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# Health Policy for Low-Income People in Pennsylvania

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**H**ealth care policy in Pennsylvania is shaped by a number of factors, including an aging population, a high rate of employer-sponsored insurance, Republican-dominated politics, and strong competition among managed care plans and hospitals. Pennsylvania's efforts to increase health insurance coverage, unlike those of many states, have bypassed major Medicaid expansions and—until it was required by federal law—reform of the private insurance market. Instead, the state has funded its own health insurance program for children, now supported with federal Children's Health Insurance Program (CHIP) funds; insurers have supported smaller expansion programs with private funds; and Blue Cross Blue Shield (BCBS) has served as an insurer of last resort. Both CHIP and Medicaid enroll a majority of beneficiaries in managed care, and Pennsylvania is one of the few states that operate managed care programs for elderly and disabled Medicaid beneficiaries.

## State Characteristics

### Sociodemographic Profile

The Commonwealth of Pennsylvania is currently the fifth most populous state in the country, with 12 million residents. Its population is less ethnically diverse and older than that of the United States as a whole. Racial and ethnic minorities comprise 14 percent of Pennsylvania's population, compared with 28 percent for the nation as a whole. African Americans are the largest minority group, representing 9.9 percent of all Pennsylvanians. Seniors represent 14.6 percent of the state population, compared with 12.1 percent for the United States, and children under 18 represent 25.0 percent of the population, compared with 26.8 percent for the United States (table 1). While the national population grew 5.2 percent between 1991 and 1996, Pennsylvania's population grew just 0.1 percent.<sup>1</sup> This slow population growth may explain the faster-than-average aging of the state. The American Association of Retired Persons (AARP) projects that in 2010 seniors will account for 15.4 percent of the population, compared with 13.3 percent for the United States.<sup>2</sup>

*The state's rate of uninsured children (6.7 percent, compared with 10.4 percent for the United States) is among the lowest in the nation.*

**Table 1**  
**State Characteristics**

<b>Sociodemographic</b>	<b>Pennsylvania</b>	<b>United States</b>
Population (1994–95) (in thousands)	11,933	260,202
Percent under 18 (1994–95) <sup>a</sup>	25.0%	26.8%
Percent 65+ (1994–95) <sup>a</sup>	14.6%	12.1%
Percent Hispanic (1994–95) <sup>a</sup>	2.3%	10.7%
Percent Non-Hispanic Black (1994–95) <sup>a</sup>	9.9%	12.5%
Percent Non-Hispanic White (1994–95) <sup>a</sup>	86.4%	72.6%
Percent Non-Hispanic Other (1994–95) <sup>a</sup>	1.4%	4.2%
Percent Noncitizen Immigrant (1996) <sup>b</sup>	1.8%	6.4%
Percent Nonmetropolitan (1994–95) <sup>a</sup>	14.6%	21.8%
Population Growth (1995–96) <sup>c</sup>	<-0.1%	0.9%
<b>Economic</b>		
Per Capita Income (1996) <sup>d</sup>	\$24,803	\$24,426
Percent Change in Per Capita Personal Income (1995–96) <sup>d</sup>	5.0%	4.6%
Percent Change in Personal Income (1995–96) <sup>d</sup>	4.9%	5.6%
Employment Rate (1997) <sup>e, f</sup>	61.1%	63.8%
Unemployment Rate (1997) <sup>f</sup>	5.2%	4.9%
Percent below Poverty (1994) <sup>g</sup>	12.4%	14.3%
Percent Children below Poverty (1994) <sup>g</sup>	18.8%	21.7%
<b>Health</b>		
Vaccination Coverage of Children Ages 19–35 Months (1996) <sup>h, i</sup>	79.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995) <sup>j</sup>	7.4%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996) <sup>k</sup>	7.4	7.2
Premature Death Rate (Years Lost per 1,000) (1995) <sup>l</sup>	41.8	46.7
Violent Crimes per 100,000 (1996) <sup>m</sup>	432.5	634.1
AIDS Cases Reported per 100,000 (1996) <sup>n</sup>	19.5	25.2
<b>Political</b>		
Governor's Affiliation (1998) <sup>o</sup>	R	
Party Control of Senate (Upper) (1997) <sup>p</sup>	20D-30R	
Party Control of House (Lower) (1997) <sup>p</sup>	99D-103R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. Three-year average of the CPS (March 1995–March 1997, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.

c. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, DC, 1997. 1995 population as of April 1. 1996 population as of July 1.

d. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.

e. U.S. Department of Labor. *State and Regional Unemployment, 1997 Annual Averages*. USDL 98-78. Washington, DC, February 27, 1998.

f. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

g. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

h. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46 (29). Hyattsville, MD, July 25, 1997.

i. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.

j. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45 (11), supp. Hyattsville, MD: National Center for Health Statistics, 1997.

k. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45 (12). Hyattsville, MD: Public Health Service, 1997.

l. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990, to July 1, 1996) as the denominator.

m. U.S. Department of Justice, FBI. *Crime in the United States, 1996*. September 28, 1997.

n. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8 (2), 1996.

o. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998*. January 15, 1997.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

Pennsylvania's urban-rural mix is unique. The state has two major urban areas: Philadelphia is the fifth-largest city in the United States and Pittsburgh ranks 45th. Under the Census Bureau's broader definition of a Metropolitan Statistical Area, Philadelphia has the sixth-largest population and Pittsburgh ranks 19th. A lower share of Pennsylvania's residents live in nonmetropolitan areas (14.6 percent) compared to the nation as a whole (21.8 percent). However, because of its size and the relatively populous rural areas between Pittsburgh and Philadelphia, Pennsylvania has the largest rural population of any state in absolute terms.<sup>3</sup>

### ***Economic Indicators***

Pennsylvania has the sixth-largest economy in the United States as measured by gross state product.<sup>4</sup> The state economy is dominated by service industries, including the financial sector, wholesale and retail trade, transportation, and government, which together comprise more than 75 percent of output.<sup>5</sup> The manufacturing sector, once dominant, has shrunk to 20 percent of the economy. The state's five largest employers include universities (Pennsylvania State University and the University of Pennsylvania), retailers (Wal-Mart Stores, Inc., and K-Mart Corporation), and an airline (US Airways, Inc.).<sup>6</sup>

Per capita income in Pennsylvania (\$24,803) was slightly higher than the national average (\$24,426) in 1996 and has grown faster than the national average since 1989,<sup>7</sup> despite the fact that its unemployment rate (5.2 percent) was higher than the national rate (4.9 percent) in 1997. In 1994, a smaller share of Pennsylvanians lived below the federal poverty level (FPL) than in the United States as a whole (12.4 versus 14.3 percent), and fewer children lived in poverty (18.8 percent versus 21.7 percent), suggesting that the state has a more equitable distribution of income than average (table 1).

### ***Health Indicators***

Most major population health indicators in Pennsylvania are worse than the national average, suggesting that

Pennsylvania's general affluence masks serious public health problems in some areas. The heart disease death rate is nearly 30 percent higher than for the nation; the rate of cancer deaths is 22 percent higher; and the rate of diabetes deaths is 25 percent higher. These rates are not age-adjusted, so the state's older-than-average population accounts for some of the elevation in rates. Among all states, Pennsylvania ranks second, fourth, and sixth highest, respectively, in these categories.<sup>8</sup>

Not all of the state's health indicators are worse than average. Pennsylvania's premature death rate (41.8 years of potential life lost before age 65 per 1,000 population) was lower than the national rate (46.7 years lost) in 1995, and the state reported fewer AIDS cases per 100,000 compared to the United States overall (19.5 versus 25.2) in 1996 (table 1).

### ***Politics***

In the past two decades, as demographic and economic shifts have moved people and money out of the state's urban centers (particularly Philadelphia) to the suburbs, there has been a corresponding shift in political power to these more affluent and conservative areas. During this time, Republicans have taken control of both houses of the legislature. As of September 1998, Republicans enjoyed a substantial majority in the Senate (30 to 20) and a small margin in the House of Representatives (103 to 99). Republicans from the Philadelphia suburbs have filled several key leadership positions. Governor Tom Ridge, also a Republican, was reelected in November 1998.

With the continued decline of manufacturing contributing to a decrease in the city's population and wealth, Pittsburgh also has seen its political influence diminish. The northern half of Pennsylvania and the central and south-central regions (the area outside the Philadelphia and Pittsburgh areas, forming "the T") are more conservative than the two metropolitan areas and have seen their political influence increase in recent years.

Philadelphia and Pittsburgh have histories of single-party dominance, and both were controlled by Republicans for a large part of this century.

More recently, however, both cities have been heavily Democratic. The state has a strong tradition of coalition-building that can, for example, pit one major city against the other, both cities against the rest of the state, or rural and urban areas against the more affluent suburbs.<sup>9</sup> Politics have been characterized as a balancing act among various coalitions.

### ***The Health Insurance Market***

Pennsylvania's health insurance market is characterized by extensive HMO penetration and stiff competition. Thirty percent of state residents were enrolled in HMOs in 1996, compared with 24 percent for the United States.<sup>10</sup> In the Philadelphia and Pittsburgh metropolitan areas, HMO penetration rates were 36 and 53 percent, respectively, in 1997, and HMO enrollment in these two markets totaled 3 million. HMO penetration rates in these areas were lower in the private market (22 and 44 percent respectively) than for the population covered by public insurance, indicating the degree to which Medicaid and Medicare, with 900,000 enrollees in HMOs, have contributed to the growth of HMOs in the state.<sup>11</sup>

Blue Cross Blue Shield insurers dominate the state's individual and group insurance markets, but commercial HMOs hold a significant share of the group market as well. Four conventional (non-HMO) BCBS plans wrote an estimated 70 percent of individual market business in 1995. Conventional commercial insurers together wrote about 20 percent, and commercial HMOs wrote an estimated 8 percent. In the group market, five conventional BCBS plans wrote more than 50 percent of business, and five BCBS HMOs wrote an estimated 12 percent of business in 1995. Commercial HMOs wrote about 25 percent, and conventional commercial insurers wrote less than 10 percent. Blue Cross of Western Pennsylvania is the largest plan in the state, holding an estimated 28 percent of the individual market's business and an estimated 24 percent of the group market.<sup>12</sup>

In the early 1990s, Pennsylvania's HMOs, particularly those serving Medicaid beneficiaries, enjoyed relatively high profits. These high margins led more HMOs to enter the state and

helped to create a highly competitive marketplace that put downward pressure on premiums over several years. Premiums dropped significantly: 20 of 24 HMOs in the state lost money in 1996,<sup>13</sup> and several experts have predicted similar widespread losses for 1997. Since these losses are unsustainable, HMOs are expected to attempt to increase premiums in the private market and to employ new cost-containment methods, including reduced payments to hospitals and physicians.<sup>14</sup> These efforts are expected to reduce HMO losses, but it is unclear whether HMOs will break even in 1998.

### *The Hospital Market*

While Pennsylvania's hospital market still has excess capacity, it has consolidated in recent years, and competitive pressures may cause this trend to continue. In the fall of 1997, Allegheny Health, Education and Research Foundation, the Philadelphia area's largest hospital system, laid off 1,200 of its 20,000 workers in an effort to cut costs and improve efficiency.<sup>15</sup> The cuts were expected, given Allegheny's recent losses and financial pressures faced by city hospital systems, but they prompted opposition from both nurses and patient advocates. At least three medium-sized acute care hospitals in the Philadelphia area have closed in recent years, including Mt. Sinai, a 183-bed facility that was part of the Allegheny system.

In September 1998, Tenet Healthcare, the nation's second-largest for-profit hospital chain, placed a bid for the purchase of eight bankrupt Allegheny hospitals in the Philadelphia area. The deal was slated to be finalized near the end of October. In a move that will mark a major shift in the city and state hospital markets, Tenet will become the first for-profit acute care presence in either Philadelphia or Pittsburgh. When Vanguard Health Systems, a rival for-profit chain, withdrew its final offer for the hospitals due to concerns over Allegheny's financial liabilities, Tenet was the only potential buyer left after a contentious bidding process that had lasted several months. Tenet's bid for the hospitals, which were valued at \$2.1 billion two years ago, was one-

sixth that amount. Just days before Vanguard dropped its bid, a preliminary internal audit revealed that Allegheny officials had withdrawn at least \$17 million from restricted endowments and private research accounts for unauthorized uses, indicating the system's financial situation was even more dire than previously believed.<sup>16</sup>

Supporters of Tenet's purchase say that it will bring increased order and the benefits of competition to a hospital market characterized by high costs and excess capacity. Opponents of the sale, including consumer advocates and unionized health care workers, claimed the takeover would result in major layoffs and inferior patient care. Philadelphia's remaining nonprofit hospitals voiced concerns that they would be forced to take on a higher volume of charity care, although under terms of the sale Tenet would agree to sustain the level of uncompensated care that Allegheny provided last year. Tenet's acquisition of a nonprofit asset for a small fraction of its former worth has provoked public concern and increased policymakers' interest in legislation that would strengthen state authority to regulate nonprofit hospital mergers and retain community benefit.<sup>17</sup>

Philadelphia-area hospitals have reported a substantial increase in uncompensated care volume, which has put further financial strain on the delivery system. Episcopal Hospital's uncompensated care burden quadrupled between 1995 and 1997, and Temple University Hospital's burden doubled between 1996 and 1997, according to the hospitals.<sup>18</sup> The Department of Public Welfare, however, has disputed the hospitals' claims of increased uncompensated care costs.

A recent study of the Philadelphia hospital market since 1995 concluded that mergers have not caused hospital facilities to close or specialty services to consolidate but may have propped up inefficient hospitals.<sup>19</sup> Hospitals, the study suggests, have been motivated to merge primarily to gain negotiating strength with health plans rather than to improve efficiency. While the failure to realize efficiency gains might slow the development of integrated delivery systems, the push toward further consolidation and integration appears strong.<sup>20</sup> With health plans under continued

financial pressure, it may be only a matter of time before the market forces hospital closures. Continued market-driven restructuring of the state health care industry could result in the loss or dislocation of between 20,000 and 40,000 health services jobs in the next five years.<sup>21</sup>

## Health Insurance Coverage

### *Detailed Insurance Trends*

Pennsylvania's rate of uninsured among the nonelderly, 11.0 percent, is significantly lower than the national rate, 15.5 percent (table 2). This difference can be explained largely by the state's above-average rate of employer-based coverage (72.6 percent, compared with 66.1 percent for the United States overall). Medicaid covers 11.2 percent of the state population, a slightly lower rate than for the country as a whole (12.2 percent), because Pennsylvania has a lower share of poor people than the national average. Medicaid covers an above-average share of the state's poor and near-poor (0 to 200 percent of the FPL) population—35.7 percent, compared with 34.1 percent for the United States. The state enrolls an above-average share of those eligible for Medicaid (85.1 versus 81.2 percent), suggesting its outreach and enrollment efforts are relatively successful.

Pennsylvania's below-average uninsured rates and above-average rates of employer-based coverage hold both for nonelderly adults (19 to 64) and children (0 to 18). Nearly three in four nonelderly adults (74.1 percent) hold employer-based coverage, placing Pennsylvania among the national leaders in that category. The state's rate of uninsured children (6.7 percent, compared with 10.4 percent for the United States) is among the lowest in the nation.

### *Medicaid Eligibility*

Pennsylvania has not expanded Medicaid eligibility substantially above the federal minimums. The program covers pregnant women and infants to 185 percent of the FPL (the minimum required for this group is 133 percent),

**Table 2**  
**Health Insurance Coverage**

Health Insurance, 1994–1995	Pennsylvania	United States
<b>Nonelderly Population</b>		
Percent Uninsured <sup>a</sup>	11.0%	15.5%
Percent Medicaid <sup>a</sup>	11.2	12.2
Percent Employer-Sponsored <sup>a</sup>	72.6	66.1
Percent Other Health Insurance <sup>a, b</sup>	5.2	6.2
<b>19–64 Population</b>		
Percent Uninsured <sup>a</sup>	12.9	17.9
Percent Medicaid <sup>a</sup>	6.9	7.1
Percent Employer-Sponsored <sup>a</sup>	74.1	67.8
Percent Other Health Insurance <sup>a, b</sup>	6.1	7.2
<b>0–18 Population</b>		
Percent Uninsured <sup>a</sup>	6.7	10.4
Percent Medicaid <sup>a</sup>	20.7	23.1
Percent Employer-Sponsored <sup>a</sup>	69.4	62.5
Percent Other Health Insurance <sup>a, b</sup>	3.2	4.0
<b>&lt;200 Percent of the Federal Poverty Level, Nonelderly Population</b>		
Percent Uninsured <sup>a</sup>	18.6	25.3
Percent Medicaid <sup>a</sup>	35.7	34.1
Percent Employer-Sponsored <sup>a</sup>	39.4	33.9
Percent Other Health Insurance <sup>a, b</sup>	6.3	6.7
<p>a. Two-year concatenated March CPS files, 1995 and 1996. These files are edited using the Urban Institute’s TRIM2 microsimulation model. Excludes those in families with active military members.</p> <p>b. “Other” includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.</p>		

but eligibility has not been expanded for other age groups. Consequently, the state covers children ages one to five with family incomes up to 133 percent of the FPL, children 6 to 15 up to 100 percent,<sup>22</sup> and older adolescents and adults up to 40 percent, which was the state’s threshold for cash payments under Aid to Families with Dependent Children (AFDC) as of July 1996. As of 1994, Pennsylvania was one of 36 states to cover the medically needy.<sup>23</sup> The maximum income for eligibility was 43 percent of the FPL, about average among states covering this group.

Shortly before passage of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the state passed Act 35, which many expect will result in a loss of insurance coverage for tens of thousands of able-bodied adult Medicaid recipients. Act 35, signed into law in May 1996, imposes a 60-month lifetime limit on AFDC (now Temporary

Assistance for Needy Families [TANF]) cash payments and requires recipients who are eligible for employment to work 20 hours per week after 24 months of assistance. Analysts believe that many beneficiaries will take jobs that ultimately make them ineligible for Medicaid but that do not carry health insurance, and that some beneficiaries will fall through the cracks, not realizing that they remain eligible for Medicaid after cash benefits are discontinued.

### *Insurance Market Reforms*

Pennsylvania had not pursued any insurance market reforms to increase access to coverage in either the small-group or individual markets before passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While many states had not implemented individual market reforms, Pennsylvania was one of only

seven states not to have enacted guaranteed issue or guaranteed renewal in the small-group market, one of only five states not to have enacted portability protections or preexisting condition restrictions for groups,<sup>24</sup> and one of just four states not to have enacted any rate restrictions for groups.<sup>25</sup> One reason for the state’s lack of insurance reforms may be the dominance of BCBS insurers, which generally practice open enrollment, and the effort mounted by BCBS to offset policymakers’ concerns about coverage by developing privately supported “Caring” programs (discussed below in the section on CHIP). The state’s political conservatism and general aversion to strong regulation of industry may be another reason.

Pennsylvania enacted its current insurance reform laws to comply with HIPAA. These laws include guaranteed issue for small groups (2 to 50 members), guaranteed renewal for groups and individuals, and portability protections and preexisting condition restrictions<sup>26</sup> for those holding group coverage or other “creditable coverage” as defined by HIPAA. State law requires BCBS to guarantee coverage to those individuals covered by HIPAA who move from group coverage to the individual market. No rate restrictions are currently imposed in either the group or individual market.

### **Medicaid Expenditures**

Pennsylvania spends more on Medicaid than most states, both as a share of state expenditures and on a per capita basis, and the state’s Medicaid spending is increasing faster than that of the United States as a whole. Pennsylvania’s Medicaid expenditures accounted for 20.9 percent of state general fund expenditures in 1995 and an even higher share of state spending (27.4 percent) counting other state funds and federal aid. Medicaid spending had accounted for 10.4 percent of general fund expenditures as recently as 1990, but the state has experienced Medicaid spending growth of more than 20 percent per year since then.<sup>27</sup> In fact, state Medicaid expenditures nearly doubled between 1990 and 1992 (table 3).

**Table 3**  
**Medicaid Expenditures**  
**by Eligibility Group and Type of Service,**  
**Pennsylvania and United States**  
 (Expenditures in Millions)

	Pennsylvania				United States			
	Expenditures	Average Annual Growth			Expenditures	Average Annual Growth		
		1996	1990-92	1992-95		1995-96	1996	1990-92
<b>Total</b>	<b>\$7,741.5</b>	<b>39.4%</b>	<b>5.3%</b>	<b>7.5%</b>	<b>\$160,968.6</b>	<b>27.1%</b>	<b>9.7%</b>	<b>2.3%</b>
<b>Benefits</b>								
Benefits by Service	6,828.1	28.9	6.9	11.1	140,290.1	18.8	10.9	5.4
Acute Care	3,314.1	26.0	13.1	13.7	84,666.5	22.3	12.8	6.6
Long-Term Care	3,514.1	31.0	2.3	8.8	55,623.6	14.6	8.2	3.5
Benefits by Group	6,828.1	28.9	6.9	11.1	140,290.1	18.8	10.9	5.4
Elderly	2,826.8	35.2	6.3	10.0	42,418.5	16.7	8.4	3.7
Acute Care	443.8	28.9	21.1	14.3	11,229.3	18.9	12.7	8.6
Long-Term Care	2,383.0	36.0	4.3	9.2	31,189.2	16.0	7.1	2.1
Blind and Disabled	2,376.9	24.4	10.8	12.5	56,601.3	17.6	13.3	8.6
Acute Care	1,349.1	34.9	19.1	15.4	33,880.1	22.9	15.8	10.7
Long-Term Care	1,027.8	17.6	3.2	8.9	22,721.2	11.9	10.1	5.7
Adults	485.7	15.7	3.2	6.2	16,956.6	21.4	9.1	0.7
Children	1,138.7	30.4	2.8	13.3	24,313.8	23.8	11.4	4.4
Disproportionate Share Hospital Administration	637.8	1,136.8	-6.4	-19.5	15,102.6	263.4	2.0	-19.6
	275.6	7.6	18.0	5.0	5,575.9	9.8	12.8	2.3

Source: The Urban Institute, 1998. Based on HCFA 2082 and HCFA 64 data.

While Medicaid enrollment has increased significantly, including a 35 percent increase to 1.75 million beneficiaries between 1990 and 1996, it is clear that rising per enrollee costs are also a driving force behind the sharp increases in spending (table 4).

Increased spending on long-term care (LTC) services for the elderly has been one of the main causes of Pennsylvania's Medicaid spending increases. LTC services accounted for 51 percent of 1996 state Medicaid service costs (compared with 40 percent for the United States), and LTC costs increased more rapidly than the national rate from 1990 to 1996. Pennsylvania's Medicaid spending on services for elderly beneficiaries (LTC and acute care) increased 140 percent between 1990 and 1996, compared with an 80 percent increase for the nation (table 3). Between 1990 and 1996, per enrollee costs for elderly beneficiaries increased 85 percent in Pennsylvania, compared with 50 per-

cent for the United States. While Pennsylvania spends less per enrollee than the national average for adults and for the blind and disabled, and slightly more per enrollee for children, the state spends substantially more than the national average on each elderly beneficiary (\$14,905 per year versus \$10,338) (table 4).

## Current State Health Policy Issues

### *Medicaid Managed Care*

The desire to contain costs continues to be one of the main reasons for Pennsylvania's push toward Medicaid managed care. Pennsylvania has operated several Medicaid demonstration projects under freedom of choice—1915(b)—waivers. These include a capitated mandatory enrollment program in the Philadelphia area (Health-

Pass) that began in 1987 and a statewide primary care case management (PCCM) program for children under 21 (Family Care Network) that began in 1994. Unlike many other states, Pennsylvania enrolls a significant share of its elderly and disabled populations in Medicaid managed care.

Enrollment in Medicaid managed care programs has increased substantially in the 1990s. Between 1991 and 1996, the share of Pennsylvania's Medicaid beneficiaries enrolled in some form of managed care increased from 12 percent to 32 percent. By March 1997, this share had increased to 62 percent, and by August 1998 it had reached 70 percent.<sup>28</sup>

Enrollment under fully capitated contracts has been particularly high in Philadelphia since the state began to implement HealthChoices, its mandatory HMO enrollment program, in the five-county Philadelphia area in early 1997. HealthChoices, which subsumed

**Table 4**  
**Medicaid Enrollment and Expenditures per Enrollee:**  
**Contributions to Total Expenditure Growth**

	Pennsylvania				United States			
	1996	Average Annual Growth			1996	Average Annual Growth		
		1990-92	1992-95	1995-96		1990-92	1992-95	1995-96
<b>Elderly</b>								
Total expenditures on benefits (millions)	\$2,826.8	35.2%	6.3%	10.0%	\$42,418.5	16.7%	8.4%	3.7%
Enrollment (thousands)	189.7	5.0	5.6	0.1	4,103.2	5.1	2.9	0.0
Expenditures per enrollee	\$14,905	28.7	0.6	9.9	\$10,338	11.0	5.4	3.7
<b>Blind and Disabled</b>								
Total expenditures on benefits (millions)	\$2,376.9	24.4	10.8	12.5	\$56,601.3	17.6	13.3	8.6
Enrollment (thousands)	347.3	11.6	11.4	5.2	6,698.2	9.8	9.3	5.2
Expenditures per enrollee	\$6,843	11.5	-0.5	6.9	\$8,450	7.1	3.7	3.2
<b>Adults</b>								
Total expenditures on benefits (millions)	\$485.7	15.7	3.2	6.2	\$16,956.6	21.4	9.1	0.7
Enrollment (thousands)	358.7	11.0	3.7	-2.6	9,225.0	11.4	5.0	-4.1
Expenditures per enrollee	\$1,354	4.2	-0.5	9.1	\$1,838	8.9	4.0	5.0
<b>Children</b>								
Total expenditures on benefits (millions)	\$1,138.7	30.4	2.8	13.3	\$24,313.8	23.8	11.4	4.4
Enrollment (thousands)	871.1	7.9	2.9	-1.6	21,270.5	13.1	4.8	-1.6
Expenditures per enrollee	\$1,307	20.8	-0.1	15.2	\$1,143	9.5	6.3	6.3

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

the HealthPass program and ultimately will be implemented throughout the state, has increased enrollment under capitated contracts to 93 percent of the area's 500,000 beneficiaries as of August 1998.<sup>29</sup> Under HealthChoices, the state contracts directly with four HMOs—Keystone Mercy, Health Management Alternatives, Oxford, and Health Partners—and retains an independent organization as a benefits consultant to provide beneficiaries with objective information on participating plans. Beneficiaries are given the opportunity to select a plan and a primary care doctor. Those not exercising this option are assigned automatically.

When the Health Care Financing Administration (HCFA) first approved HealthChoices for all Philadelphia-area beneficiaries, there was concern among advocates for low-income groups that some beneficiaries forced to enroll in HMOs would not receive proper care. HCFA approved the program on the condition that the state require plans to develop adequate physician and hospital networks, specific standards of

care for special populations, and a system to handle consumer complaints. Pennsylvania's Medicaid program also requires that contracting HMOs include federally qualified health centers (FQHCs) in their networks and pay these providers cost-based reimbursement. According to state officials, even without this requirement, plans would voluntarily contract with FQHCs because of these providers' effectiveness in serving the health needs of Medicaid beneficiaries.<sup>30</sup>

Within a year of implementation, HealthChoices was in crisis. All four contracting plans lost money in 1997, and their relationships with the state and providers are strained. Three of the four plans take more than three months to pay provider bills. In December 1997, 350 doctors at Temple University School of Medicine ended their contract with Health Partners over late payments. In addition, according to published reports, the plans' own data show they may not be providing some prepaid basic care, such as immunizations.<sup>31</sup>

In 1998, a state-commissioned report concluded that the state's capitation rate is insufficient to cover necessary services for the disabled population and that it underestimates administrative costs.<sup>32</sup> The state Medicaid program disputed many of the report's findings and claimed that the program's most pressing need is for contracting HMOs to become more efficient.<sup>33</sup> Still, the Medicaid program offered the plans an increase in their capitation payments in early 1998 when it appeared that at least one of the four plans was considering withdrawal from the program.

In Allegheny County (Pittsburgh) and the nine surrounding counties, 49 percent of Medicaid beneficiaries were voluntarily enrolled in HMOs as of August 1998.<sup>34</sup> The state expects this share to increase substantially after January 1999 when it introduces mandatory enrollment through HealthChoices in the Pittsburgh area. Further expansion of HealthChoices is expected to continue in 2000 after readiness assessments are conducted in additional parts of the state.

## Children's Health Insurance Program

In May 1998, HCFA approved Pennsylvania's Children's Health Insurance Program plan to expand coverage to low-income children through a state-designed program. The new program is nearly identical to an existing state program established in 1993, but it increases eligibility slightly.<sup>35</sup> The program will cover children ages 6 through 18 with family incomes up to 185 percent of the FPL and younger children up to 235 percent of the FPL. The program will pay full premiums for children under 185 percent of the FPL, while families with enrolled children between 185 and 235 percent of the FPL will share in the cost of premiums. A recent state law authorized expansion of the full-subsidy program to 200 percent of the FPL for all children through 18 and expansion of the partial-subsidy program for all children through 18 between 200 and 235 percent of the FPL, but HCFA approval of a formal amendment to the state's CHIP plan is necessary to change the program's eligibility criteria. At present, there are approximately 75,000 uninsured children below 200 percent of the FPL in Pennsylvania.<sup>36</sup>

Pennsylvania was one of three states for which the Balanced Budget Act of 1997 grandfathered approval of the existing program's benefits package.<sup>37</sup> The state's CHIP expansion builds on the administrative infrastructure and health plan networks of the existing program, which had enrolled 54,000 children as of July 1997, with an annual budget of \$33.5 million. CHIP will continue to contract with five health plans, including one state-licensed HMO and four nonprofit subsidiaries of large insurers, that offer a range of managed care and indemnity products, and it will primarily purchase managed care coverage, except in rural areas where managed care is unavailable. CHIP enrollment is increasing slowly. As of August 1998, the program enrolled 61,000 children.<sup>38</sup> Only 7,000 new children—about 1 out of every 10 eligible—have received CHIP coverage since the program reopened.

Pennsylvania also has three privately funded health insurance programs for children—the Western

Pennsylvania BCBS Caring program, the Independence BCBS Caring program, and the Aetna U.S. Healthcare CHIP Plus program—which had enrolled a total of 21,000 children as of October 1997. These programs, which target children who were ineligible under the state program's former eligibility criteria, will continue to operate alongside the new CHIP program.

## Managed Care Regulation

During the 1998 legislative session, protecting consumers from potential abuses of managed care organizations was a prominent health policy issue that culminated in a comprehensive managed care bill of rights. As proposed by Governor Ridge, the law includes provisions designed to protect the confidentiality of patient information; provide consumers information on plan costs, benefits, and networks; ensure coverage of emergency services; require utilization review by practitioners; and prohibit gag clauses and financial incentives in provider contracts.

## Conclusions

While it is not significantly richer than most states, Pennsylvania has an uninsured rate that is lower than the national average, due mainly to its relatively high rate of employer-sponsored insurance. Historically, Pennsylvania has not used Medicaid expansions to increase coverage; rather, the state has funded its own insurance program for children. The recently implemented CHIP, which builds on its predecessor, may ultimately cover many low-income children who otherwise would be uninsured. The state has not aggressively pursued insurance market reforms to improve access to private coverage, perhaps because of BCBS's dominance, but access to private insurance appears relatively high, particularly in the group market.

As the state grapples with the desire to limit Medicaid expenditure growth and as private employers attempt to control their workers' health care costs, the state's managed care organizations face stiff competition and are experiencing considerable financial

strain. Pressure on HMOs to control costs has drawn attention to quality-of-care issues, both for the Medicaid population and in the private market. It appears likely that competition and reduced provider payments will lead to further consolidation in the hospital market and reduction of excess capacity. As in other states, the tension between financial pressures and the desire for high-quality care is likely to drive further change in health care financing and delivery.

## Notes

1. United States Census Bureau, *Statistical Abstract of the United States: 1997*, p. 28.

2. AARP Public Policy Institute, *Reforming the Health Care System: State Profiles*, 1997, p. 154.

3. Pennsylvania Economy League Web site: [www.libertynet.org/pel](http://www.libertynet.org/pel).

4. U.S. Census Bureau, *Statistical Abstract of the United States: 1997*, p. 450.

5. U.S. Census Bureau, *Statistical Abstract of the United States: 1997*, p. 451.

6. Pennsylvania Department of Labor and Industry, Office of Employment Security.

7. U.S. Department of Commerce, Bureau of Economic Analysis.

8. AARP Public Policy Institute, *Reforming the Health Care System: State Profiles*, 1997, p. 217.

9. Pennsylvania Economy League Web site: [www.libertynet.org/pel](http://www.libertynet.org/pel).

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11. *Interstudy Competitive Edge: Regional Market Analysis*, version 8.1, 1998, pp. 150–151.

12. Alpha Center Health Insurer Database, 1998.

13. The Hospital and Healthsystem Association of Pennsylvania.

14. *Pittsburgh Business Times*, as reported in *American Healthline*, January 29, 1998.

15. *Philadelphia Inquirer*, as reported in *American Healthline*, October 14, 1997.

16. *Philadelphia Inquirer*, as reported in *American Healthline*, September 21, 1998.

17. *Philadelphia Inquirer*, as reported in *American Healthline*, October 1, 1998.

18. *Philadelphia Inquirer*, as reported in *American Healthline*, March 31, 1998.

19. Economic and Social Research Institute, Washington, DC.

20. Interview with Mark Pauly, Ph.D., Benheim Professor and Vice Dean, Wharton School of Business, University of Pennsylvania, August 11, 1998.

21. Pennsylvania Economy League Web site: [www.libertynet.org/pel](http://www.libertynet.org/pel).

22. Each year, federal law requires that the age ceiling on Medicaid eligibility for children with family incomes under 100 percent of the FPL be increased by a year until all children 18 and under are eligible.

23. The medically needy program is an optional eligibility under Medicaid that allows persons with incomes just above the TANF eligibility limit to qualify for Medicaid coverage. Persons can “spend down” to medically needy eligibility if their medical expenses are sufficiently large.

24. Alpha Center, *Implications for State Health Reform of the Health Insurance Portability and Accountability Act of 1996*, pp. 2–3.

25. Blue Cross Blue Shield Association, *State Legislature Health Care and Insurance Issues: 1997*, Appendix.

26. HIPAA requires states to enforce a maximum look-back period of no more than six months and a waiting period of no more than one year.

27. National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

28. Alpha Center survey of state Medicaid agencies, April 1997; Pennsylvania Department of Public Welfare.

29. Pennsylvania Department of Public Welfare.

30. Alpha Center survey of state Medicaid agencies, April 1997.

31. *Philadelphia Inquirer*, as reported in *American Healthline*, February 12, 1998.

32. Arthur Andersen, LLP.

33. *Philadelphia Inquirer*, as reported in *American Healthline*, February 12, 1998.

34. Pennsylvania Department of Public Welfare.

35. Before Pennsylvania submitted a plan to use federal CHIP funds, the state program (also called the Children’s Health Insurance Program) could enroll only a small share of eligible children, due to funding constraints. Nominally, the eligibility limits were the same as they are now, except children older than 16 were ineligible.

36. Urban Institute projections using Current Population Survey data.

37. New York and Florida are the other two states.

38. Pennsylvania Department of Insurance, Children’s Health Insurance Program.

### *About the Author*

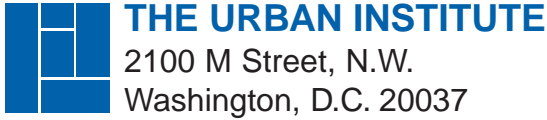
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