
	Percent	3.6%	2.9%
Below High-Income Means Test Threshold (no change in premium share)	Number	619,227	421,369
	Percent	96.4%	97.1%
Beneficiaries Affected: 65+ Population Estimates by Age, 2002-2004			
65-74 years	% above High-Income Means Test Threshold	3.9%	3.4%
	% below High-Income Means Test Threshold	96.1%	96.6%
75+ years	% above High-Income Means Test Threshold	3.3%	2.4%
	% below High-Income Means Test Threshold	96.7%	97.6%
Beneficiaries Affected: 65+ Population Estimates by Employment Status, 2002-2004			
Employed	% above High-Income Means Test Threshold	9.0%	7.5%
	% below High-Income Means Test Threshold	91.0%	92.5%
Not Employed	% above High-Income Means Test Threshold	2.9%	2.1%
	% below High-Income Means Test Threshold	97.1%	97.9%

See Technical Report for information on data sources and calculation.

Section 3: Market Impact Tables

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Introduction of Regional Managed Care Plans

State Profile: Florida

	Florida	U.S. State Median
Overall Market Share of Medicare Fee-For-Service and Managed Care in State (third quarter 2004)		
% of Medicare Beneficiaries Enrolled in Fee-For-Service	81.2%	94.5%
% of Medicare Beneficiaries Enrolled in Managed Care (Medicare Advantage)	18.8%	5.5%
Composition of Medicare Advantage (MA) Enrollment in State (last quarter 2005)		
Total MA Enrollment	641,096	32,432
HMO Plans:		
# Enrolled	576,477	24,337
% of MA Enrollment	89.9%	65.6%
Local/Demonstration PPO Plans:		
# Enrolled	10,352	294
% of MA Enrollment	1.6%	2.2%
Cost Plans:		
# Enrolled	6,099	62
% of MA Enrollment	1.0%	1.0%
Private Fee-For-Service Plans:		
# Enrolled	1,063	1,621
% of MA Enrollment	0.2%	5.2%
Other MA Plans:		
# Enrolled	47,105	1,456
% of MA Enrollment	7.3%	3.0%
State's Medicare Advantage (MA) Regional Context		
# of States in MA Region, 2006	1	--
States in MA Region, 2006	FL	--
State's Share of Regional MA Enrollment, last quarter 2005		--
HMO Plans	100.0%	--
Local/Demonstration PPO Plans	100.0%	--
Other Plans	100.0%	--
All MA Plans	100.0%	--
# of Regional MA Plans Established, June 2006	4	--
Regional MA Plan Providers, June 2006	2	--
	Humana: 3 plans	--
	United: 1 plan	--

See Technical Report for information on data sources and calculation.

Introduction of Regional Managed Care Plans

State Profile: Minnesota

		Minnesota	U.S. State Median
Overall Market Share of Medicare Fee-For-Service and Managed Care in State (third quarter 2004)			
% of Medicare Beneficiaries Enrolled in Fee-For-Service		85.5%	94.5%
% of Medicare Beneficiaries Enrolled in Managed Care (Medicare Advantage)		14.5%	5.5%
Composition of Medicare Advantage (MA) Enrollment in State (last quarter 2005)			
Total MA Enrollment		130,858	32,432
HMO Plans:	# Enrolled	40,645	24,337
	% of MA Enrollment	31.1%	65.6%
Local/Demonstration PPO Plans:	# Enrolled	36	294
	% of MA Enrollment	0.0%	2.2%
Cost Plans:	# Enrolled	60,347	62
	% of MA Enrollment	46.1%	1.0%
Private Fee-For-Service Plans:	# Enrolled	21,118	1,621
	% of MA Enrollment	16.1%	5.2%
Other MA Plans:	# Enrolled	8,713	1,456
	% of MA Enrollment	6.7%	3.0%
State's Medicare Advantage (MA) Regional Context			
# of States in MA Region, 2006		7	--
States in MA Region, 2006		IA, MN, MT, NE, ND, SD, WY	--
State's Share of Regional MA Enrollment, last quarter 2005			--
HMO Plans		75.5%	--
Local/Demonstration PPO Plans		8.2%	--
Other Plans		78.7%	--
All MA Plans		73.4%	--
# of Regional MA Plans Established, June 2006		5	--
Regional MA Plan Providers, June 2006		1	--
		Blue Cross Blue Shield: 5 plans	--

See Technical Report for information on data sources and calculation.

Introduction of Regional Managed Care Plans

State Profile: North Dakota

		North Dakota	U.S. State Median
Overall Market Share of Medicare Fee-For-Service and Managed Care in State (third quarter 2004)			
% of Medicare Beneficiaries Enrolled in Fee-For-Service		99.0%	94.5%
% of Medicare Beneficiaries Enrolled in Managed Care (Medicare Advantage)		1.0%	5.5%
Composition of Medicare Advantage (MA) Enrollment in State (last quarter 2005)			
Total MA Enrollment		1,582	32,432
HMO Plans:	# Enrolled	92	24,337
	% of MA Enrollment	5.8%	65.6%
Local/Demonstration PPO Plans:	# Enrolled	0	294
	% of MA Enrollment	0.0%	2.2%
Cost Plans:	# Enrolled	826	62
	% of MA Enrollment	52.2%	1.0%
Private Fee-For-Service Plans:	# Enrolled	627	1,621
	% of MA Enrollment	39.6%	5.2%
Other MA Plans:	# Enrolled	37	1,456
	% of MA Enrollment	2.3%	3.0%
State's Medicare Advantage (MA) Regional Context			
# of States in MA Region, 2006		7	--
States in MA Region, 2006		IA, MN, MT, NE, ND, SD, WY	--
State's Share of Regional MA Enrollment, last quarter 2005			--
HMO Plans		0.2%	--
Local/Demonstration PPO Plans		0.0%	--
Other Plans		1.1%	--
All MA Plans		0.8%	--
# of Regional MA Plans Established, June 2006		5	--
Regional MA Plan Providers, June 2006		1	--
		Blue Cross Blue Shield: 5 plans	--

See Technical Report for information on data sources and calculation.

Introduction of Regional Managed Care Plans

State Profile: Pennsylvania

		Pennsylvania	U.S. State Median
Overall Market Share of Medicare Fee-For-Service and Managed Care in State (third quarter 2004)			
% of Medicare Beneficiaries Enrolled in Fee-For-Service		75.6%	94.5%
% of Medicare Beneficiaries Enrolled in Managed Care (Medicare Advantage)		24.4%	5.5%
Composition of Medicare Advantage (MA) Enrollment in State (last quarter 2005)			
Total MA Enrollment		547,633	32,432
HMO Plans:	# Enrolled	493,046	24,337
	% of MA Enrollment	90.0%	65.6%
Local/Demonstration PPO Plans:	# Enrolled	39,576	294
	% of MA Enrollment	7.2%	2.2%
Cost Plans:	# Enrolled	89	62
	% of MA Enrollment	0.0%	1.0%
Private Fee-For-Service Plans:	# Enrolled	4,012	1,621
	% of MA Enrollment	0.7%	5.2%
Other MA Plans:	# Enrolled	10,911	1,456
	% of MA Enrollment	2.0%	3.0%
State's Medicare Advantage (MA) Regional Context			
# of States in MA Region, 2006		2	--
States in MA Region, 2006		PA, WV	--
State's Share of Regional MA Enrollment, last quarter 2005			--
HMO Plans		99.2%	--
Local/Demonstration PPO Plans		99.7%	--
Other Plans		8.3%	--
All MA Plans		96.1%	--
# of Regional MA Plans Established, June 2006		3	--
Regional MA Plan Providers, June 2006		1	--
		Humana: 3 plans	--

See Technical Report for information on data sources and calculation.

Introduction of Regional Managed Care Plans

State Profile: Washington

		Washington	U.S. State Median
Overall Market Share of Medicare Fee-For-Service and Managed Care in State (third quarter 2004)			
% of Medicare Beneficiaries Enrolled in Fee-For-Service		84.1%	94.5%
% of Medicare Beneficiaries Enrolled in Managed Care (Medicare Advantage)		15.9%	5.5%
Composition of Medicare Advantage (MA) Enrollment in State (last quarter 2005)			
Total MA Enrollment		130,846	32,432
HMO Plans:	# Enrolled	116,906	24,337
	% of MA Enrollment	89.3%	65.6%
Local/Demonstration PPO Plans:	# Enrolled	2,615	294
	% of MA Enrollment	2.0%	2.2%
Cost Plans:	# Enrolled	138	62
	% of MA Enrollment	0.1%	1.0%
Private Fee-For-Service Plans:	# Enrolled	8,907	1,621
	% of MA Enrollment	6.8%	5.2%
Other MA Plans:	# Enrolled	2,279	1,456
	% of MA Enrollment	1.7%	3.0%
State's Medicare Advantage (MA) Regional Context			
# of States in MA Region, 2006		4	--
States in MA Region, 2006		ID,OR,UT,WA	--
State's Share of Regional MA Enrollment, last quarter 2005			--
HMO Plans		45.1%	--
Local/Demonstration PPO Plans		15.7%	--
Other Plans		0.4%	--
All MA Plans		37.0%	--
# of Regional MA Plans Established, June 2006		0	--
Regional MA Plan Providers, June 2006		0	--
			--

Source: See Technical Report for information on data sources and calculation.

Section 4: Provider Impact Tables

Redistribution of Graduate Medical Education Resident Caps

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Redistribution of Graduate Medical Education Resident Caps

State Profile: Florida

	Florida	U.S. State Median
Teaching Hospitals and Medical Residents in State		
# of Teaching Hospitals Receiving GME Payments, 2002	44	15
% of U.S. Teaching Hospitals Receiving GME Payments in State, 2002	3.4%	1.2%
# of Accredited Residency Programs, 2003	246	97
% of U.S. Accredited Residency Programs in State, 2003	3.0%	1.1%
# of Resident Physicians in Accredited Residency Programs, 2003	2,884	998
% of U.S. Resident Physicians in Accredited Residency Programs in State, 2003	2.9%	1.0%
Medicare GME Payments Received by Teaching Hospitals in State		
Total GME (DME & IME) Payment Received, 2002 (millions)	\$189.9	\$62.1
State's Share of Total GME Payments in U.S., 2002	2.5%	0.8%
Total DME Payment to State, 2002 (millions)	\$61.3	\$21.3
Total DME Payment as a % of State's Total GME, 2002	32.3%	32.3%
State's Share of Total DME Payments in U.S., 2002	2.5%	0.9%
Total IME Payment to State, 2002 (millions)	\$128.6	\$39.8
Total IME Payment as a % of State's Total GME, 2002	67.7%	67.7%
State's Share of Total IME Payments in U.S., 2002	2.5%	0.8%

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Florida, continued

		Florida	U.S. State Median
Impact of Redistribution of Medicare GME Resident Caps on Teaching Hospitals in State			
# of Teaching Hospitals with a Gain in Resident Slots, 2005	DME	6	4
	IME	6	4
% of Teaching Hospitals in State with a Gain in Resident Slots, 2005	DME	12.5%	27.8%
	IME	12.5%	27.8%
Average # of Resident Slots Gained per Teaching Hospital, 2005	DME	8.7	11.1
	IME	6.5	9.3
# of Teaching Hospitals with a Loss in Resident Slots, 2005	DME	14	3
	IME	20	5
% of Teaching Hospitals in State with a Loss in Resident Slots, 2005	DME	29.2%	29.2%
	IME	41.7%	36.9%
Average # of Resident Slots Lost per Teaching Hospital, 2005	DME	-2.5	-2.9
	IME	-3.5	-3.5
Net Change in Overall # of Resident Slots in State, 2005	DME	17.3	20.9
	IME	-30.4	7.2

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Minnesota

	Minnesota	U.S. State Median
Teaching Hospitals and Medical Residents in State		
# of Teaching Hospitals Receiving GME Payments, 2002	23	15
% of U.S. Teaching Hospitals Receiving GME Payments in State, 2002	1.8%	1.2%
# of Accredited Residency Programs, 2003	151	97
% of U.S. Accredited Residency Programs in State, 2003	1.8%	1.1%
# of Resident Physicians in Accredited Residency Programs, 2003	2,038	998
% of U.S. Resident Physicians in Accredited Residency Programs in State, 2003	2.0%	1.0%
Medicare GME Payments Received by Teaching Hospitals in State		
Total GME (DME & IME) Payment Received, 2002 (millions)	\$136.8	\$62.1
State's Share of Total GME Payments in U.S., 2002	1.8%	0.8%
Total DME Payment to State, 2002 (millions)	\$34.1	\$21.3
Total DME Payment as a % of State's Total GME, 2002	24.9%	32.3%
State's Share of Total DME Payments in U.S., 2002	1.4%	0.9%
Total IME Payment to State, 2002 (millions)	\$102.7	\$39.8
Total IME Payment as a % of State's Total GME, 2002	75.0%	67.7%
State's Share of Total IME Payments in U.S., 2002	2.0%	0.8%

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Minnesota, continued

		Minnesota	U.S. State Median
Impact of Redistribution of Medicare GME Resident Caps on Teaching Hospitals in State			
# of Teaching Hospitals with a Gain in Resident Slots, 2005	DME	5	4
	IME	4	4
% of Teaching Hospitals in State with a Gain in Resident Slots, 2005	DME	27.8%	27.8%
	IME	22.2%	27.8%
Average # of Resident Slots Gained per Teaching Hospital, 2005	DME	12.5	11.1
	IME	13.5	9.3
# of Teaching Hospitals with a Loss in Resident Slots, 2005	DME	9	3
	IME	11	5
% of Teaching Hospitals in State with a Loss in Resident Slots, 2005	DME	50.0%	29.2%
	IME	61.1%	36.9%
Average # of Resident Slots Lost per Teaching Hospital, 2005	DME	-4.9	-2.9
	IME	-3.7	-3.5
Net Change in Overall # of Resident Slots in State, 2005	DME	18.3	20.9
	IME	13.2	7.2

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: North Dakota

	North Dakota	U.S. State Median
Teaching Hospitals and Medical Residents in State		
# of Teaching Hospitals Receiving GME Payments, 2002	5	15
% of U.S. Teaching Hospitals Receiving GME Payments in State, 2002	0.4%	1.2%
# of Accredited Residency Programs, 2003	7	97
% of U.S. Accredited Residency Programs in State, 2003	0.1%	1.1%
# of Resident Physicians in Accredited Residency Programs, 2003	103	998
% of U.S. Resident Physicians in Accredited Residency Programs in State, 2003	0.1%	1.0%
Medicare GME Payments Received by Teaching Hospitals in State		
Total GME (DME & IME) Payment Received, 2002 (millions)	\$7.4	\$62.1
State's Share of Total GME Payments in U.S., 2002	0.1%	0.8%
Total DME Payment to State, 2002 (millions)	\$12.1	\$21.3
Total DME Payment as a % of State's Total GME, 2002	33.2%	32.3%
State's Share of Total DME Payments in U.S., 2002	0.5%	0.9%
Total IME Payment to State, 2002 (millions)	\$24.3	\$39.8
Total IME Payment as a % of State's Total GME, 2002	66.7%	67.7%
State's Share of Total IME Payments in U.S., 2002	0.5%	0.8%

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: North Dakota, continued

		North Dakota	U.S. State Median
Impact of Redistribution of Medicare GME Resident Caps on Teaching Hospitals in State			
# of Teaching Hospitals with a Gain in Resident Slots, 2005	DME	3	4
	IME	2	4
% of Teaching Hospitals in State with a Gain in Resident Slots, 2005	DME	60.0%	27.8%
	IME	40.0%	27.8%
Average # of Resident Slots Gained per Teaching Hospital, 2005	DME	1.8	11.1
	IME	2.6	9.3
# of Teaching Hospitals with a Loss in Resident Slots, 2005	DME	0	3
	IME	3	5
% of Teaching Hospitals in State with a Loss in Resident Slots, 2005	DME	0.0%	29.2%
	IME	60.0%	36.9%
Average # of Resident Slots Lost per Teaching Hospital, 2005	DME	0.0	-2.9
	IME	-0.9	-3.5
Net Change in Overall # of Resident Slots in State, 2005	DME	5.5	20.9
	IME	2.5	7.2

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Pennsylvania

	Pennsylvania	U.S. State Median
Teaching Hospitals and Medical Residents in State		
# of Teaching Hospitals Receiving GME Payments, 2002	87	15
% of U.S. Teaching Hospitals Receiving GME Payments in State, 2002	6.8%	1.2%
# of Accredited Residency Programs, 2003	546	97
% of U.S. Accredited Residency Programs in State, 2003	6.7%	1.1%
# of Resident Physicians in Accredited Residency Programs, 2003	6,685	998
% of U.S. Resident Physicians in Accredited Residency Programs in State, 2003	6.7%	1.0%
Medicare GME Payments Received by Teaching Hospitals in State		
Total GME (DME & IME) Payment Received, 2002 (millions)	\$727.1	\$62.1
State's Share of Total GME Payments in U.S., 2002	9.6%	0.8%
Total DME Payment to State, 2002 (millions)	\$246.6	\$21.3
Total DME Payment as a % of State's Total GME, 2002	33.9%	32.3%
State's Share of Total DME Payments in U.S., 2002	9.9%	0.9%
Total IME Payment to State, 2002 (millions)	\$480.5	\$39.8
Total IME Payment as a % of State's Total GME, 2002	66.1%	67.7%
State's Share of Total IME Payments in U.S., 2002	9.4%	0.8%

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Pennsylvania, continued

		Pennsylvania	U.S. State Median
Impact of Redistribution of Medicare GME Resident Caps on Teaching Hospitals in State			
# of Teaching Hospitals with a Gain in Resident Slots, 2005	DME	27	4
	IME	25	4
% of Teaching Hospitals in State with a Gain in Resident Slots, 2005	DME	32.9%	27.8%
	IME	30.5%	27.8%
Average # of Resident Slots Gained per Teaching Hospital, 2005	DME	9.5	11.1
	IME	7.0	9.3
# of Teaching Hospitals with a Loss in Resident Slots, 2005	DME	24	3
	IME	29	5
% of Teaching Hospitals in State with a Loss in Resident Slots, 2005	DME	29.3%	29.2%
	IME	35.4%	36.9%
Average # of Resident Slots Lost per Teaching Hospital, 2005	DME	-6.3	-2.9
	IME	-6.4	-3.5
Net Change in Overall # of Resident Slots in State, 2005	DME	107.1	20.9
	IME	-9.9	7.2

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Washington

	Washington	U.S. State Median
Teaching Hospitals and Medical Residents in State		
# of Teaching Hospitals Receiving GME Payments, 2002	20	15
% of U.S. Teaching Hospitals Receiving GME Payments in State, 2002	1.6%	1.2%
# of Accredited Residency Programs, 2003	114	97
% of U.S. Accredited Residency Programs in State, 2003	1.4%	1.1%
# of Resident Physicians in Accredited Residency Programs, 2003	1,465	998
% of U.S. Resident Physicians in Accredited Residency Programs in State, 2003	1.5%	1.0%
Medicare GME Payments Received by Teaching Hospitals in State		
Total GME (DME & IME) Payment Received, 2002 (millions)	\$78.4	\$62.1
State's Share of Total GME Payments in U.S., 2002	1.0%	0.8%
Total DME Payment to State, 2002 (millions)	\$22.3	\$21.3
Total DME Payment as a % of State's Total GME, 2002	28.4%	32.3%
State's Share of Total DME Payments in U.S., 2002	0.9%	0.9%
Total IME Payment to State, 2002 (millions)	\$56.1	\$39.8
Total IME Payment as a % of State's Total GME, 2002	71.6%	67.7%
State's Share of Total IME Payments in U.S., 2002	1.1%	0.8%

See Technical Report for information on data sources and calculation.

Redistribution of Graduate Medical Education Resident Caps

State Profile: Washington, continued

		Washington	U.S. State Median
Impact of Redistribution of Medicare GME Resident Caps on Teaching Hospitals in State			
# of Teaching Hospitals with a Gain in Resident Slots, 2005	DME	3	4
	IME	5	4
% of Teaching Hospitals in State with a Gain in Resident Slots, 2005	DME	16.7%	27.8%
	IME	27.8%	27.8%
Average # of Resident Slots Gained per Teaching Hospital, 2005	DME	17.6	11.1
	IME	5.6	9.3
# of Teaching Hospitals with a Loss in Resident Slots, 2005	DME	3	3
	IME	4	5
% of Teaching Hospitals in State with a Loss in Resident Slots, 2005	DME	16.7%	29.2%
	IME	22.2%	36.9%
Average # of Resident Slots Lost per Teaching Hospital, 2005	DME	-0.8	-2.9
	IME	-0.7	-3.5
Net Change in Overall # of Resident Slots in State, 2005	DME	50.6	20.9
	IME	24.9	7.2

See Technical Report for information on data sources and calculation.