

## MEDICAID COPAYMENTS: A BITTER PILL FOR THE POOR

In 1965, Congress amended the Social Security Act to create Medicaid, a Federal grant-in-aid program which allows states to enter into agreements with the Secretary of Health and Human Services to fund health care services for public assistance recipients and specific low income individuals and families.<sup>1</sup> In fiscal year 1980, approximately twenty-one and a half million individuals were eligible for the Medicaid program.<sup>2</sup>

Since the program's inception as Title XIX of the 1965 Social Security Act, Medicaid expenditures have risen from \$238 million in 1966<sup>3</sup> to expenditures of \$27.6 billion in 1980.<sup>4</sup> Projected expenditures for fiscal year 1982 are expected to spiral to \$32.6 billion with the states paying approximately forty percent of this amount.<sup>5</sup> If this trend continues, federal health care, of which Medicaid and Medicare<sup>6</sup> constitute the bulk, will rise to \$236 billion by 1990.<sup>7</sup>

The spiraling costs of the Medicaid program have placed a severe fiscal strain upon both federal and state governments. On the federal level, the rising cost of Medicaid seriously threatens any possible balancing of the federal budget. At the state level, these rising costs impose a severe fiscal strain upon state budgets. Because Medicaid represents the most rapidly rising cost in most state budgets, many states have found it necessary to curtail other important state expenditures to maintain their Medicaid program.<sup>8</sup>

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1. Subchapter XIX-Grants To States for Medical Assistance Programs

§ 1396. Authorization of appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance. 42 U.S.C. § 1396 (1976).

2. HEALTH CARE FINANCING ADMINISTRATION, HEALTH CARE FINANCING PROGRAM STATISTICS, Table 1.1 (1980) [hereinafter cited as HCFA STATISTICS].

3. *Medicare and Medicaid: Problems, Issues, and Alternatives, Hearings Before Senate Committee on Finance*, 91st Cong., 1st Sess. 42 (1970) [hereinafter cited as *Medicare and Medicaid*].

4. Wall Street Journal, Feb. 1, 1982, at 43, col. 3.

5. *Id.*

6. Medicare covers hospital, physician and other medical services for: individuals aged 65 and older; disabled persons entitled to social security cash benefits for four consecutive months; and most persons with end-stage renal disease. Medicare is divided into two parts, Hospital Insurance known as part A and Supplementary Medical Insurance known as part B. HCFA STATISTICS, *supra* note 2, at 1 (1981).

7. Wall Street Journal, Feb. 1, 1982, at 43, Col. 3.

8. Michigan, for example, has made enormous sacrifices to maintain their Medicaid program.

This note focuses upon one method states often employ in their attempt to reduce Medicaid costs: the imposition of a cost-sharing requirement, commonly known as copayments. Copayments embody the conflict between the need for essential medical services for the indigent and the need for state fiscal integrity. This note discusses how copayments are an inadequate and inappropriate tool for budgetary restraint. Copayments increase rather than decrease state Medicaid expenditures and deprive Medicaid recipients of needed medical services. This note discusses effective alternatives some states have implemented to achieve fiscal integrity while retaining necessary medical programs for the indigent.

### THE MEDICAID PROGRAM: AN OVERVIEW

In 1965, Congress amended the Social Security Act of 1935 to include grants to states for medical assistance programs.<sup>9</sup> Unlike Medicare which is available as a matter of right to all individuals paying Social Security taxes,<sup>10</sup> Medicaid focuses upon specific low income groups. The report of the Committee on Ways and Means notes

a state [Medicaid] plan to be approved must include provisions for medical assistance for all individuals receiving aid or assistance under state plans approved under Titles I, IV, IX, XIV and XVI [of the Social Security Act]. The people who are eligible for assistance under these titles are the most needy and it is appropriate for medical care costs to be met first for these people.<sup>11</sup>

It is only if this group is provided for that states may include medical assistance to the less needy.

Medicaid is a program of matching funds for state plans approved by the Secretary of Health and Human Services.<sup>12</sup> Federal funds are available contingent upon the state's per capita income and range from 50 to 77.5% of the state program costs. All states, the District of Columbia, Puerto Rico, Guam, and the Northern Marianas participate in

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Over a period of the last ten years, the Medicaid share of the Michigan budget has increased from 7 to 12% and the public welfare share of the Michigan budget has increased from 12 to 20%. Concomitantly, other areas have experienced severe cuts to make up for the increased Medicaid expenses. The Education share of the Michigan budget dropped from 52 to 38% and in the last six months, the education budget was cut by one hundred million dollars to pay for health and welfare needs. Paul Allen, director of the Michigan Medicaid program notes: This is a real manifestation of the fact that health and welfare are eating up more state dollars. The dollars have got to come from someplace so they're coming from these other programs. Ironically, Michigan's Medicaid program is recognized as one of the best run in the nation and offers a comprehensive list of services. Demkovich, *For State Squeezed by Medicaid Costs, the Worst Crunch is Still to Come*, NAT'L J., Jan. 10, 1981, at 48.

9. Social Security Act of 1965, Pub.L. No. 89-97, 79 Stat. 437(1965) (codified as amended at 42 U.S.C. § 1396 (1976)).
10. HCFA STATISTICS, *supra* note 2, at 1.
11. H.R. REP. NO. 213, 89th Cong., 1st Sess. 66 (1965), *reprinted in* 1965 U.S. CODE CONG. AND AD. NEWS 2017.
12. 42 U.S.C. § 1396 (1974). When the author uses the term matching funds, the author refers to federal financial participation in the Medicaid program. Federal expenditures vary with the state's per capita income and currently range from 50% to 77.55% of program medical expenditures. HCFA STATISTICS, *supra* note 2, at 2.

the Medicaid program.<sup>13</sup>

Medicaid is a program of statutory provisions and HHS regulations of labyrinthine complexity.<sup>14</sup> State programs differ substantially in eligibility criteria and services provided. This results from the Congressional desire to provide states with flexibility in the design and implementation of their programs.<sup>15</sup> Additionally, since the federal government pays a substantial portion of state Medicaid costs, state Medicaid programs are subject to substantial federal regulation, particularly regarding the curtailment of services.<sup>16</sup>

Federal regulations mandate that a state program must provide medical assistance to specific groups of individuals.<sup>17</sup> At a minimum, the state program must offer medical assistance to the categorically needy.<sup>18</sup> Those individuals who are eligible for cash assistance under AFDC, or who are needy, blind, or disabled individuals, and meet the income and resource levels are eligible in most states for supplemental security income.<sup>19</sup>

States may extend Medicaid to the medically needy,<sup>20</sup> an option that permits states to cover individuals who meet all criteria, except income, for categorically needy assistance, and who have substantial medical bills.<sup>21</sup> Federal regulations allow states to include a spend-down provision to cover individuals who do not meet the categorically needy income levels but whose medical bills effectively reduce their income to the categorically needy threshold.<sup>22</sup>

Federal regulations require that state Medicaid programs provide the following services to the categorically needy: In- and Out-patient hospital services, rural health clinic services, other laboratory and X-ray services, skilled nursing facility services for individuals age twenty-one or older, early and periodic screening, diagnosis and treatment, family planning services and supplies, physician services and home health services.<sup>23</sup> Additionally, states may offer a comprehensive list of

13. *Id.* Arizona which has never had a Medicaid program opted to participate as of October 1, 1982.

14. *Friedman v. Berger*, 547 F.2d 724 (2d Cir. 1976).

15. States have great flexibility in determining eligibility, services and the scope of services within the federal guidelines. Courts have traditionally been very respectful of this flexibility. *Dandridge v. Williams*, 397 U.S. 471 (1970).

16. States will often attempt to implement cutbacks without following federal notice requirements. The courts respond by enjoining the cutbacks until the notice provisions are properly complied with. *See Claus v. Smith*, 519 F. Supp. 829 (N.D. Ind. 1981); *Kimble v. Solomon*, 599 F.2d 599 (4th Cir. 1979); *Becker v. Toia*, 439 F. Supp. 324 (S.D.N.Y. 1977).

17. 42 C.F.R. § 435.1-.1011 (1979).

18. 42 C.F.R. § 435.100-.135 (1979).

19. *Id.*

20. 42 C.F.R. § 435.300-325 (1979). Financial eligibility for the medically needy varies from program to program ranging from a high of \$6,552 per year in Hawaii to a low of \$1,512 per year in Puerto Rico for a family of four. HCFA STATISTICS, *supra* note 2, Table 4.2.

21. 42 C.F.R. § 435.300-325 (1979). *See also* HCFA STATISTICS, *supra* note 2, at 65.

22. State programs often provide Medicaid coverage to other needy groups, such as individuals eligible for a state welfare program. However, federal funds are not available to cover these individuals.

23. 42 C.F.R. § 440.210 (1979).

services to both the categorically and the medically needy for which federal funds will be available.<sup>24</sup>

Congress recently amended the Social Security Act to allow states substantially more freedom in the services provided to the medically needy.<sup>25</sup> The new regulations enable a state to offer services to the medically needy without being bound by requirements as to a minimum number of services, or a mix of institutional and non-institutional services. States may offer services to one group of individuals (e.g., the elderly) without being required to offer comparable services to other groups. The intent of the 1981 amendments is to provide states with flexibility in establishing the eligibility criteria and the scope of services provided under the medically needy program.<sup>26</sup> This allows states to fine-tune their medically needy programs according to the needs of different population groups.<sup>27</sup>

In addition to specific medical service requirements, federal regulations mandate the degree and scope of services that must be provided. Adequate transportation to and from providers must be provided.<sup>28</sup> Each service under the state plan must be sufficient in amount, duration, and scope to reasonably achieve its purpose.<sup>29</sup> Services may not be denied, reduced in amount or scope merely because of the diagnosis,

24. Federal regulations provide that the state may make available a broad range of services: a) Inpatient hospital services (other than services in an institution for tuberculosis or mental disease) and rural health clinic services; b) Outpatient hospital services; c) Other laboratory and X-ray services; d) Skilled nursing facility services; e) Early and periodic screening, diagnosis and treatment (ESPD); f) Family planning services; g) Physician's services; h) Medical care or other remedial care recognized by state law and furnished by licensed practitioners within the scope of their practice as defined by state law; i) Home health care services; j) Private duty nursing services; k) Clinic services; l) Dental services; m) Physical therapy, related services; n) Prescribed drugs, dentures and prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye; o) Any other diagnostic, screening, preventive and rehabilitative services; p) Inpatient hospital services, skilled nursing facility services and intermediate care facilities for individuals 65 years or older in an institution for tuberculosis or mental diseases; q) Intermediate care facility services (other than institutional services for mental disease or tuberculosis) for individuals who are determined . . . to be in need of such care; r) Inpatient psychiatric hospital services for individuals under age 21. . . ; s) Any other medical care and any other type of remedial care recognized under state law specified by the secretary. 42 U.S.C. § 1396d (1976).

25. Omnibus Budget Reconciliation Act of 1981, Pub.L. No. 97-35, §§ 2171-2172, 95 Stat. 357 (1981). Previously, state plans providing services to the medically needy had to insure that the state program offered the mandatory services for the categorically needy, or any seven of the medical services offered under the Medicaid program. If the state plan opted to cover inpatient hospital services or skilled nursing facility services, physician services for individuals undergoing such treatment had to be included. 42 C.F.R. § 440 (1979).

26. *Summary of Finance Committee Recommendations, Social Security Provisions* in S. REP. NO. 139, 97th Cong., 1st Sess. 427, reprinted in 1981 U.S. CODE CONG. AND AD. NEWS 396, 697-98.

27. Congress did however establish specific restrictions. A state which does offer medically needy services must provide ambulatory services to children and prenatal and delivery services for pregnant women. Where a state provides institutional services for any medically needy group, it must provide ambulatory services for the same. Finally, if the state Medicaid program covers mentally retarded in intermediate care facilities, it must provide all services required prior to the 1981 amendment to medically needy individuals. *See supra*, note 24.

28. 42 C.F.R. § 431.53 (1979). Provider means any individual or entity furnishing Medicaid services under a provider agreement with a Medicaid agency 42 C.F.R. § 430.1 (1979).

29. 42 C.F.R. § 440.230 (1979).

type of illness, or condition.<sup>30</sup>

States may implement, however, appropriate limitations based upon criteria of medical necessity or to control overutilization of medical services. States use this provision to reduce the scope of services they must provide, by often limiting the number of days that a state will reimburse inpatient hospital care.<sup>31</sup> The differences in state eligibility requirements and the scope of services offered produces substantial variation among state Medicaid programs.

### The Medicaid Crisis

When Congress considered implementing the Medicaid program, the Department of Health, Education and Welfare<sup>32</sup> estimated that Medicaid would cost the government \$238 million dollars in its first year of operation.<sup>33</sup> Current expenditures will reach \$32.6 billion.<sup>34</sup> This spiraling cost has created what will be referred to as the Medicaid crisis.<sup>35</sup>

From 1967 to 1976, the Medicaid program grew rapidly. HEW estimated that program costs for the first year of operation would be \$238 million.<sup>36</sup> The entire \$238 million was spent, but only by six states which were able to implement a Medicaid program in that year.<sup>37</sup> The budget the President submitted to Congress in 1967 allocated \$2.25 billion as the federal share for forty-eight state Medicaid programs.<sup>38</sup> In actuality, only thirty-seven states were able to implement Medicaid programs, at a cost exceeding \$3.54 billion.<sup>39</sup> The number of recipients doubled from 11.5 million in 1967 to almost 23 million in 1977.<sup>40</sup>

From 1977 to the present, slowing growth and substantial changes in the coverage of recipients has characterized the Medicaid Program. Since 1977, when the program reached the highwater mark of its en-

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30. *Id.*

31. *Beal v. Doe*, 432 U.S. 438 (1979) is interesting in this regard. Medicaid recipients brought an action challenging the denial of coverage for non-therapeutic abortions. The Supreme Court noted that nothing in the Medicaid statute suggests that states are required to fund every medical procedure that falls within the delineated categories of medical care. The Court noted that states were given broad discretion in determining the extent of medical care, providing that assistance be "reasonable" and "consistent with the objectives of the Act." *Beal*, 432 U.S. at 444. See also S. DAVIDSON & T. MARMOR, *THE COST OF LIVING LONGER* (1980).

32. Now known as the Department of Health and Human Services.

33. *Medicare and Medicaid*, *supra* note 3, at 42.

34. *Wall Street Journal*, Feb. 1, 1982, at 43, col. 3.

35. An analysis of private sector health costs indicates that the spiraling cost of Medicaid is symptomatic of the health care industry in general. Hospital costs have soared from \$3.9 billion in 1950 to \$76 billion in 1978, an average annual increase of 11.2%. Nursing home expenditures have risen at an annual rate of 17.2%. While the consumer price index rose 87% for all items from 1970-1979, medical care service charges rose 200% over the same period. DEP'T OF HEW, *HEALTH, UNITED STATES* 181 (1979).

36. *Medicare and Medicaid*, *supra* note 3, at 42.

37. *Id.*

38. *Id.*

39. *Id.*

40. HCFA STATISTICS, *supra* note 2, at Table 2.1.

rollment,<sup>41</sup> the number of recipients has declined at an annual rate of 3.1%. Medicaid costs have continued to spiral, however, from \$16,277,000 in 1977 to \$20,474,000 in 1979 despite 1.5 million fewer recipients.<sup>42</sup>

Medicaid's increasing coverage of long term institutional care and state fiscal difficulties account for the Medicaid crisis. As of 1979, 42.3% of Medicaid reimbursements covered nursing home costs while an additional 31.4% of Medicaid reimbursements covered hospitalization costs.<sup>43</sup> In sum, 73.7% of the Medicaid budget was spent on institutional care. The increase in aged and disabled individuals on Medicaid and a reduction in the coverage of children reflects the increasing institutionalization of Medicaid. Institutional care represents the costliest sector of health care. Because other medical services covered by Medicaid have leveled off, or grown slowly, Medicaid now predominantly covers institutional care.

State fiscal difficulties compound this problem. In times of recession, less revenue is available to states from state and federal coffers. Concomitant with decreased revenues is an increasing demand upon state welfare services by the seasonally and permanently unemployed. As Medicaid program costs outgrow available state revenues and as the federal government reduces matching funds, state budgets become increasingly burdened.

States have several options available to reduce the budgetary strains from spiraling Medicaid costs:

- (1) increase revenues to pay for the rising costs of Medical services;
- (2) reduce fraud and administrative costs while increasing third party collection efforts;
- (3) increase the scope of the state Medicaid program to include federal matching funds for services which were previously only provided by the state;
- (4) reduce certain services by controlling rates, supervising utilization, tightening eligibility requirements, or increasing the recipient's out of pocket expenses.

This note focuses upon the last option: the imposition of a cost sharing requirement (otherwise known as a copayment) which mandates that recipients pay part of the cost of their medication.<sup>44</sup>

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41. *Id.* In 1978, this figure dropped by 700,000 to 22,197,000 and the following year, fell to 21,540,000.

42. *Id.* Table 2.9.

43. *Id.* Figure 1.1.

44. Currently, the following states have copayments: Alabama, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Idaho, Iowa, Kansas, Maine, Michigan, Maryland, Minnesota, Missouri, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin. NATIONAL GOVERNOR'S ASSOCIATION, CATALOGUE OF STATE PROGRAM CHANGES: SPRING 1982 UPDATE XX-XXI (May 1982).

## COPAYMENTS

Federal regulations permit a state Medicaid program to require the Medicaid recipient to pay a nominal portion of the cost of the service prior to receiving it.<sup>45</sup> The provider then bills the state for the cost of the service less the copayment paid by the recipient. Theoretically this reduces state Medicaid costs in two respects. First Medicaid costs are reduced by the amount of the copayment. However, this reduction is minimal due to federal regulations which restrict copayments to a nominal charge per service.<sup>46</sup> Second, states hope to instill a cost consciousness in Medicaid recipients and thereby deter unnecessary utilization of services. To do this, states require that recipients bear part of their medication costs.

Specific limitations upon the use of copayments existed under previous law. Copayments could not be imposed upon mandatory services which must be made available to the categorically needy. However, copayments could be imposed on any other service offered to the categorically needy.<sup>47</sup> Copayments also could be imposed upon any service offered to the medically needy.<sup>48</sup> Copayments are computed on the basis of the cost of the service rather than the income of the recipient and must be nominal in amount.<sup>49</sup>

Section 131 of the Tax Equity and Fiscal Responsibility Act of 1982 substantially changes the present federal regulations to expand the scope of copayments.<sup>50</sup> Pursuant to this new law, states may impose nominal copayments on all Medicaid recipients, including the categorically needy. Congress specifically exempted certain services from these copayment requirements, including services furnished to individuals under eighteen years of age, services furnished to pregnant women (if such service relates to the pregnancy), and services furnished to inpatients in a medical institution where the inpatient receives a personal

45. The pertinent federal regulations provide: Any copayment it [the state Medicaid agency] imposes may not exceed the amounts shown in the following table:

State Payment For the Service	Maximum Copayment Chargeable to the Recipient
\$10 or less	\$ .50
\$11 to 25	\$1.00
\$26 to 50	\$2.00
\$51 or more	\$3.00

42 C.F.R. § 447.54 (3) (1979).

46. The scope and cost of Medicaid copayments may be increased if the state acquires a waiver from the Secretary of HHS. The Secretary of HHS may waive compliance with any of the requirements of Medicaid if the experimental, pilot or demonstration project is likely to assist in promoting the objectives of the Social Security Act. 42 C.F.R. § 1315 (1974).

47. Mandatory services are: in and out-patient hospital services, rural health clinic services, other laboratory and X-ray services, skilled nursing facility services for individuals under age 21, family planning services and supplies for individuals of child bearing age, physician's services and home health care services. 42 C.F.R. § 447.53 (1979).

48. 42 C.F.R. § 447.53(b) (1979).

49. 42 C.F.R. § 447.54(3) (1979).

50. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 131, 96 Stat. 324 (1982).

needs allowance and emergency services.<sup>51</sup> The law also provides that the secretary is to promulgate regulations to determine "nominal in amount,"<sup>52</sup> but if an individual is unable to pay the nominal copayment, the provider of medical services may not deny services.<sup>53</sup> The Conference Committee estimates that this provision will reduce federal Medicaid costs by forty-two million dollars, presumably in reduced utilization of medical services.<sup>54</sup>

### The Legislative History of Copayments

Copayments were originally permitted on all services, with the exception of inpatient hospitalization that are available under Medicaid, provided that the copayment was reasonably related to the recipient's income.<sup>55</sup> In 1972, copayments attained their present form after a conflict between the Senate and the House of Representatives. The House was deeply concerned with the escalating costs of Medicaid and proposed copayments as a cost reduction tool.<sup>56</sup> The Senate was more concerned with the accessibility of the poor to medical services.<sup>57</sup> After the conference committee, copayments attained their present "nominal form."<sup>58</sup>

The 1972 amendments authorized the Secretary of HEW to implement standards insuring that copayments would in fact be nominal. The secretary promulgated a flat fee dependent upon the cost of the medical service provided. However, the flat fee violates Congressional intent. Under the regulations, the copayment is nominal only with respect to the cost of the service provided, not the income of the recipient.

51. *Id.* § 131(b)(2)(A), (B), (C) & (D). See also *id.* § 131(b)(2)(b)(2)(A), (B), (C) & (D).

52. *Id.* § 131(b)(3).

53. *Id.* § 131(c).

54. Ultimately, the Senate Finance Committee estimated this provision would save \$142 million by 1985. S. REP. NO. 494, 97th Cong., 2d Sess. vol.1 reprinted in September 1982 U.S. CODE CONG. AND AD. NEWS 7.

55. Copayments were not permitted for inpatient hospitalization. Social Security Act of 1965, § 1902(a)(14) (1965).

56. Your committee [on Ways and Means] has been concerned that costs of the Medicaid program have been escalating much more rapidly than had been anticipated and believes that an element of cost-consciousness on the part of patients and physicians should be introduced into the program as a cost control device.

H.R. REP. NO. 231, 92nd Cong., 1st Sess. 73, 74 (1972).

57. The committee [on Finance] does not intend them (copayments) to apply to inpatient hospital services, skilled nursing home care or other similar services where the practitioner determines utilization, use of the services, such as initial office visits to physicians and dentists for routine care. With respect to those services for which the practitioner in the main determines utilization the committee expects that the major control of utilization will occur through professional review mechanism. . . Limiting copayments and deductibles for the medically needy is only compatible with the committee's belief that such cost-sharing devices in the Medicaid program should not impose such a financial hardship on the recipient that he is hesitant to seek needed medical services when ill.

S. REP. NO. 1230, 92nd Cong., 2nd Sess. 219, 220 (1972).

58. 42 C.F.R. § 447.54 (1979).



ent.<sup>59</sup> It is possible, indeed common, for a recipient to be charged nominal copayments but to require so many services as to have a copayment bill which is far from nominal.<sup>60</sup> In testimony before the Subcommittee on Health and the Environment, the Director of the National Health Law Program cited several case studies illustrating this problem. For example,

A San Francisco woman . . . at the time of the California copayment experiment had been recently hospitalized with malnutrition. In addition, she had suffered emotional problems requiring psychiatric care. Her small VA benefit was supplemented by categorical assistance up to the cash maximum, and she received Medicaid. She could not afford to meet her desperate need for improved food and still pay the \$1 copayment for each of several physicians visits she truly needed. She lived in dread of emergencies, unable to meet the copayment.<sup>61</sup>

Unfortunately, cases such as these are not unique.<sup>62</sup> Representative Claude Pepper (D-Fla.) perhaps summarized best the effect of copayments upon the poor when he noted:

For the elderly poor, a fifty cent copayment which seems insignificant to most of us can mean the difference between a needed perscription, and a quart of milk or a loaf of bread. What right do we have to ask them to make this choice? There are people living in or approximate to my district who have to make the choice every day between a cup of coffee and morning newspaper.<sup>63</sup>

Middle-class taxpayers, who bear the burden of social welfare programs' heavy costs, are well in accord with copayments.<sup>64</sup> If Medicaid

59. Chavkin and Cypen, *Cost-Sharing Under Medicaid*, 12 CLEARINGHOUSE REV. 287 (1978). The flat fee is merely a charge per service. See *supra* note 45.

60. While the federal regulations permit states to establish a cumulative maximum on the amount they may charge in copayments, few, if any, have chosen to do so. 42 C.F.R. § 447.54 (1980).

61. *Hearings on H.R. 7028, 7029, 7030, 7031 and 7468 Before the Subcomm. on Health and the Environment*, 96th Cong., 2d Sess. (1980) (testimony of the Director of the National Health Law Program) [hereinafter cited as Testimony of NHLP].

62. In *Claus v. Smith*, 519 F.Supp. 829 (N.D.Ind.1981), an action brought by the Legal Services Program of Northern Indiana to enjoin a copayment program instituted in Indiana, the plaintiffs submitted affidavits detailing their financial status. One of the representative plaintiffs required 25 prescriptions of \$10.00 or less, 12 prescriptions between \$10 and \$25, and four bills for physical therapy \$50.00 or more. She also required transportation for her physical therapy. Her copayment bill for the above would be \$45.50. For a woman on a very limited income, this is far from nominal although it is nominal per service. The other representative plaintiffs in *Claus* suffered from similar limited resources and high medical bills.

63. HOUSE SELECT COMM. ON AGING, H.R. DOC. NO. 181, 96th Cong., 1st Sess., 28 (Comm. Print 1979) (statement of Rep. Claude D. Pepper, Chairman of the Subcomm. on Health & Long-Term Care of the House Select Comm. on Aging).

64. In general, cost-sharing is sensible in health programs, particularly as applied to the middle class and individuals who can afford the copayment. Copayments do not work well as applied to poverty level groups. Poverty level individuals have little if any discretionary income and may be forced to choose between food and medication. But, copayments are a very powerful and attractive political argument: they allow states to retain many services yet appear cost-conscious to the taxpayer. As a general rule, we readily accept the philosophy that it is only just that an individual contribute what he can towards his own care. Telephone interview with Gerald Riley, Head of the Washington State Medicaid Program (Aug. 19, 1982).

recipients require services, they will be available to them, but recipients will be expected to contribute towards the cost of any services. Copayments therefore permit a state to appear compassionate towards the indigent yet cost conscious to the taxpayer.

In practice, however, copayments have been found to be expensive and difficult to administer.<sup>65</sup> New York, for example, implemented a copayment program in 1969 which it later terminated because it became an administrative nightmare. Health care providers often confront the difficult choice of turning away recipients in need of medical services because they cannot afford copayments, absorbing the copayment thus rendering their participation less lucrative, or ultimately passing the copayment on to the public in terms of higher medical costs.<sup>66</sup>

Dr. Milton Roemer suggests that copayments may ultimately cost a state substantially more than is saved.<sup>67</sup> Dr. Roemer received a grant from HEW to examine the effects of a California copayment plan upon the utilization rate by Medicaid recipients.<sup>68</sup> Dr. Roemer discovered that copayments were "penny-wise and pound foolish" because they inhibit medical care whether it is advisable or not.<sup>69</sup> While use of ambulatory care services by the copayment group decreased, the use of the

65. BLOOMSBURG STUDY, A POSITION PAPER ON COPAYMENTS 4 (1976). A private study prepared for the Commonwealth of Massachusetts when it was considering the implementation of copayments in its Medicaid program.
66. Three basic problems states implementing copayments face are administrative costs, reduction in the number of providers because copayments impose an additional burden on them, both in terms of administration, as well as financially, and ultimately increased costs to the state from the first two. Additionally, states must implement provisions to insure that individuals who are unable to afford copayments still receive services. The alternative is to turn an individual away in desperate need of medication, possibly to die. For example, a poor couple in San Antonio recently sought admission to a clinic for the wife's complaints of coughing and congestion. Unable to pay the facility's three dollar charge (the husband only had 18¢ in his pocket) they were turned away. Two days later, the wife died of double pneumonia. Testimony of NHLP, *supra* note 61, at 6.
67. Dr. Milton Roemer teaches at the University of California at Los Angeles, School of Public Health. Dr. Roemer examined utilization rates of medical care by Medicaid recipients six months prior to the implementation of copayments and 12 months afterwards. M. Roemer, C. Hopkins and F. Gartside, *Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish*, 13 MEDICAL CARE 457 (1975) [hereinafter cited as Roemer].
68. California implemented a copayment plan requiring Medicaid recipients to pay one dollar for the first two visits to a physician and 50¢ for the first two drug prescriptions per month. See generally *California Welfare Rights Organization v. Richardson*, 348 F. Supp. 491 (N.D. Cal. 1972).
69. "These findings suggest that the effect of copayment requirements for ambulatory services (and prescriptions) in a medical care environment for low income families were [sic] to exert a deterrent effect on demand or utilization. The inhibiting effect applied to office visits, — the bedrock of general medical care — and also to typical diagnostic tests (urinalysis), to preventive procedures (Pap Smears), and to drug prescriptions. Easy access to and use of general ambulatory services are widely considered to have preventive value by permitting prompt diagnosis and treatment of an illness before it becomes more serious. . . . These findings also have serious financial implications. Hospitalization is by far the costliest sector of medical care. A reduced rate of ambulatory care may yield short-term financial savings, but a subsequent increase in the rate of hospital use could more than outweigh these amounts." Roemer, *supra* note 67, at 464, 465. Note that Roemer's study reaffirms the concerns of the U.S. Senate Committee. Copayments do in fact inhibit preventive care and effectively deter individuals from seeking medical assistance until their illness has become aggravated.

more expensive non-ambulatory services increased, more than offsetting any savings gained through lower ambulatory cost.<sup>70</sup> Roemer estimated that copayments ultimately cost the state of California an extra \$1.2 million.<sup>71</sup>

The Rand Corporation has produced two studies concerning copayments. The first study reexamined the findings of Roemer, utilized the same data, but evaluated it through different statistical methods.<sup>72</sup> This study verified Roemer's findings and noted that "copayments for ambulatory services in a welfare population as a means of controlling costs may well be ineffectual or even self defeating."<sup>73</sup> In 1981, the Rand Corporation reported the interim results of a controlled study examining the effects of copayments on utilization of medical services.<sup>74</sup> The Rand study clearly contradicted Roemer's findings and specifically found that cost-sharing reduces medical utilization, without a concomitant increase in institutional or non-ambulatory care costs.<sup>75</sup>

Despite the scientific accuracy of the 1981 Rand study, several factors suggest that it is inapplicable to cost-sharing among Medicaid recipients. First, only five percent of the individuals in the Rand study were Medicaid recipients.<sup>76</sup> The average income of participants varied from a high of \$11,800 in Seattle to a low of \$6,400 in Georgetown County, South Carolina.<sup>77</sup> Second, the study specifically excluded individuals sixty-two years or older.<sup>78</sup> Such individuals constitute at least

70. Ambulatory care is outpatient care. It refers to patients whose illness does not necessitate the patient being confined to bed. J.E. SCHMIDT, ATTORNEY'S DICTIONARY OF MEDICINE AND WORD FINDER, vol. I, at A143 (1982). Ambulatory care includes such things as physicians's visits, prescriptions and most preventive care etc. Non-ambulatory care is basically institutional care. Non-ambulatory care is far more expensive than ambulatory, and where alternate treatment is available, one ambulatory, one-non-ambulatory, the ambulatory care is generally the most cost efficient.

71. Roemer, *supra* note 67, at 465.

72. L. HELMS, J. NEWHOUSE, C. PHELPS, COPAYMENTS AND DEMAND FOR MEDICAL CARE: THE CALIFORNIA EXPERIENCE (1978).

73. *Id.* at vi.

74. "Conditional upon the validity of our assumptions, our results indicate that strong price effects may be at work in the welfare population. Requiring a one dollar copayment for physician's visits decreased the demand for physicians services by eight percent but increased the demand for hospital inpatient services by 17%. And while the confidence interval is large. . . point estimates indicate that there was a three percent to eight percent increase in overall program cost. Thus copayments for ambulatory services in a welfare population as a means of controlling costs may well be ineffectual or even self defeating". *Id.* at 16. Roemer's study was not in fact a scientifically accurate study and hence has been impeached on those grounds. The Medicaid control groups were not randomly chosen and were not matched. Immediately prior to the Roemer study, California had implemented prior authorization requirements which lowered the demand for certain services, and may have distorted the results. Likewise, the two copayment groups were not exactly alike and differed in several major respects. The initial Rand study reaffirms the Roemer results — but is conditional upon the accuracy of the samples.

75. J. NEWHOUSE, W. MANNIN, C. MORRIS, SOME INTERIM RESULTS FROM A CONTROLLED TRIAL OF COST SHARING IN HEALTH INSURANCE (1981) [hereinafter cited as INTERIM RESULTS]. Unlike the Roemer study, the Rand study scientifically selected 7,706 participants in six sites across the country and was statistically designed to be accurate.

76. Telephone interview with Joseph Newhouse, one of the authors of the interim report (Aug. 19, 1982).

77. INTERIM RESULTS, *supra* note 75, Table 1.

78. *Id.* at 4. The Rand study found that as cost-sharing declines, more individuals seeking care

15.6% of Medicaid recipients and, as retired individuals, may not have the discretionary income with which to pay copayments. Third, because the Rand study reimbursed individuals for cost-sharing, no one lost money by participating in the program.<sup>79</sup> However, Medicaid recipients are not reimbursed for copayment costs. If an individual cannot afford the copayment, he doesn't receive the service. Fourth, and most important, the Rand study does not purport to study the effect copayments have upon the individual's health. Roemer's study strongly indicates that copayments exact a demanding cost upon an individual's health. The Rand study is accurate only for what it purports to study: cost-sharing in the general population, rather than the Medicaid population.<sup>80</sup>

Copayments are designed to deter Medicaid recipients from overutilizing medical services. Little evidence exists however to demonstrate that Medicaid recipients overutilize medical services. Dr. Karen Davis of the Department of Health and Human Services, noted in a hearing before the Subcommittee on Health and the Environment that:

the poor in fact receive fewer health services than they need. There is little evidence at present that the poor in general overutilize health care services. The poor in every age group are less likely to have seen a physician during the past year than the nonpoor. Medicaid beneficiaries specifically show little evidence of overutilization. . . . [m]ore importantly it appears that low income Americans may actually receive fewer health services than they require. The poor continue to be less healthy than the nonpoor. If health services were used according to need, then the poor would use more services than the nonpoor. In fact, the poor receive fewer services than more affluent people of comparable health status.<sup>81</sup>

In most instances, physicians, not recipients, determine the level of medical service utilization. As of 1980, physician decisions on behalf of patients were responsible for \$154 billion in medical expenditures.<sup>82</sup> To the extent that physicians determine utilization, copayments on such services will be ineffective, or alternatively, will result in recipients failing to receive needed medical attention because they cannot afford the copayment.

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rise and the number of ambulatory visits per user increases. The study also found that cost sharing for ambulatory services decreases hospital admission among adults. The summary of the report notes, "Cost sharing unambiguously reduces expenditures; it is not pennywise and pound foolish." *Id.* at v, vi.

79. *Id.* at 8. A family always gained financially by joining.

80. Interview with Newhouse, *supra* note 76. Mr. Newhouse feels that despite the low Medicaid participation in the study, the study is applicable to copayments among Medicaid recipients. He points in particular to the fact that the response of the lowest third and the highest third of the income distribution are similar.

81. *Hearings on HR 7028, 7029, 7030, 7031 and 7468 Before the Subcomm. on Health and the Environment, 97th Cong. 1st Sess. 8 (1980)* (Statement of Karen Davis, Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services).

82. NATIONAL COMMISSION ON SOCIAL SECURITY, *SOCIAL SECURITY IN AMERICA'S FUTURE* 291 (1981).

Copayments infringe upon Medicaid recipients with little or no discretionary income, with their effect falling most heavily upon large families, the chronically ill, and the elderly.<sup>83</sup> Copayments deter necessary as well as unnecessary services. Finally, copayments often result in the selective use of medical services. Many Medicaid recipients, particularly the chronically ill and the elderly require a large number of medications and therapeutic services. Copayments often force recipients to choose among needed services. Ultimately, individuals may ignore certain prescriptions resulting in the worsening of their medical condition, or possible death.<sup>84</sup>

### ALTERNATIVES TO COPAYMENTS

There are many cost effective alternatives to copayments which states may implement to reduce Medicaid costs. These alternatives include lock-ins, second opinions, fiscal control of institutional care, pre-admission screening, and competitive bidding. These alternatives focus on making the Medicaid program more cost efficient, rather than deterring necessary utilization of medical services. Because state programs differ substantially, not every solution will be applicable to every state. Nor will one solution be sufficient to completely resolve state fiscal difficulties. Each state must implement a combination of different programs to render their respective Medicaid programs more effectively.

#### Lock-ins

States concerned that certain recipients are overutilizing drugs, outpatient departments, or other services may lock a recipient into a specific physician or pharmacist.<sup>85</sup> The recipient will then only receive medical services from the specific physician or pharmacist he is locked into. This effectively precludes the recipient from doctor shopping and

83. Copayments produce a more drastic curtailment of medical services for the poor than for other groups. Copayments implemented in Canada resulted in a seven percent reduction for the general population, but an 18% reduction in the use of physician's services by the poor. Beck, *The Effect of Copayment on the Poor*, J. HUMAN RESOURCES, Vol. IV, No. 1, at 140.

84. "Studies done in California on selective drug use indicated that after copayments were instituted, 28% of the pharmacy respondents in the California experiment indicated that Medicaid recipients were selectively filling their prescriptions. Drug use may conceivably result in death. Patients suffering from hypertension are often treated with diuretics which have the effect of reducing the volume of the blood and increasing the kidney output. Unfortunately, electrolyte imbalance may also occur. If this electrolyte imbalance continues unchecked, severe consequences may result including tachycardi and cardia arrhythmia which can lead to death, particularly in elderly individuals. The possibility of these side effects would ordinarily be guarded against by prescribing an electrolyte such as potassium chloride. A Medicaid recipient, discouraged from utilizing services by the introduction of cost-sharing might choose to fill the prescription only for the diuretic, thereby unwittingly inviting the possibility of further illness or death. The specter of selective filling of prescriptions is more than a mere possibility." Chavkin and Cypen, *Cost Sharing Under Medicaid*, 12 CLEARINGHOUSE REV. 288 (1978).

85. As of Spring, 1982, 35 states had implemented some type of a lock-in procedure, whether on a demonstration basis, on certain procedures, services or recipient categories, or as a full fledged program. NATIONAL GOVERNOR'S ASSOCIATION, CATALOGUE OF STATE MEDICAID PROGRAM CHANGES p. xix (1982).

eliminates the recipient's ability to purchase excess quantities of drugs. The Medicare Management Information System makes lock-in possible through computer monitoring by the states of the utilization of medical services by specific recipients.<sup>86</sup>

The Missouri lock-in program is exemplary, both in terms of fiscal integrity and protection of recipients' medical needs. In Missouri, the Medicaid Management Information System first identifies individuals who overutilize services.<sup>87</sup> The state Medicaid agency then reviews the medical history of the recipient to determine if the usage was justified, examines the provider's history, and ultimately contacts the recipient's caseworker to gather other information which might explain the pattern of overutilization. Unjustified usage results in a special notation on the Medical Identification card which locks a recipient into one provider. Services subsequently provided by other providers will not be paid for by the state. Missouri has locked in approximately 6,000 recipients with savings of \$1.82 million per year.<sup>88</sup>

Lock-ins may also apply to providers whom the state feels dispense excessive service.<sup>89</sup> Lock-in programs specifically identify and place stringent controls upon individuals who overutilize Medicaid services yet do not limit the utilization of necessary care. The lock-in program clearly presents a viable alternative to copayments.

## Second Opinions

States compelled to reduce unnecessary utilization may want to require Medicaid recipients to obtain a second opinion before certain types of elective surgery. Recently Michigan and Massachusetts implemented programs requiring a second consultation prior to elective surgery. Both states report a twenty percent reduction in the types of elective surgery required.<sup>90</sup> States may easily implement the second consultation program and recognize substantial savings<sup>91</sup> in terms of

86. The Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 established standards that states must meet for the processing of claims and administrative accountability. To meet these standards, states must establish sophisticated computerized information systems. The prototype of these information systems is the Medicaid Management Information System (MMIS). Chavkin, *An Introduction to the Medicaid Management Information System (MMIS) or Your Friend the Computer*, 12 CLEARINGHOUSE REV. 99 (1978).

87. MMIS identifies those individuals who in one calendar quarter use four or more different physicians, 75 or more physician or other professional services, four or more pharmacists, 75 or more prescriptions or two or more hospitals for inpatient care. B. SPITZ, STATE GUIDE TO MEDICAID COST CONTAINMENT 31 [hereinafter cited as STATE GUIDE].

88. *Id.*

89. Thus effectively permitting a state to limit overutilization of Medicaid services due to providers. The medical care provider can greatly profit by providing elaborate health care; in general, a provider gets little or nothing for keeping people well. NATIONAL COMMISSION ON SOCIAL SECURITY, SOCIAL SECURITY IN AMERICA'S FUTURE 353 (1981) (Supplementary statement on Medicare/Medicaid by Ms. Duskin and Ms. Miller).

90. A second opinion is much less expensive than surgery, nonetheless, second consultations will generally only be effective in those areas where high rates for nonconfirmation may be expected. STATE GUIDE, *supra* note 87, at 27.

91. Currently seven states require a second opinion for certain procedures. Two states have

reduced unnecessary care.

### Fiscal Control of Institutional Care

Another alternative is for states to focus on the spiraling cost of institutional care. As previously noted, Medicaid expenditures for institutional care, the costliest segment of health care in the national economy, have grown enormously.<sup>92</sup>

The Omnibus Reconciliation Act of 1980 and the Omnibus Budget Reconciliation Act of 1981 contain major provisions designed to help states reduce the staggering costs of institutional care.<sup>93</sup> These Acts simplify the modification of nursing home reimbursement methods, permit the reduction of payments for hospitalized patients awaiting nursing home placement and encourage the development of community based long term care service.

Many states have reassessed their institutional care reimbursement methods in light of spiraling institutional care costs.<sup>94</sup> Arkansas, Missouri and Utah have enacted flat rates for nursing home reimbursement. Georgia reduced its inflation factor for nursing home reimbursement from 12.6% to 4.6%. Minnesota has capped nursing home cost increases at ten percent for 1982, while Wisconsin has done so at seven percent. Idaho has sought voluntary reductions of five percent in nursing home costs, while Colorado seeks to pass part of nursing home costs on to local government.<sup>95</sup>

Many of these state cutbacks, however, have thrown the increasing cost of institutional care back upon the provider. This forces the provider to either absorb the cost as a reduction in profits, or alternatively, to pass the cost on to other users of institutional care in the general public. Reduced payments to providers of medical services raises the specter of reduced quality of services to the recipient. The answer to the reduction of Medicaid costs lies in reducing spiraling institutional care costs while retaining adequate services.

The Michigan Medicaid program has been a leader in finding innovative and adequate alternatives to expensive institutional care.<sup>96</sup> In Michigan's Medicaid program, administrative costs last year for the

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proposed programs in this area. NATIONAL GOVERNOR'S ASSOCIATION, CATALOGUE OF STATE MEDICAID PROGRAM CHANGES, xix (1982).

92. Program expenditures are heavily weighted toward institutional service, particularly long term care. Expenditures for care in nursing homes constitutes 42% of program costs while inpatient hospital care represents 28%. The remaining 30% goes primarily for physician services, outpatient hospital care and medication. CONGRESSIONAL BUDGET OFFICE, MEDICAID: CHOICES FOR 1982 AND BEYOND, xii (1981).
93. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2172, 95 Stat 357 (1981).
94. Twenty-four states have implemented changes in their nursing home reimbursement methods in 1981 and 1982 to reduce costs. THE INTERGOVERNMENTAL HEALTH POLICY PROJECT, RECENT OR PROPOSED CHANGES IN STATE MEDICAID CARE 12 (1982).
95. GENERAL ACCOUNTING OFFICE, PRELIMINARY FINDINGS ON PATIENT CHARACTERISTICS AND STATE MEDICAID EXPENDITURES FOR NURSING HOME CARE 12 (1982).
96. Demovich, *For States Squeezed by Medicaid Costs, the Worst Crunch is Still to Come*, NAT'L J., Jan. 10, 1981, at 48.

\$1.16 billion budget were only twenty-six million dollars. Michigan has successfully utilized long term community based care as an effective alternative to institutional care. Specific programs include home chore services and adult foster care for persons who would otherwise be hospitalized. The total enrollment between these two programs totals 4,000 more than the nursing home population. George Allen, director of the Michigan Medicaid program suggests that these programs explain why Michigan spends twenty-nine cents per dollar of the Medicaid budget on institutional care as opposed to the national average of forty-five cents per Medicaid dollar.<sup>97</sup>

Other states have successfully experimented with less expensive alternatives to institutional care. Idaho allows a tax deduction of \$1,000 to individuals who maintain immediate relatives aged sixty-five or older in their home.<sup>98</sup> Oklahoma has developed a "Non-Technical Medical Care in Own Home" where friends and neighbors after training, assist Medicaid recipients in their home. The program costs the state much less than institutional care. In Boston, a "life-line" telephone program maintains contact with frail and infirm residents of a housing project.<sup>99</sup> A Seattle program helps isolated elderly individuals find someone they can live with to share expenses and provide mutual support.<sup>100</sup> All of these programs provide vital support to individuals who might otherwise be institutionalized. Programs such as these reduce state institutional care costs.<sup>101</sup>

#### Pre-Admission Screening

Pre-admission screening may likewise be used to limit admission to nursing homes to individuals who truly need institutional care.<sup>102</sup> Virginia has implemented a very effective program in this area.<sup>103</sup> An interdisciplinary committee of the local health department determines whether services are available in the community to assist the recipient, or whether institutionalization is necessary. During the first ten months of this program, the interdisciplinary committee reviewed 1,755 cases of which 395 were determined capable of remaining in the community. This pre-admission screening saved the state \$1.6 million.<sup>104</sup> Virginia has found that approximately twenty-one percent of the individuals

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97. *Id.*

98. IDAHO CODE § 63-3022(L)(1)(C) (1982).

99. Protective Services for the Elderly Act of 1977, OKLA. STAT. ANN. §§ 801-810.

100. *See generally* STATE GUIDE, *supra* note 87, at 32.

101. *Id.*

102. However, community based care is not a panacea for institutional care, and cannot replace institutional care in all circumstances. Some studies indicate that many alternative programs without specific controls must act as an additional service to a person who would not be institutionalized anyway. William Weissert, Towards a Continuum of Care for the Elderly: A Note of Caution, presented at the American Public Health Association's annual meeting in Detroit, Michigan (October 1980).

103. STATE GUIDE, *supra* note 87, at 33.

104. *Id.* at 34.



seeking admission to nursing homes could remain in the community.<sup>105</sup>

Similarly, pre-admission screening could effectively be used to reduce overutilization of hospital emergency room services.

Medicaid recipients in urban areas often rely upon hospital emergency rooms for care which could easily be provided in a less expensive environment.<sup>106</sup> Screening emergency room admissions therefore would substantially reduce non-emergency room use of these facilities.<sup>107</sup> Patients could be referred to clinics and physicians. Alternatively, reimbursing hospitals at lower clinic or physician rates produces a strong incentive for the hospital to channel non-emergency medical care to clinics.

### Competitive Bidding

Finally, states must not ignore administrative methods which can substantially reduce Medicaid program costs. For example, federal regulations require states to seek reimbursement from third parties where a third party is liable for the medical costs of the recipients.<sup>108</sup> A variety of private and other public sources are liable for the medical costs of the recipients. The failure of state Medicaid programs to discover and charge these sources for medical services constitutes subsidizing private insurance companies and other public agencies at state taxpayer expense.<sup>109</sup> Minnesota and North Carolina have implemented effective programs. Minnesota invested \$263 thousand in a third party liability program and recouped \$9 million in 1979.<sup>110</sup> North Carolina's project cost \$120 thousand in administrative costs and recouped \$6 million.<sup>111</sup> Third party reimbursement can be a goldmine for states attempting to recoup costs.

States likewise can reduce Medicaid costs by utilizing the massive purchasing power of the state Medicaid program. States can solicit competitive bids for the use of services and equipment used in the

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105. *Id.*

106. Since nursing homes generally are not reimbursed for specific services rendered, but rather on a per diem basis, there is a strong incentive for nursing homes to admit individuals who could in fact remain in the community. *Id.*

107. A 1970 assessment of Philadelphia General Hospital revealed that 90% of the emergency room cases were diagnosed as everyday medical problems such as influenza, gastrointestinal upset and superficial infection. *Id.*

108. 42 C.F.R. § 433.135 (1980).

109. Typically, private health insurance companies as well as other governmental agencies (workmen's compensation, Veteran's Administration, Champus) are liable for the health costs of a recipient.

110. STATE GUIDE, *supra* note 87, at 48.

111. Maryland has successfully implemented a probate recovery program which has yielded Maryland three million dollars after an investment of \$150,000 in 1979. Federal regulations clearly encourage states to recoup third party liability. Notions of federalism preclude the federal government from specifically enabling state legislatures to recoup this money. Enabling legislation is necessary. For example, Minnesota gave the Department of Public Welfare the rights of assignment and subrogation for each client, and prevented private insurance carriers from writing contracts which terminated or restricted coverage if an individual was found eligible for medicaid. STATE GUIDE, *supra* note 87, at 49.

Medicaid program rather than pay itemized costs for individual services rendered under the Medicaid program. At present, competitive bidding in the purchase of Medicaid supplies and services is limited to some types of durable medical equipment such as hearing aids.<sup>112</sup> Several bills in Congress have considered giving states more power to bid for services at volume discount rates. The Congressional Budget Office suggests that expanded competitive bidding could save a state ninety million dollars immediately, and up to \$600 million in the long run.<sup>113</sup>

The state of Washington has effectively used competitive bidding for the bulk purchase of eyeglass lenses. Michigan has duplicated the Washington effort with anticipated savings of \$500 thousand<sup>114</sup> and is currently considering utilizing competitive bidding for hearing aids, laboratory services and drugs.

### CONCLUSION

Twenty-one and a half million Americans rely upon Medicaid for necessary medical services. Because of fiscal strains, both the state and federal government have considered serious cutbacks in the services offered. Many states have implemented copayments. This deceptively expedient solution, however, is ultimately an equally bitter pill for the poor, as well as for state budgets.

Roemer best summarized copayments when he noted "copayments are penny-wise and pound foolish." There is no quick solution to this complex problem. The solutions examined in this note: lock-ins, second opinions, fiscal control of institutional care, pre-admission screening and competitive bidding, are far from comprehensive. Any relief that will come will come not through the implementation of any one cost reduction program but rather through the implementation of a variety of cost-reduction programs. States can maintain fiscal integrity while also offering a substantial Medicaid program.

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112. CONGRESSIONAL BUDGET OFFICE, MEDICAID CHOICES FOR 1982 AND BEYOND 47 (1981).

113. *Id.*

114. STATE GUIDE, *supra* note 87, at 52.

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