United States General Accounting Office

GAO

Report to the Chairman, Committee on Finance, U.S. Senate

April 1994

HEALTH CARE ALLIANCES

Issues Relating to Geographic Boundaries

GAO/HEHS-94-139

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-256940

April 8, 1994

The Honorable Daniel Patrick Moynihan
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

A common feature of many health reform bills is the creation of public or private health purchasing groups, commonly called alliances.[1] These entities have been proposed primarily as a means for broadening coverage, pooling risks, providing consumers with a choice of health care plans, and disseminating information on the costs and quality of plans. Decisions about the number, size, and characteristics of people within each alliance will significantly affect the price of insurance and access to health care. Three major legislative proposals incorporate alliances: the Clinton bill, the Chafee/Dole bill, and the Cooper/Breaux bill.[2] Though differing in both major and minor ways, alliances in these and more recent bills, such as the Stark proposal, embody the same basic concept of pooled purchasing. Moreover, a growing number of states are turning to statewide cooperatives as a way of increasing the overall level of insurance, especially among those who work for small businesses.

On December 23, 1993, you requested a study on issues related to geographic boundaries for proposed regional health alliances amidst concerns about the impact of how alliance boundaries might be drawn. All of these proposals leave the tough choices of alliance boundaries to the states. Providers, insurers, and consumers are already lobbying at the federal and state levels about real or perceived problems relating to how alliances may be structured. These concerns include the potential for establishing boundaries that (1) unfairly advantage particular geographic and socioeconomic groups regarding the cost and quality of health care, (2) change the way consumers receive care and the markets in which health providers operate, (3) segment various high-risk groups, and (4) isolate underserved areas, such as rural regions and urban centers. On February 24, 1994, we testified before your committee on the preliminary results of our work.

[1]Two proposals refer to purchasing cooperatives or purchasing groups. For our discussion, we will refer to these entities as alliances.

[2]The formal names for the three major reform bills are as follows: (1) the Clinton bill, the Health Security Act (S. 1757/H.R. 3600); (2) the Cooper/Breaux bill, the Managed Competition Act of 1993 (S. 1579/H.R. 3222); and (3) the Chafee/Dole bill, the Health Equity and Access Reform Today Act of 1993 (S. 1770/H.R. 3704).

This report expands on the information contained in our testimony. Specifically, we discuss the (1) provisions of major health reform bills concerning the configuration of alliance boundaries; (2) features and procedures for establishing Metropolitan Statistical Areas (MSAs), which are important geographic units contained in each proposal that influence how boundaries are to be drawn; (3) experiences of two states that have established entities similar to alliances; and (4) issues relating to the potential effects of alliance boundaries on existing health markets, access to health care, and distribution of health care costs within a state.

Results in Brief

In each of the three major health reform proposals, decisions on alliance boundaries are left to the states except for provisions in all three bills that require that MSAs remain intact, primarily as a means to prevent discrimination against high-risk populations by health plans. The bills vary on whether alliance boundaries can cross state lines, the minimum population size requirement for an alliance area, and the number of alliances that can operate in each coverage area. All bills permit health plans to operate across state lines or alliance boundaries.

Because MSAs are important to drawing alliance boundaries in each bill, concerns have been raised about how they are defined. The Office of Management and Budget (OMB) defines MSAs using statistical information furnished by the Bureau of the Census and occasionally considers the views of local officials. Direct congressional action has also led in a few instances to changes in MSA definitions. In the future, if changes in MSA definitions require states to reconfigure their alliance boundaries, the implications for health plans and health delivery may be substantial.

Florida and Washington, two states that have already begun the process of implementing health care reform, illustrate the intensity of decisions related to the size, number, and boundaries of alliances. For example, Florida legislators drew upon existing health planning districts in a political compromise to create 11 alliance areas for the state, ranging in population from about 500,000 to over 2 million. Moreover, legislation establishing four alliances in Washington outlined broad parameters for boundaries—namely that these determinations be based on population, geography, and other factors—but left the ultimate decision to the state's Health Services Commission.

The number of alliances that states would ultimately create and the placement of the alliance boundaries have raised questions for consumers,

employers, and providers. These concerns relate to whether or by how much the creation of alliance boundaries will impact the provision of care in existing health markets, segment and limit access to care for disadvantaged or high-risk populations, and redistribute health care costs among different geographic and socioeconomic groups.

Background

Health alliances use pooled buying power of a large group of individuals and employers to develop a more affordable insurance product by spreading the risk over a larger population. Small groups and individuals are particularly disadvantaged in today's insurance market. Some cannot obtain insurance at any price because of their actual or perceived health status. Through the larger risk pooling created by alliances, small employers and individuals can gain or increase bargaining clout with health insurers, plans, and providers and allow individuals a greater choice of health plans.

The health alliance in the Clinton administration's proposal, the health plan purchasing cooperative in the Cooper/Breaux bill, and the purchasing group in the Chafee/Dole bill all draw their basic structure from the managed competition approach to health care reform. While the bills differ on several key aspects, they all serve as an organization through which employers or individuals purchase their health insurance. These alliances generally help administer subsidies for low-income members, provide members with information on the costs and quality of plans, and allocate collected premiums to health plans.

Each proposal is different in such areas as whether alliances can negotiate premiums, whether the purchase of insurance through the alliance is required, whether employers have to contribute to premiums, and what segments of the population can be covered by alliances. Nonetheless, a substantial share of the population is eligible to obtain its insurance coverage through these alliances. Because all three proposals may place enrollees in the alliance that covers the area they live in, there are concerns that the geographic boundaries defined by the states could affect access to particular providers and the price of health insurance.

To gain perspective on the potential issues that could arise because of a state's choice of alliance boundaries, we reviewed the legislation on geographic boundary limits in each proposal as well as the literature and positions of interest groups on geographic boundary issues. We also made site visits to Florida and Washington, where some decisions regarding the

location of alliance boundaries have already been made within the context of state reform efforts. We also drew upon our previous work and current efforts in assessing existing public and private alliances that have been in operation for some time.[3]

Several geographic issues discussed in the following sections do not specifically pertain to the provisions in any of the health reform proposals. These include concerns regarding regional differences in the adequacy, availability, and choices of health care providers in underserved rural and central city areas. While some provisions of the various health reform proposals affect these concerns, where or how a geographic boundary is drawn probably cannot correct problems of access to health services for all citizens in a defined alliance area.

To understand the process for establishing MSAs, we reviewed various OMB documents that described the definitions of and guidelines for establishing these areas as well as annual bulletins and other reports that provided the rationale for changes in metropolitan area definitions. In addition, we interviewed OMB officials to obtain their positions on various aspects of the agency's process for changing definitions and on the nature of recent changes to metropolitan areas.

Our work was performed between December 1993 and March 1994 in accordance with generally accepted government auditing standards.

Geographic Boundary Provisions Contained in Reform Bills

Each of the three health reform proposals we examined gives the states responsibility for and flexibility in establishing alliance boundaries, with only a few constraints (see table 1).

[3]See Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

Table 1: Geographic Provisions of Health Proposals for Alliances

	Clinton Plan (S. 1757/ H.R. 3600)	Cooper/Breaux Plan (S. 1579/ H.R. 3222)	Chafee/Dole Plan (S. 1770/H.R. 3704)
Alliance can subdivide an MSA	No	No	No
Number of alliances that operate in each coverage area	One	One	None, one, or more than one
Alliance can cross state lines	No	Yes	Yes
Minimum size requirement for alliance area	None—National Health Board reviews for sufficient market size	Minimum 250,000 eligible individuals residing in alliance area[a]	Minimum 250,000 individuals residing in alliance area

[a]Individuals, and their families, who are unemployed, self-employed, employed in firms of fewer than 101 workers, or Medicaid-eligible are generally considered to be eligible for coverage through an alliance.

In all three legislative proposals, alliance boundaries are not permitted to subdivide an MSA[4] or, in effect, a Primary Metropolitan Statistical Area (PMSA).[5] Both the Chafee/Dole and Cooper/Breaux bills require that designated alliance areas have a minimum population base of 250,000. While the Clinton plan does not specify a number, it does require that the alliance area include a population sufficiently large to provide the alliance with bargaining power to promote competition among plans.

Both the Clinton and Cooper/Breaux plans specify that a single alliance will operate in each area. The Chafee/Dole plan only requires that the state designate health care coverage area boundaries; if one (or more) alliance forms, then it must serve the entire coverage area.[6] The Clinton plan does not permit alliance boundaries to cross state lines; however, both the Cooper/Breaux and Chafee/Dole plans permit alliance boundaries to cross state lines. All bills permit health plans to operate across state lines or alliance boundaries.

[4]A metropolitan area consists of a large population center and adjacent communities that have a high level of economic and social integration with that population center. Metropolitan areas are classified as a Metropolitan Statistical Area (MSA) or a Consolidated Metropolitan Statistical Area (CMSA). CMSAs, which contain 1 million or more people, consist of at least two separate statistical areas called Primary Metropolitan Statistical Areas (PMSA) (see app. I).

[5]In the Clinton proposal, an alliance can subdivide an MSA or a PMSA if that area crosses state lines.

[6]Unlike the other two bills, the Chafee/Dole bill permits the creation of competing alliances. A single alliance may operate in more than one coverage area.

Maintaining Metropolitan Areas Central to the Three Proposals

Each health care proposal requires states to keep MSAs intact when defining alliance boundaries, primarily to prevent discrimination of disadvantaged or high-risk groups by health plans. While some of the largest disparities in income distribution are found between inner city and suburban areas within MSAs, there may also be differences in income and other characteristics among contiguous MSAs and between metropolitan communities and rural areas. While the requirement that MSAs remain intact may prevent some redlining that isolates areas with high-risk populations, potential gerrymandering in defining alliance boundaries could be a problem.

Future issues may emerge if changes in MSA definitions require states to reconfigure their alliance boundaries. Over the past decade, changes in MSA definitions have generally affected only a few areas of the country. Changes were based primarily on a yearly evaluation of statistical data in relationship to criteria established each decade by OMB. However, in selected cases such decisions have also been based on local opinion or congressional action. Given the potential importance of health alliance boundaries, there are concerns that a change in the definition of an MSA by OMB may require states to reconfigure their alliance boundaries.

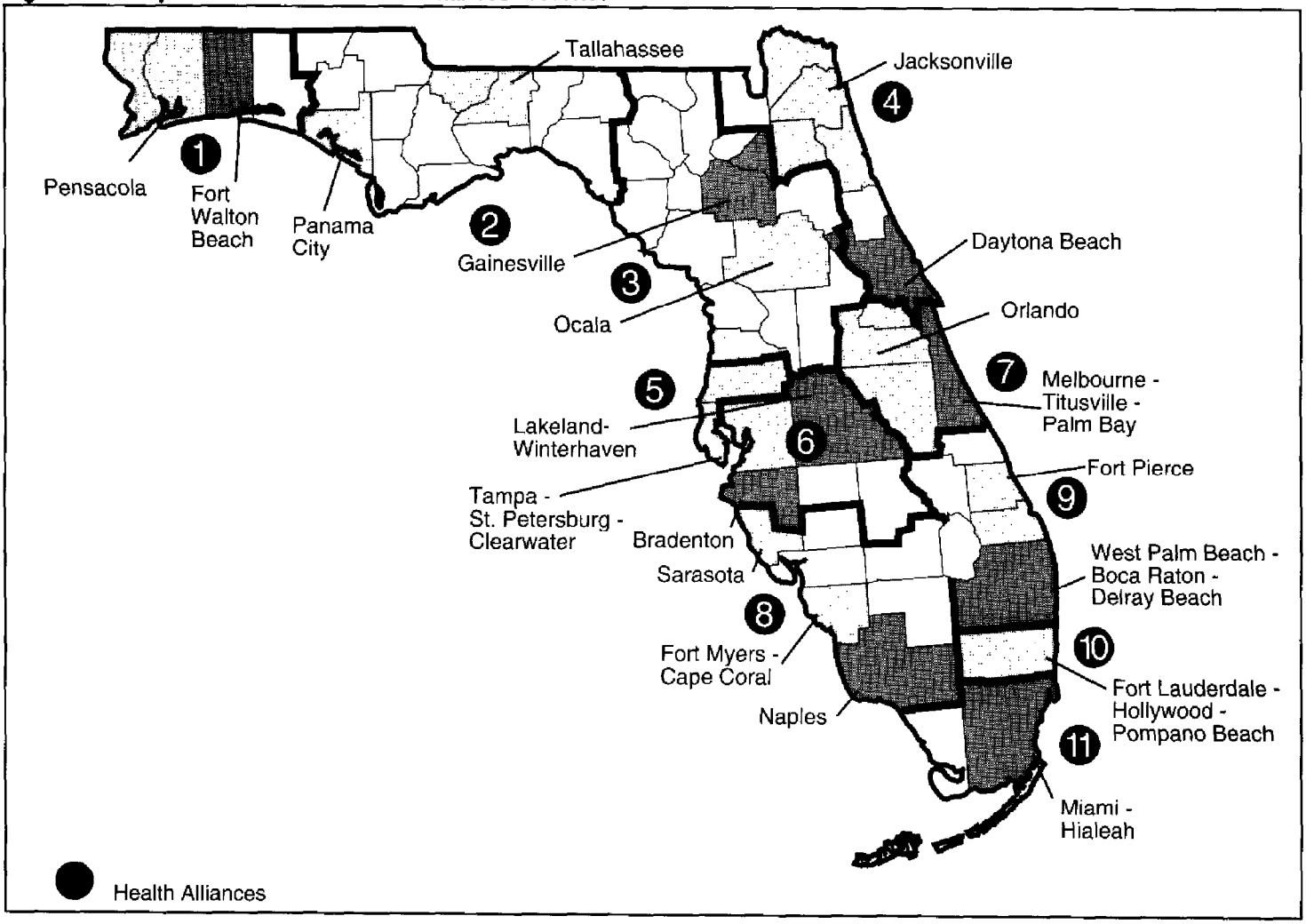
Many are concerned that future issues may emerge if changes in MSA definitions require states to reconfigure their alliance boundaries. Other concerns center around the extent to which political influences, namely the opinion of local officials and congressional action, may affect OMB's definition of MSAs given the potential importance of health alliance boundaries (see app. I for more information on metropolitan areas).

Recent Experiences in Florida and Washington Illustrate the Political Process Involved in Determining Alliance Boundaries

Florida and Washington have already faced the difficult decisions required in defining boundaries for alliance-like structures as part of their health reform legislation. Their experiences may be instructive as to the different points of view regarding the size, number, and boundaries of alliances.

Using the existing geographical structure of its Health and Rehabilitative Services (HRS) planning districts, Florida legislators divided the state into 11 separate alliance areas, ranging in population from about 500,000 to over 2 million (see fig. 1).

Figure 1: Metropolitan Areas and Health Alliances in Florida



Note: Shaded regions represent metropolitan areas.

Initial legislative proposals anticipated five to six alliances based on health market areas, but market areas are not well defined and local leaders could not agree on their specific boundaries. Thus, the Florida Legislature compromised by relying on existing HRS planning districts. However, the legislators provided for the option of future mergers of up to three contiguous alliances that are not primarily urban into a single alliance.

Florida's alliance boundaries generally conform to the proposed requirements of the national health reform bills. However, portions of the Tampa-St. Petersburg-Clearwater MSA are included in three separate alliances. Also, the smaller alliances in the Florida panhandle may not meet the Cooper bill requirement of a minimum 250,000 eligible individuals.

Alliance boundaries established under the Washington Health Services Act of 1993 also reflected political compromise. The legislation authorized the creation of four alliances and left to the state's Health Services Commission the decision on specific boundaries for these alliances. The legislation also requires that the decision be based on population, geographic factors, market conditions, and other factors deemed appropriate by the commission. The legislation specified only that the population covered by an alliance should be at least 150,000, which is smaller than the minimum size required under the Cooper and Chafee plans. The Washington Senate would have preferred two alliance areas; the Washington House was concerned about the potential power of larger alliances and wanted 10 areas.

States' Placement of Boundaries Raises Some Concerns

Consumers, employers, and providers have raised questions about the number of alliances that states will create and how boundary lines will be drawn. While these concerns cover a broad spectrum, questions have surfaced in the key areas of how the creation of alliance boundaries will affect the provision of care in existing health markets, segment and limit access to care for disadvantaged or high-risk populations, and redistribute health care costs among different geographic or socioeconomic groups.

Potential Impact on the Provision of Care

Individuals seeking insurance through the alliance that includes the area they live in may have concerns about whether they will still be able to use physicians, hospitals, and other health care facilities that may be located outside the boundaries of their alliance. Similarly, physicians, hospitals, and other providers may also have concerns as to whether they will be able to maintain the part of their patient base that is located in another alliance area. Whether these concerns are justified depends more on the service areas covered and provider networks and coordination mechanisms developed by health plans than the geographic boundaries of alliances.

Perhaps the more important issue is whether the structure of the alliances will make coordination across areas and development of broad-ranging networks by health plans easier or more difficult. On the one hand, the creation of a standard benefits package and the broader coverage expected under these plans could make coordination easier. On the other hand, coordination could be more difficult if states or alliances have different requirements for the collection and dissemination of provider data. This could result in health plans not seeking certification, and thus the permission, to operate in multiple alliances or states. Similarly, if alliance fee schedules are not roughly comparable, providers may avoid serving patients from neighboring alliances.

Obviously, the larger the number of alliances established, the more coordination there will have to be, and, possibly, the higher the administrative costs. Ultimately, plans will have to assess whether the benefits of operating in a different alliance area outweigh the costs incurred in terms of meeting any additional requirements.

Coordination could be most critical in areas where alliance boundaries separate existing health markets. This may be likely in the 41 metropolitan areas that span state boundaries such as in the Washington, D.C., and Philadelphia metropolitan areas.

Administration officials contend that coordination should be no more difficult than it is today, when plans operate across state lines. While the necessary coordination is anticipated under reform, no provisions in the Clinton bill explicitly provide mechanisms or incentives for this coordination.

The Cooper/Breaux and Chafee/Dole bills also contain stipulations to minimize the impact of alliance boundaries on the provision of care for individuals and providers. As with the Clinton proposal, they permit plans to operate in multiple alliances or states and allow states to coordinate their plan requirements. Further, to keep health markets that span state lines intact, the Cooper/Breaux and Chafee/Dole bills allow multistate alliances. Interstate cooperation would be needed to create these alliances, and additional issues could arise, such as the creation of an adequate oversight mechanism for and the inclusion of Medicaid-eligible populations in multistate alliances. Neither of these bills specifies the mechanisms or incentives to do so.

Potential Risk Segmentation and Limited Access to Care

Other concerns center around whether some alliances within a state will have a disproportionate share of a state's high-risk population. Such alliances could have greater difficulty attracting a sufficient number of health plans that would offer consumers an adequate choice of plans. The extent to which boundaries could cause this to happen depends on factors like the number of alliances in a state and whether states have metropolitan areas with markedly different demographic profiles. For example, some isolation of high-risk communities could occur if states created a number of geographically smaller alliances, such as one alliance for each metropolitan area. Such risk segmentation could occur in areas with specific characteristics, such as unusual industrial, environmental, or epidemiological conditions (for example, the West Virginia coal mining region or areas with large concentrations of Acquired Immune Deficiency Syndrome cases). Moreover, risk segmentation could also exist when two adjacent MSAs have different proportions of Medicaid populations, as in the case of two primary metropolitan areas in southern Florida. For example, 16 percent of the population in the Miami PMSA is eligible for Medicaid compared with only 8 percent for the neighboring Ft. Lauderdale PMSA.

Isolation of rural areas depends largely on whether states choose to separate rural areas in establishing alliance boundaries. Because the MSA rule has little relevance to rural areas, states could establish boundary lines to segment rural populations that are potentially high-risk or underserved. The Cooper/Breaux and Chafee/Dole requirements that alliance areas have a population of at least 250,000 and the Clinton requirement that alliance population size be sufficiently large to promote competition among plans make segregation of rural areas difficult or unlikely.

Further, risk segmentation may also occur on the plan level if plans are not required to provide services throughout an alliance or metropolitan area. The Clinton bill contains a provision that allows states to require a health plan to cover all or selected portions of an entire alliance area. The Chafee/Dole bill requires every alliance to service an entire coverage area. However, as with the Cooper/Breaux bill, the Chafee/Dole proposal apparently has no provisions regarding health plan service areas. Minnesota is attempting to address this problem in its reform initiative by dividing the state into 20 health service areas. Any plan operating in a particular service area must demonstrate that it provides a reasonable level of access to care for those in all geographic areas within that health service area.

Providing adequate care in rural areas has long been a challenge, and doubts have been expressed about whether the managed competition concept even has applicability to such areas. For example, the California Public Employees' Retirement System (CalPERs) health alliance serving state and local workers throughout California illustrates the limited choices that can exist in rural areas. While CalPERs offers a fee-for-service plan and over 20 health maintenance organizations (HMO) plans to its members, few HMOs operate in the more rural and remote areas of the state. Thus, rural residents tend to choose the more expensive fee-for-service plan under CalPERs in large measure because their choice is restricted.

Redistribution of Health Care Premiums

Another question that has been asked about alliance boundaries is whether boundaries will be drawn in such a way as to redistribute health costs among different groups. Under each proposal some people may pay more for insurance than they do now, and those extra payments will indirectly subsidize other people who will pay less than before. In general, however, such redistribution is less a consequence of new health alliances than of health insurance reform.[7] Currently, most individual firms pay premiums that reflect the health status and medical costs of their workers. Firms with a few high-risk workers may be unable to get insurance unless they exclude those workers. Since a major goal of health care reform is to provide guaranteed access to affordable insurance, covering these high-risk people will necessarily entail that some of their costs will be paid by others.

While cost redistribution is inevitable under reform, alliance boundaries could affect whose premiums change and by how much. Larger alliances would provide greater risk sharing among a state's population, but this could result in some persons paying higher premiums. Because premiums will be community-rated, persons living in lower-cost areas would pay more and persons in higher-cost areas would pay less if health plans attempt to serve the entire alliance area. For example, persons in Flint or Saginaw, Michigan, would pay more if their alliance included Detroit. At present, average net health insurance claims costs in the Detroit area are about 20 percent higher than costs in Flint and nearly one-third higher than in the Saginaw area.

[7]The demographics of redistribution can take many forms, for example between high- and low-income groups, between rural and urban populations, between easy and hard-to-serve areas, or between young and old individuals. Exactly which groups are affected by, and the extent of, the redistribution will likely vary across regions according to the representation of the different groups within each region.

On the other hand, creation of smaller alliances within a state could also result in higher premiums for some persons, as disproportionate shares of high-risk persons are concentrated in some alliances. Citizens in those alliances would pay more because of the greater costs of these high-risk persons.

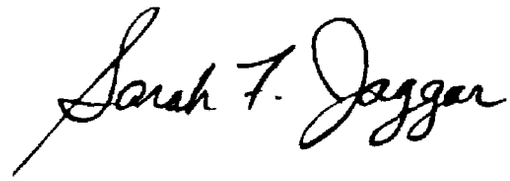
Conclusion

Alliances have been proposed as a means for broadening coverage, pooling risks, providing consumers with a choice of health care plans, and disseminating information on the costs and quality of plans. However, the major health reform proposals relying on alliances have various boundary provisions that raise concerns. These concerns include the potential for gerrymandering, changing the provision and receipt of health care, segmenting high-risk groups, and isolating underserved areas.

Although we did not obtain official agency comments on this report, we discussed the information contained in this report on metropolitan areas with OMB officials. They generally agreed with our treatment of the subject, and we incorporated their comments where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and the Director of OMB and other interested parties. Please call me on (202) 512-7119 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix II.

Sincerely yours,



Sarah F. Jaggar
Director, Health Financing
and Policy Issues

Features of and Procedures for Establishing Metropolitan Areas

Each health care proposal requires states to keep Metropolitan Statistical Areas intact when defining alliance boundaries as a means to prevent discrimination of disadvantaged or high-risk groups by health plans. Concerns have been raised that procedures for defining MSAs and alliance boundaries could become political decisions that might affect existing health markets.

The Office of Management and Budget establishes definitions for MSAs using statistical information furnished by the Bureau of the Census. In addition, changes to MSA definitions have been occasionally influenced by the views of local officials and congressional action. In this appendix, we discuss (1) the concept of metropolitan areas, (2) how metropolitan areas are used in federal funding programs, (3) the process used by OMB to define and change MSAs, and (4) how local opinion and congressional actions have affected various changes to MSA definitions.

The Metropolitan Area Concept

In general, a metropolitan area consists of a large population center and adjacent communities that have common economic and social characteristics. Current OMB standards define an MSA as an area including one city with 50,000 or more inhabitants or an urbanized area of at least 50,000 inhabitants and a total metropolitan population of at least 100,000 (75,000 in New England). Moreover, counties that contain the largest city are the central county, along with any adjacent counties that have at least 50 percent of their population in the urbanized area surrounding the largest city. Additional outlying counties are included in the MSA if they meet various requirements of commuting to the central counties and possess other metropolitan features (such as population density and percent urban). In New England, MSAs are defined in terms of cities and towns rather than counties.[1]

A metropolitan area that has more than 1 million population and meets certain other requirements of the OMB standards may be classified as a Consolidated Metropolitan Statistical Area. Each CMSA consists of two or more major components recognized as Primary Metropolitan Statistical Area.

[1]Because of this unique city/town configuration, OMB has a special definition for this sector: New England County Metropolitan Areas (NECMAs). However, NECMAs do not replace New England metropolitan areas as the standard area.

As of June 1993, OMB recognized 253 MSAs, 76 PMSAs, and 19 CMSAs.[2] The number of metropolitan areas contained in a state can vary widely; 4 states have only 1 metropolitan area, while 10 states have over 10. A sizable number of MSAs and PMSAs—41—cross state lines (see table I.1).

Table I.1: Metropolitan Areas Crossing State Borders

Metropolitan statistical areas	Primary metropolitan statistical areas
Augusta-Aiken, GA-SC	Boston, MA-NH
Charlotte-Gastonia-Rock Hill, NC-SC	Lawrence, MA-NH
Chattanooga, TN-GA	Lowell, MA-NH
Clarksville-Hopkinsville, TN-KY	Portsmouth-Rochester, NH-ME
Columbus, GA-AL	Worcester, MA-CT
Cumberland, MD-WV	Cincinnati, OH-KY-IN
Davenport-Moline-Rock Island, IA-IL	Newburgh, NY-PA
Duluth-Superior, MN-WI	Philadelphia, PA-NJ
Evansville-Henderson, IN-KY	Wilmington-Newark, DE-MD
Fargo-Moorhead, ND-MN	Portland-Vancouver, OR-WA
Fort Smith, AR-OK	Washington, DC-MD-VA-WV
Grand Forks, ND-MN	
Huntington-Ashland, WV-KY-OH	
Johnson City-Kingsport-Bristol, TN-VA	
Kansas City, MO-KS	
La Crosse, WI-MN	
Las Vegas, NV-AZ	
Louisville, KY-IN	
Memphis, TN-AR-MS	
Minneapolis-St. Paul, MN-WI	
New London-Norwich, CT-RI	
Norfolk-Virginia Beach-Newport News, VA-NC	
Omaha, NE-IA	
Parkersburg-Marietta, WV-OH	
Providence-Fall River-Warwick, RI-MA	
St. Louis, MO-IL	
Sioux City, IA-NE	
Steubenville-Weirton, OH-WV	
Texarkana, TX-Texarkana, AR	
Wheeling, WV-OH	

[2]These totals include 3 MSA's, 3 PMSAs, and 1 CMSA in Puerto Rico.

The metropolitan area concept is intended to provide a nationally consistent set of definitions for collecting, tabulating, and publishing federal statistics. The federal government uses these definitions for purposes such as Census Bureau statistics on population, housing, industry, trade, as well as in Bureau of Labor Statistics data on employment, payroll, and labor markets. The private sector also uses the metropolitan area definitions for marketing research.

Programmatic Uses of Metropolitan Area Definitions

Although initially established for statistical purposes, metropolitan area definitions are used by various federal agencies to structure the geographic basis for allocating federal funds. Some examples include the following:

- The Farmers Home Administration makes rural housing loans in towns of 10,000 to 20,000 population only if they are located outside of metropolitan areas.
- The Community Development Block Grant program (CDBG) improves the housing environment and economic opportunities of low and moderate income persons. The Department of Housing and Urban Development targets 70 percent of CDBG funds to so-called entitlement communities (cities of 50,000 or more, or central cities of metropolitan areas and metropolitan counties of more than 200,000 population, excluding the entitlement cities). Thirty percent of the funds go to nonentitlement communities, which may be located either within or outside a metropolitan area. The CDBG program uses various data at the metropolitan area level in formulas designed to determine funding levels.
- The Health Care Financing Administration (HCFA) uses metropolitan areas for Medicare payment purposes, along with other factors. HCFA's Medicare payments for inpatient hospital services are partially based on whether a hospital is located within a metropolitan area. Medicare reimbursements are higher for hospitals located in metropolitan areas than those in nonmetropolitan areas. HCFA uses statistical data for metropolitan areas in its payment formula, which includes a hospital wage index relating the amount hospitals pay to treat particular illnesses. In addition, HCFA establishes cost levels for reimbursing home health agencies and cost limits for routine service in skilled nursing facilities based on metropolitan areas.

As previously noted, metropolitan areas are important in determining the allocation of federal funds. The provision of major health reform proposals

that states may not separate MSAs when drawing alliance boundaries would represent another important application of the metropolitan area concept.

OMB's Process for Defining Metropolitan Areas

As authorized by the Paperwork Reduction Act of 1980 (44 U.S.C. 3504), OMB establishes the standards for defining metropolitan areas. These standards are developed and published in the Federal Register before each decennial census. In developing the standards, OMB considers comments received directly from the public and during a public hearing, and recommendations from a 15-member Federal interagency committee on metropolitan areas. In general, OMB standards outline baseline statistical criteria that must be met for classification as a particular type of metropolitan area. Moreover, the standards require that, for selected cases, OMB solicit and consider local opinion, which is a reflection of public views on the application of the standards.

Major revisions to metropolitan area definitions are made after each decennial census, when the Census Bureau provides OMB with population and commuting data. A 15-member federal interagency committee on metropolitan areas applies the standards to the census data, and considers local opinion in some instances, to develop revised definitions. The committee then submits its recommendations to OMB for final approval. The OMB Director makes the final decision on all changes to MSA definitions.

Minor changes to metropolitan area definitions occur in June of each year between the decennial census. These intercensal changes are largely based on the Census Bureau's annual population estimates, which identify areas that are close to meeting the specific statistical thresholds for revision. Since the mid-1980s, these changes have consisted chiefly of adding or deleting metropolitan areas based on population changes.

Decennial Census Provides Baseline Statistical Data for Defining Metropolitan Areas

OMB standards for defining metropolitan areas require that an area meet various statistical thresholds for classification as a particular type of metropolitan area. In addition, the standards outline the requirements for designating the central city or county within metropolitan areas. For determining metropolitan areas and their central cities or counties, data from the decennial census are applied to the standards. Although extensive, these statistical requirements primarily relate to population density as well as commuting patterns of employed persons. For example, for classification as one of possibly several central cities within an MSA,

census data must show that the city has either the largest population or at least 250,000 people.

Local Opinion Considered in Selected Cases

OMB recognizes that the statistical requirements may not always be sufficient for determining changes to metropolitan area definitions. Therefore, in selected instances, OMB considers local opinion in making final decisions. Local opinion is considered for

- combining two adjacent metropolitan areas (of fewer than 1 million people) whose central cities are within 25 miles of each other;
- identifying PMSAs within CMSAs;
- assigning a county or place that, based on commuting, is eligible for inclusion in more than one metropolitan area; and
- titling PMSAs and CMSAs.

OMB solicits local opinion on a matter through the appropriate congressional delegation. In this situation, OMB sends letters to each member of the congressional delegation urging him or her to contact a wide range of groups in his or her communities, including business and other leaders, the Chamber of Commerce, planning commissions, and local officials. The letter contains the various options OMB is considering for the matter, which are derived from an application of the statistical criteria. For example, from a review of statistical data, local officials for one MSA could be asked whether they would prefer to remain a separate entity or become combined with another MSA. After the views of local officials and other citizens are obtained, the congressional member indicates the consensus by placing a mark next to the appropriate option.

Once OMB receives local opinion on a matter, the interagency committee considers all comments it received along with relevant statistical data. Based on its review, the committee makes its recommendation to OMB for final decision. After deciding on the matter, OMB will not again request local opinion on the same matter until after the next decennial census.

Changes to Metropolitan Area Definitions Based on Political Factors

Over the past decade, some changes to definitions of metropolitan areas have been shaped by political factors that extend beyond the statistical criteria established by OMB. The views of local officials have played a role in OMB decisions, as in a 1993 decision affecting the Nassau-Suffolk, New York, PMSA. Furthermore, in other instances, Members of the

Congress have adopted changes in metropolitan area definitions through legislation. A discussion of these issues follows.

Local Opinion a Factor in OMB's Recent Decision on Nassau-Suffolk, New York, PMSA

Local opinion has played a role in some changes to metropolitan area definitions since 1980. Specifically, in 1993, Census population data showed that the two-county PMSA of Nassau-Suffolk, New York, was eligible for separation. OMB then asked the appropriate congressional members to solicit local views on whether the jurisdictions should remain a two-county PMSA, or split up so that Suffolk County would be recognized as a one-county PMSA, and Nassau County would be included in the PMSA with New York City. Receiving no response from the congressional delegation, OMB ruled to include Nassau-Suffolk in the New York PMSA. When OMB announced this definition, Nassau County officials protested to OMB about the change and were later given another opportunity to respond to the issue. Their subsequent responses resulted in OMB maintaining the two-county Nassau-Suffolk PMSA.

The controversy over the Nassau-Suffolk redesignation centered around HCFA's Medicare reimbursements to hospitals. According to letters from members of the New Jersey congressional delegation, New Jersey stood to gain financially because the change in PMSA had potential to provide the state with $200 million in federal Medicare reimbursements. New Jersey hospitals allegedly had been losing millions of dollars on Medicare reimbursements. On the other hand, New York localities would have lost substantial Medicare reimbursements. For example, members of the New York congressional delegation alleged that hospitals in New York City stood to lose approximately $121 million in reimbursements.

Congressionally Mandated Changes to Metropolitan Area Definitions

Other changes to metropolitan area definitions have resulted from congressional action. During the 1980s five changes in metropolitan area definitions resulted from legislative mandates. Two examples of such changes are the following:

- In 1988, Congress passed a law for the exclusive purpose of creating the Decatur, Alabama, MSA, which merged the counties of Morgan and Lawrence, Alabama, into a single MSA. According to the legislative history, if designated as an MSA, the two counties stood to receive additional funding from federal programs, such as higher Medicare hospital reimbursements and CDBG grants. Furthermore, MSA status would have allowed these communities to address the issue of the decline in certain

industries by facilitating their joint activities to leverage local efforts to develop and expand their economies. OMB had originally ruled that the area fell short of certain population density thresholds for MSA classification. Congressional action on this matter resulted because OMB's administrative process did not address the unique nature of this situation. Constituents argued that the two counties should not have been denied MSA status because OMB's formula for computing population density considered an unpopulated area of federal forestland occupying a portion of Lawrence County. The two counties would have qualified for MSA designation if the unpopulated forest area were excluded from OMB's formula.

- In the Deficit Reduction Act of 1984, a provision was added to create the Kansas City, Missouri-Kansas MSA, which merged Kansas City, Missouri, and Kansas City, Kansas, into a single MSA. According to the legislative history, this provision was designed to ensure that the two cities and their surrounding counties were treated as one MSA for purposes of federal taxes and other programs. Previously, the two cities and associated counties had been treated as separate PMSAs.

The three other legislative mandates to metropolitan area definitions were enacted as part of continuing resolutions.[3]

[3]These three changes are as follows: (1) In 1984, P.L. 98-473 created the St. Louis, MO-IL MSA. This change rescinded OMB's previous designation of the St. Louis-East St. Louis-Alton, MO-IL CMSA, which contained three PMSAs: St. Louis, MO; Alton-Granite City, Illinois; East St, Louis-Belleville, Illinois; (2) In 1986, P.L. 99-500 added Harvey County, Kansas to the Wichita, Kansas MSA, and (3) in 1988, P.L. 100-202 added part of Sullivan City in Crawford County, Missouri, to the St. Louis, MO-IL MSA.

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