Executive Summary
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State Health Care Reform: Retargeting Medicaid Hospital Payments to Expand Health Insurance Coverage

Christopher J. Meyer

State officials committed to reforming health care must make a threshold decision: whether to use existing government health care funding to help individuals and families buy their own health insurance or to continue funneling taxpayer dollars into existing health care institutions to defray the costs of caring for the uninsured in emergency rooms.

The Role of Public Hospitals. American public hospitals have long served a critical community role by providing a health care safety net for low-income and uninsured individuals. In addition, they provide specialty and trauma services and stand as symbols of civic pride and accomplishment in their local communities. However, their financing has become increasingly dependent on discrete sources of federal funding, particularly from Medicaid.

Indeed, these hospitals' very survival often depends on preferential federal and state policies. Without these policies, some of these institutions could not survive, much less compete in delivering high-quality care and first-rate service to low-income patients, especially if these patients could choose from a broad range of health care options. A sound health policy reform would prioritize the interests of patients over the interests of institutions.

The long-term financing for these public institutions is in flux. Currently, 42 states are moving forward with plans to expand health insurance coverage to low-income and uninsured populations while simultaneously trying to control costs. These state efforts, combined with the increasing government subsidies required to support community "safety-net" facilities, will jeopardize these hospitals' traditional sources of revenue. In pursuing state health care reform, state legislators should seriously consider a new approach to financing that would transform these institutions from regular beneficiaries of taxpayer funding to active competitors for taxpayer dollars in a new and improved state-based health insurance market.

Rising Costs. By design or default, policymakers have gradually shifted their focus from delivering health care to providing health insurance. During the 1940s and 1950s, this trend was strongly encouraged by major changes in the federal tax treatment of health insurance. Persons who have private health coverage through their employers can take advantage of an unlimited tax break to purchase health insurance. They can use this group insurance to finance their care at hospitals and doctors' offices with limited restrictions. Not surprisingly, the existing third-party payment arrangement has helped to fuel rising health care costs.

More recently, this trend has been driven by the government's growing and now-dominant role in

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health care spending. Seniors receive their health coverage through Medicare, the huge entitlement program serving senior and disabled citizens. Medicare provides not only hospitalization benefits, but also fee-for-service supplemental coverage for patients to secure medical services from physicians under a set of specified federal rules and guidelines. Low-income citizens without insurance through their employers or the much smaller non-group market must rely on Medicaid, assuming that they are eligible under state and federal law. In Medicaid, government acts as the financier, purchaser, and regulator in the health care sector and even competes with private-sector institutions.

Finally, the federal and state governments reimburse hospitals and other health facilities, primarily through federal and state supplemental payments, for most of the uncompensated care provided to patients who cannot or choose not to purchase private health insurance. These two groups of citizens are the primary customers of public and safety-net hospitals.

A New and Better Policy. Government's role in health care is rapidly expanding and not likely to end in the foreseeable future. Because government will likely continue to subsidize the purchase and provision of health care for a large number of citizens, its focus should shift from subsidizing health care institutions to subsidizing people. Policymakers could accomplish this in a variety of ways: by taking advantage of federal waivers and demonstration projects, converting Medicaid dollars into funding pools for premium support to enable beneficiaries to purchase private health insurance, and redirecting federal and state supplemental payments to safety-net hospitals into a funding pool to expand private insurance coverage for the poor and the uninsured, thereby easing the burden on already overcrowded emergency rooms.

This policy of propping up public hospitals with supplemental payments creates a two-tiered health care system that diminishes individuals' freedom to choose the best health care at an affordable price. Further, subsidizing public health insurance programs increases the likelihood that individuals, especially low-income citizens, will substitute public coverage for private health insurance.

What State Policymakers Should Do. Federal regulatory changes and authorizations have encouraged several states to enact reforms. To its credit, the Bush Administration has begun to crack down on how states pool dollars to apply for federal matches of Medicaid supplemental funds. Recent audits have led nearly 30 states to dial back controversial financing practices. The Congressional Budget Office estimates that more formal rules prohibiting certain intergovernmental transfers and payback arrangements would save taxpayers and the Medicaid program nearly $18 billion over five years and more than $42 billion over 10 years. However, Congress has twice blocked implementation of these regulations.

Beyond these proposed rules and state rollbacks, two other major policy options would refocus reform on patient care instead of buildings:

- **Transform Medicaid supplemental funding (potentially billions of dollars) into a fund for personal health insurance coverage.**
- **Use federal waivers to create premium assistance for private health coverage.**

Conclusion. Most state officials sincerely want to improve health care access and quality for their citizens. The most effective way to achieve health care equality is to enable their citizens, including low-income individuals and families, to access superior private health insurance coverage instead of depending on substandard public programs or obtaining routine care in hospital emergency rooms. By transferring Medicaid dollars to help poorer individuals and families access solid private coverage and thereby reducing the overcrowding in emergency rooms, innovative state officials can begin to change the broader health care system in America.

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American public hospitals have long served a critical community role by providing a health care safety net for low-income and uninsured individuals. In addition, they provide specialty and trauma services and stand as symbols of civic pride and accomplishment in their local communities. However, over the years, their financing has become increasingly dependent on discrete sources of federal funding, particularly from Medicaid, the huge federal and state program designed to provide health care for the poor and the indigent.

Indeed, these hospitals' very survival often depends on federal and state policies that give them preferential treatment. Without these policies, some of these institutions could not survive, much less compete in delivering high-quality care and first-rate service to low-income patients, especially if these patients could choose from a broad range of health care options. A sound health policy reform would prioritize the interests of patients over the interests of institutions.

The long-term financing for these public institutions is in flux. Currently, 42 states are moving forward with plans to expand health insurance coverage to low-income and uninsured populations while

Talking Points

- The most important priority of health care reform is to improve the quality of patient care and enhance the ability of individuals to take direct, personal responsibility for their own health care.
- The current policy of propping up public hospitals with supplemental payments creates a two-tiered health care system that diminishes individuals' freedom to choose the best health care at an affordable price. It effectively places the interests of public hospitals above the interests of their patients.
- In a normally functioning market, if individuals are unsatisfied or not receiving quality care, a hospital will become uncompetitive, lose their business, and be forced to restructure or close. However, public hospitals generally do not face such competition on cost and quality and are therefore more susceptible to mismanagement and negligence.

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simultaneously trying to control costs.[1] These state efforts, combined with the increasing government subsidies required to support community "safety-net" facilities, will jeopardize these hospitals' traditional sources of revenue. In pursuing state health care reform, state legislators should seriously consider a new approach to financing that would transform these institutions from regular beneficiaries of taxpayer funding to active competitors for taxpayer dollars in a new and improved state-based health insurance market.

By design or default, policymakers in the United States have gradually shifted their focus from delivering health care to providing health insurance. During the 1940s and 1950s, this trend was strongly encouraged by major changes in the federal tax treatment of health insurance. Persons who receive private health coverage through their places of employment can take advantage of an unlimited tax break—essentially a subsidy—to purchase health insurance. They can use this group insurance to finance their care at hospitals and doctors' offices with limited restrictions. Not surprisingly, the existing third-party payment arrangement has helped to fuel rising health care costs around the country.

More recently, this trend has been driven by the government's growing and now-dominant role in health care spending. Seniors receive their health coverage through Medicare, the huge entitlement program serving senior and disabled citizens. Medicare provides not only hospitalization benefits, but also fee-for-service supplemental coverage for patients to secure medical services from physicians under a set of specified federal rules and guidelines. Low-income citizens without insurance through their employers or the much smaller non-group market must rely on Medicaid, assuming that they are eligible under state and federal law. In Medicaid, government acts as the financier, purchaser, and regulator in the health care sector and even competes with private-sector institutions.

Finally, the federal and state governments reimburse hospitals and other health facilities, primarily through federal and state supplemental payments, for most of the uncompensated care provided to patients who cannot or choose not to purchase private health insurance. These two groups of citizens are the primary customers of public and safety-net hospitals.

Government's role in health care is rapidly expanding and not likely to end in the foreseeable future. Because government will likely continue to subsidize the purchase and provision of health care for a large number of citizens, its focus should shift from subsidizing health care institutions to subsidizing people. Policymakers could accomplish this in a variety of ways: by taking advantage of federal waivers and demonstration projects, converting Medicaid dollars into funding pools for premium support to enable beneficiaries to purchase private health insurance, and redirecting federal and state supplemental payments to safety-net hospitals into a funding pool to expand private insurance coverage for the poor and the uninsured, thereby easing the burden on already overcrowded emergency rooms.

The current policy of propping up public hospitals with supplemental payments creates a two-tiered health care system that diminishes individuals' freedom to choose the best health care at an affordable price. Further, subsidizing public health insurance programs—whether through direct provision of services, provider subsidies, or direct health insurance—increases the likelihood that individuals, especially low-income citizens, will substitute public coverage for private health insurance. State officials should consider alternative financial and structural options for patients who depend on these institutions.

The High Price of the Status Quo

Current hospital payment arrangements desperately need to be reformed, but any attempt to

1. Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Molly O'Malley, and Caryn Marks, *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008*, Kaiser Commission on Medicaid and the Uninsured, October 2007, p. 9, at *http://www.kff.org/medicaid/upload/7699.pdf* (July 22, 2008).

reform hospital payments, especially payments to public hospitals, generally meets with strong opposition. Indeed, the opposition often insists that the status quo is perfectly acceptable—or should be to public officials and taxpayers alike—and that any deficiencies could easily be rectified with even larger infusions of taxpayers' money.

Defenders of the current public health care safety net point to the declining number of public hospitals, their growing unprofitability because of costlier patient populations, and the increasing instability that would result if communities lost their hospitals. These concerns are valid, but they ignore the most important priority: improving the quality of patient care and enhancing the ability of individuals to take direct, personal responsibility for their own health care.

While all American health care professionals may strive to improve patient outcomes, not all face the same set of economic incentives. In a normally functioning market, if individuals are unsatisfied or not receiving quality care, the hospital will become uncompetitive, lose their business, and be forced to restructure or close. Public hospitals generally do not face competition on cost and quality and are therefore more susceptible to mismanagement and negligence. In some cases, the federal and state public financing arrangements become little more than shameless exercises in rent-seeking or bold demonstrations of lucrative financial "gaming" by state and local officials.

Los Angeles. The Martin Luther King Jr./Drew Medical Center[2] in Los Angeles is a notorious example of a failed public hospital. Standing as a symbol of political power and justice for African–Americans, the hospital operated for over 30 years as a safety-net provider in south Los Angeles.

The hospital quickly earned the moniker "Killer King" for gross lapses in patient care. King/Drew spent more on malpractice claims than any of California's other 17 public hospitals and was cited for violating the state's health regulations more often than 97 percent of other hospitals statewide.[3] National outrage and media attention focused on King/Drew after reports that patients admitted for routine procedures had received improper dosages of medicines and had been permanently disabled or killed due to preventable surgical and treatment errors.

The hospital's defenders claimed that the facility was ill-equipped and lacked sufficient financial means. Yet the hospital spent more per patient than 75 percent of the other public and teaching hospitals in California and far more than the three other general hospitals operated by the county.[4] Other defenders claimed that it treated sicker patients who were more expensive to treat. However, neighboring Harbor–UCLA Medical Center, which had operating revenues comparable to King/Drew's, treated more patients in its emergency department, admitted nearly twice as many patients per year, and performed more complex procedures (e.g., open heart surgery and kidney transplants), thus drawing on patients who were sicker and required more expensive care.[5]

Ultimately, King/Drew suffered from a lack of competitive accountability, poor management, and improper financial dealings—a common trend among failing public hospitals.[6]

New Orleans. While King/Drew teaches lessons about the danger of poor-quality health care when competitive pressures are absent, Charity Hospital in New Orleans illustrates the danger of tying a health care safety net to buildings instead of people.

2. The hospital was renamed Martin Luther King Jr.–Harbor Hospital.
3. Tracy Weber and Charles Ornstein, "Killer King: County-Run Hospital Mired in Poor Care, Financial Misdeeds and Empty Promises," *IRE Journal*, Vol. 28, No. 3 (May/June 2005), pp. 32–33.
4. *Ibid.*
5. Charles Ornstein, Tracy Webber, and Steve Hymon, "Underfunding Is a Myth, but the Squandering Is Real," *The Los Angeles Times*, December 6, 2004, at *http://www.latimes.com/news/local/la-me-kdday2dec06,0,121956,full.story* (July 24, 2008).
6. Tracy Weber, Charles Ornstein, and Steve Hymon, "Massive Overhaul of Ailing Hospital Urged," *The Los Angeles Times*, December 23, 2004, at *http://www.latimes.com/news/local/la-me-solutions23dec23,0,7059764,full.story* (July 25, 2008).

Founded in 1736, Charity was the oldest continually operating hospital in the U.S. and remained a crucial source of care for the city's low-income and uninsured patients. While Charity served as the critical safety net for these citizens, it created a two-tiered system of second-class care. Charity was almost the only option for patients on Medicaid or without insurance. Private hospitals often neglected the role of providing care to low-income and uninsured patients because they knew that Charity would serve this role. This arrangement institutionalized a two-tiered system in which privately insured patients could access facilities across New Orleans, while publicly insured and uninsured residents had few options but Charity.

Charity Hospital is representative of the one-size-fits-all health care arrangements for the disadvantaged in urban areas across the United States. Hurricane Katrina forced the closure of Charity, eliminating the source of care for more than one in five city residents.[7] Their health care suffered because they lacked personal, portable health insurance. By tying the financing of health care to a building, the government's safety net and plan to provide access failed.

Reliance on public dollars to operate Charity also drained resources that otherwise could have sponsored the purchase of private insurance for low-income and Medicaid residents. As they reconsider health care reform, Louisiana officials have an opportunity to rethink the financing mechanisms of health care for these residents.

One Size "Fits" All. King/Drew and Charity Hospital are quintessential examples of failed public policy. The lessons of this failure have a broader application for state officials who are embarking on serious health system reform.

Public hospitals have played a crucial historical role, but the nature of that role has changed over time. Created as safety-net providers for those with little means, these hospitals had missions of teaching and providing specialty care. This arrangement existed since the early days of the republic, with the federal government playing a role in providing health care via the Public Health Service (PHS). Most notably, the government took on the role as provider of health care during and after times of war, with the PHS caring for wounded veterans. State and local governments followed this model by founding large-scale charity hospitals to provide access for the poor.

With the creation of Medicaid and Medicare in 1965, public hospitals began to provide care to these newly "insured" patients. Encouraged by the injection of new funds, these hospitals expanded their building programs, creating large public hospital complexes and extending access to rural areas. Private hospitals, realizing the steady stream of patients and reimbursements from the public insurance programs, soon began to compete for these patients, particularly Medicare patients, leaving many public hospitals to care for Medicaid and uninsured citizens.[8] Because Medicaid is a defined-benefit program, benefits would diminish during economic downturns. When state and public hospital budgets became strained, officials would limit access and care opportunities for low-income patients or, in extreme cases, close safety-net facilities altogether.

Today, there are more than 1,100 public hospitals, most of which are owned by county governments. Nearly three in four are in rural areas.[9] Their largest source of revenue is Medicaid, which accounts for 35 percent of their income.[10] The central question for taxpayers is whether or not they and the growing number of low-income patients are receiving the highest value for the dollars that their legislators are spending. The answer is clearly "No."

7. Kaiser Commission on Medicaid and the Uninsured, "A Pre-Katrina Look at the Health Care Delivery System for Low-Income People in New Orleans," Henry J. Kaiser Family Foundation, January 2006, at *http://www.kff.org/uninsured/upload/7442.pdf* (August 1, 2008).
8. PricewaterhouseCoopers, *Report on Louisiana Healthcare Delivery and Financing System*, 2006, at *http://www.braf.org/atf/cf/%7B3362ED43-A4BC-4AF0-A266-F7CBC831C6E8%7D/lrapwcfinal.pdf* (August 20, 2008).
9. Marsha Regenstein and Jennifer Huang, "Stresses to the Safety Net: The Public Hospital Perspective," Kaiser Commission on Medicaid and the Uninsured, June 2005, at h*ttp://www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf* (August 5, 2008).

The Vicious Cycle of Public Health Care Financing

The current public financing of care through safety-net hospitals creates a vicious cycle. Public safety-net institutions treat a disproportionately high number of Medicaid and uninsured patients because these patients generally lack other points of access to doctors and other medical professionals. Lower Medicaid and supplemental reimbursements, combined with the relatively higher proportion of Medicaid and uninsured patients versus privately insured patients, increase the costs borne by the hospital.

At least, this is the primary reason that champions of the status quo give when insisting on increased taxpayer financing of safety-net care facilities. State officials who are serious about health system change should examine this claim more closely.

The truth is that existing public health care reimbursement arrangements encourage the delivery of services in costlier, hospital-based settings. Over the past decade, the volume of inpatients, who typically receive higher reimbursement rates from Medicaid, has declined, while outpatient volume has increased.[11] Even with this shift in patient contact, Table 1 shows that 33 percent of visits by Medicaid patients to an outpatient health care setting in 2006 were to a hospital facility, compared to just 14 percent of visits by privately insured patients.[12] Further, economic barriers to health care access (i.e., lack of private health coverage) disproportionately affect minority patients and increase their reliance on emergency departments for care.[13]

Similarly, Table 2 shows that Medicaid patients use hospital outpatient facilities nearly four times as often as privately insured patients and more than twice as often as uninsured individuals. Medicaid patients' utilization of hospital emergency departments is even more troubling, even though their primary-care utilization rate is 60 percent higher than that of privately insured patients. If taxpayers' dollars were moved away from hospital settings and toward outpatient facilities located in communities, policymakers might witness a patient shift similar to declining inpatient care.

Distribution of Outpatient Visits in 2006

Characteristic	Primary Care Offices	Surgical Specialty Offices	Medical Specialty Offices	Total Hospital-Based Outpatient Services *(HOD—Hospital Outpatient Departments, HED—Hospital Emergency Departments)*
Private Insurance	49.9%	17.3%	18.6%	14.2% (6.8% HOD, 7.4% HED)
Medicaid or SCHIP	50.7%	6.9%	9.5%	33.0% (16.9% HOD, 16.1% HED)
Uninsured	32.9%	9.8%	13.4%	43.9% (14.7% HOD, 29.2% HED)

Source: Susan M. Schappert and Elizabeth A. Rechsteiner, "Ambulatory Medical Care Utilization Estimates for 2006," Centers for Disease Control and Prevention *National Health Statistics Report* No. 8, August 6, 2008, p. 11, Table 1, at *http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf* (August 20, 2008).

Table 1 • B 2177 heritage.org

10. Calculation by Kaiser Commission on Medicaid and the Uninsured, based on Obaid Zaman, Ellen Lukens, and Linda Cummings, *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, October 2006, at *http://www.naph.org/naph/publications/Survey2004.pdf* (August 20, 2008).
11. Regenstein and Huang, "Stresses to the Safety Net."
12. Susan M. Schappert and Elizabeth A. Rechsteiner, "Ambulatory Medical Care Utilization Estimates for 2006," Centers for Disease Control and Prevention *National Health Statistics Report* No. 8, August 6, 2008, at *http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf* (August 20, 2008).
13. John S. O'Shea, "The Crisis in Hospital Emergency Departments: Overcoming the Burden of Federal Regulation," Heritage Foundation *Backgrounder* No. 2050, July 9, 2007, p. 10, at *http://www.heritage.org/Research/HealthCare/bg2050.cfm*.

Number of Outpatient Visits Per 100 Persons in 2006

Characteristic	Primary Care Offices	Surgical Specialty Offices	Medical Specialty Offices	Hospital Outpatient Departments	Hospital Emergency Departments
Private Insurance	167.4	57.9	62.4	22.8	24.9
Medicaid or SCHIP	272.1	36.9	51.1	90.6	86.5
Uninsured	53.5	15.9	21.7	23.8	47.4

Source: Susan M. Schappert and Elizabeth A. Rechsteiner, "Ambulatory Medical Care Utilization Estimates for 2006," Centers for Disease Control and Prevention *National Health Statistics Report* No. 8, August 6, 2008, p. 12, Table 2, at *http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf* (August 20, 2008).

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Effects of Public Hospital Privatization and Closure

Many state and local governments are abandoning their roles in the hospital business, selling the facilities to private operators or closing them. While many champions of the current financing system claim that care for the disadvantaged and uninsured would suffer following the closure or privatization of a public hospital, the empirical evidence does not support this claim.

According to an Urban Institute study of five localities across the U.S., the absence of public facilities due to privatization, closure, or reduction in bed and facility capacity did not lead to a loss of safety-net care.[14] Three of the localities closing public hospitals in the 1990s shifted patients from former public hospitals to community clinics. This improved the efficiency of services and gave patients better access to needed care and referral services.

Most important, private institutions accepted the mission of providing care. Under the previous arrangement, private operators did not need to provide these services because the public safety-net facility guaranteed access and received reimbursement for providing care. While these locations did not address the ability of individuals to use insurance and choose their health care providers, the study does show that eliminating monolithic public hospitals does not necessarily lead to the loss of safety-net care.

Further, evidence suggests that safety-net hospitals are beginning to compete and adopt private-sector strategies to attract privately insured, higher-paying patients. One recent study noted that safety-net facilities in Boston, Miami, and California's Orange County are changing their public image to appeal to a broader group of patients. The study concluded that expanding private insurance coverage is the most direct way to ensure that safety-net providers remain viable.[15]

How Medicaid Financing Creates Segregated Health Care

Medicaid provides health coverage for over 60 million low-income and disabled Americans at a cost of approximately $350 billion per year. States pay qualified health care providers for a range of covered services and then seek reimbursement from the federal government for the federal share of those payments. Medicaid is the largest source of revenue for public hospitals, providing approximately 35 percent of their bottom lines.[16]

Safety-net hospitals provide the majority of care to Medicaid and uninsured patients. To compensate

14. Randall R. Bovbjerg, Jill A. Marsteller, and Frank C. Ullman, "Health Care for the Poor and Uninsured After a Public Hospitals' Closure or Conversion," Urban Institute *Occasional Paper* No. 39, September 2000, at *http://www.urban.org/UploadedPDF/309647_occa39.pdf* (July 24, 2008).
15. Peter J. Cunningham, Gloria J. Bazzoli, and Aaron Katz, "Caught in the Competitive Crossfire: Safety-Net Providers Balance Margin and Mission in a Profit-Driven Health Care Market," *Health Affairs*, Vol. 27, No. 5 (2008).

hospitals for uncompensated and higher costs of caring for these patients, Medicaid provides two broad forms of supplemental payments in addition to the traditional service reimbursement rates for beneficiaries' health care.

Disproportionate Share Payments. The largest source of support is the Disproportionate Share Hospital (DSH) payment, which is in addition to the regular payments that public hospitals receive for providing inpatient care to Medicaid beneficiaries. Federal law requires states to make these payments to hospitals that serve a disproportionate number of low-income patients. Payments are limited to the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.

However, the distribution of DSH dollars is not equal either within or across states. For example, in 2005, DSH spending ranged by state from less than 1 percent in Delaware, New Mexico, and North Dakota to more than 18 percent in Louisiana. In Wisconsin, Milwaukee has about 17 percent of the state population but receives more than 85 percent of the state's DSH dollars. On the opposite end, San Diego has 9 percent of California's population but receives only 4 percent of the state's DSH allocation.[17]

DSH payments were also a major cause of the rapid growth in Medicaid spending in the early 1990s.[18] The DSH program, while providing critical resources for safety-net facilities, is the subject of some controversy because some states have employed financial gimmicks. For example, many states were not using actual state appropriations for their share of DSH payments, and providers were not keeping all of their DSH dollars.

Thus, the bulk of DSH spending was not being used to cover safety-net hospitals' uncompensated care costs as Congress had intended. Instead, these schemes increased the funds available to such hospitals, leading to expansions in their programs, which resulted in more patients using their facilities. Expanding health care access is usually preferable, just not through the emergency department. These additional funds could have been used to subsidize private coverage or more choice-based models of Medicaid managed care.

Upper Payment Limits. The other major source of supplemental funding is the Upper Payment Limit (UPL), which allows states to pay categories of providers as a group up to the "upper limit" of what Medicare would pay for those services. Hospitals "pool" their UPLs, allowing a state to apply those dollars toward additional federal reimbursement, which the state government then redistributes to a few safety-net hospitals.

By paying a lower reimbursement rate to the hospitals, a state can avoid using general fund dollars for the program. This arrangement also ensures that other hospitals will not see Medicaid or uninsured patients because the state concentrates reimbursements on a few hospitals. Both the Bush Administration and Congress have sought to restrain UPL supplemental funding.

The Cost. According to the Government Accountability Office, federal and state governments spent at least $23.48 billion on Medicaid supplemental payments in 2006.[19] The federal government picked up more than half of the tab, with Medicaid sending an additional $13.38 billion to the states to cover public and safety-net hospitals' added costs. DSH payments accounted for nearly 75 percent of Medicaid supplemental payments in 2006.

Under the current financing system, supplemental Medicaid payments are critical to the survival of many public hospitals. One study found that nearly $0.75 of every dollar of Medicaid DSH spending went to hospitals that had negative total margins before receiving the payments.[20]

16. Calculation by Kaiser Commission on Medicaid and the Uninsured, based on Zaman *et al.*, *America's Public Hospitals and Health Systems*.
17. Bovbjerg *et al.*, "Health Care for the Poor and Uninsured After a Public Hospitals' Closure or Conversion."
18. Teresa A. Coughlin, Brian K. Bruen, and Jennifer King, "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs*, Vol. 23, No. 2 (2004).
19. U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, May 2008, at *http://www.gao.gov/new.items/d08614.pdf* (August 2, 2008).

2006 Medicaid Supplemental Payments

In Billions of Dollars

	Total	Federal Share	Percent	State Share	Percent
Disproportionate Share Hospital	$17.15	$9.65	56.27%	$7.50	43.73%
Other Payments	$6.33	$3.73	58.93%	$2.60	41.07%
Total	$23.48	$13.38	56.98%	$10.10	43.02%

Source: U.S. Government Accountability Office, "CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments," May 2008, at *http://www.gao.gov/new.items/d08614.pdf* (August 2, 2008).

Table 3 • B 2177 heritage.org

A New Patient Focus. Defenders of the status quo argue that any cuts in Medicaid spending would stress these hospitals, but this argument misses a much larger point. The primary concern should be the patients and their continued suffering under the existing arrangements, not the hospital's bottom line.

If policymakers' primary concern is patients, then they should carefully redirect the distribution of supplemental funds to ensure that individuals have adequate health coverage. Then, if a state experiences a downturn and a hospital is forced to close, the individuals and families relying on that particular hospital will not be trapped without portable, sufficient health insurance to use at other medical facilities.

The Use and Abuse of Medicaid Supplemental Payments

Medicaid supplemental payments are made in addition to the nearly $30 billion spent annually to support the nation's 1,100 public and safety-net hospitals.[21] The state and federal governments share this cost, with the federal government paying about 56 percent. While this seems fair, the distribution creates serious inequities among and within the states. Even more seriously, it often masks a classic shell game between state and federal officials in which the taxpayer is always the loser. The actual burden on federal taxpayers is much higher than 56 percent.

States can decrease their burden of financing public hospitals by using federal supplemental Medicaid payments. However, an accurate assessment of the real federal share or effective matching rate must account for imaginative "recycling" gimmicks that states use to avoid spending their general fund dollars.

For example, a state will overpay a county-run health care provider for Medicaid benefits that are far in excess of typical rates. The federal government then reimburses the state for half or more of this inflated cost. (The exact percentage varies by state.) After the state receives the federal matching funds, it then requires the hospital to rebate the excess payment, leaving the state with a windfall of federal funds.

In 2005, the federal share of supplemental funds was officially 56.8 percent. In reality, however—after accounting for "recycling," intergovernmental transfers (IGTs), provider taxes, and other state transfers—it was actually 86 percent.[22]

A number of states have engaged in this egregious practice. Reliance on non–general fund appropriations results in a computed federal share of 100 percent for Missouri, Vermont, and Wyoming. Additionally, California, Florida, Georgia, and Texas exceeded a 95 percent federal share. A 2001 survey of 34 states estimated that gains by states and hospitals from supplemental federal Medicaid payments exceed $6 billion.[23] A review of 10 states by the Department of Health and Human Services found that DSH payments exceeded hospital-specific limits by more than $1.6 billion.[24]

20. Regenstein and Huang, "Stresses to the Safety Net."
21. *Ibid.*
22. Teresa A. Coughlin, Stephen Zuckerman, and Joshua McFeeters, "Restoring Fiscal Integrity to Medicaid Financing?" *Health Affairs*, Vol. 26, No. 5 (2007).
23. Coughlin *et al.*, "States' Use of Medicaid UPL and DSH Financing Mechanisms."

Of course, not all state officials engage in "fuzzy math" to extract more federal dollars. Nonetheless, this practice should be ended because it is an unjust and irresponsible abuse of taxpayers' money. Many above-board states (and their patients) suffer or are denied crucial resources because they choose not—or have not figured out how—to game the Medicaid payment system. More broadly, increased funding of buildings and institutions through uncompensated care pools or direct subsidies to hospitals almost certainly contributes to the crowding out of private health insurance. Meanwhile, because these public institutions can depend on federal subsidies, they experience little competitive pressure either to improve efficiency in delivering quality care or to be more accountable to patients.

Chicago Gimmicks. From 1991 to 2000, the Illinois Department of Public Aid made $5.9 billion in supplemental payments to Cook County to support inpatient, outpatient, and clinical services at public facilities in the county. The primary recipient was Cook County Hospital,[25] which is another monolithic 900-bed public safety-net facility, serving about 1 million people annually.[26]

These supplemental payments exceeded the actual costs incurred by Cook County for the period by nearly $900 million. Further, Cook County used the enhanced payments to cover costs that would not have qualified otherwise for Medicaid reimbursement. Patients who did qualify for Medicaid accounted for 55 percent of inpatient days and 87 percent of outpatient visits at Cook County Hospital.[27]

Regulations prohibited transferring funds from state-owned facilities to the state government to beef up state "contributions," but they did not prohibit transferring funds from local government facilities. As a result, Illinois, with the help of Cook County hospitals, reaped "windfall profits."

Federal officials often cannot keep pace with states' creative "compliance" with regulatory changes or clever initiatives to exploit ambiguities in Medicaid rules. Further, these arrangements illustrate the difficulty of engaging in meaningful state health insurance reforms when so much federal taxpayer money is at stake and dedicated to supporting the existing system of public hospitals.

Even with these funds, Cook County Hospital and its affiliated facilities experienced quality control problems and cost overruns. As recently as 2005, inspections revealed medical errors and health violations, including incorrect prescriptions and improper use of equipment.[28] Facing a financial crisis and administrative malfeasance, including allegations of bribery and political patronage, the hospital chief resigned and support grew for turning the hospital over to an independent governing body because federal officials threatened to withhold funds unless reforms were implemented.[29]

However, there is a much better way to serve low-income patients, depoliticize the process, and make the entire system far more patient-friendly. Illinois could shift its Medicaid dollars away from institutions and toward people. Illinois could begin by focusing on the healthiest, most populous, and least expensive group within the Medicaid population—the "moms and kids." Children and non-elderly adults make up more than 70 percent of the state's Medicaid population but account for only about 25

24. Daniel R. Levinson, Inspector General, U.S. Department of Health and Human Services, "Audit of Selected States' Medicaid Disproportionate Share Hospital Programs," memorandum to Mark B. McClellan, Administrator, Centers for Medicare and Medicaid Services, March 16, 2006, at *http://www.oig.hhs.gov/oas/reports/region6/60300031.pdf* (July 26, 2008).
25. Michael F. Mangano, Acting Inspector General, U.S. Department of Health and Human Services, "Review of Illinois' Use of Intergovernmental Transfers to Finance Enhanced Medicaid Payments to Cook County for Hospital Services," memorandum to Michael McMullan, Acting Principal Deputy Administrator, Health Care Financing Administration, March 22, 2001, at *http://oig.hhs.gov/oas/reports/region5/50000056.pdf* (August 3, 2008).
26. *Ibid.*
27. *Ibid.*
28. Kate Marshall, "County-Owned Hospital Tries to Keep Funding," *The Times* (Northwest Indiana), August 21, 2005, at *http://www.thetimesonline.com/articles/2005/08/21/news/illiana/b5611ea0f259205586257064000125l5.txt* (August 11, 2008).
29. Meghan Streit, "Cook County Hospital Chief Resigns," *The Times* (Northwest Indiana), March 7, 2008, at *http://www.thetimesonline.com/articles/2008/03/07/news/illiana/doc0e88cf434ccee43f86257405000713a1.txt* (August 11, 2008).

Illinois Medicaid Population and Spending

For Fiscal Year 2005

Enrollment Group	Number	Percent	Overall Spending By Group (In Millions)	Percent	Per Capita
Children	1,275,200	53%	$1,713	16%	$1,343
Adults	436,200	18%	$934	9%	$2,141
Elderly	397,600	17%	$2,362	22%	$5,941
Disabled	283,700	12%	$4,102	39%	$14,459
Unknown	–	–	$1,400	13%	
Total	2,392,700	100%	$10,510	100%	

Source: Kaiser State Health Facts, "Illinois: Medicaid & SCHIP," Henry J. Kaiser Family Foundation, at *http://www.statehealthfacts.org/profilecat.jsp?rgn=15&cat=4* (August 22, 2008).

Table 4 • B 2177 heritage.org

percent less than 30 percent of Illinois' total Medicaid spending ($10 billion in fiscal year 2005).[30]

With these funds, plus a portion of the federal government's more than $200 million in DSH payments for 2008, the state could easily move moms and kids into private insurance plans.[31] Many of these families already access public facilities for medical care and would likely choose to continue receiving medical services in the same facilities. This would bring more private insurance dollars into the safety-net hospitals, improving their bottom lines. Others could choose to obtain care in other locations, forcing public facilities to improve quality, choice, and access across the spectrum to retain their business or to accept permanently reduced revenues.

Boston Politics. The Illinois case illustrates the mechanisms that states use to maximize federal Medicaid supplemental dollars while minimizing their own shares. On the other hand, in Massachusetts, the distribution of supplemental dollars seems to be driven more by narrow political considerations than by any policy commitment to stated health reform goals.

By all accounts, the 2006 health reform in Massachusetts has largely succeeded in enrolling hundreds of thousands of previously uninsured residents in some form of private or state-subsidized insurance. The key catalyst for this reform was the future disposition of federal Medicaid money. With federal officials dissatisfied with how the state had been using federal funds, Massachusetts faced losing hundreds of millions of dollars in federal Medicaid matching funds that went primarily to two safety-net hospitals: Cambridge Health Alliance (CHA) and Boston Medical Center (BMC).[32]

Under the reform proposal and a historic federal–state agreement, the supplemental funds supporting these institutions were redirected from the hospitals' coffers to low-income uninsured residents to help them purchase health insurance, allowing them to access facilities of their choice instead of depending on emergency rooms at CHA and BMC. A central and revolutionary goal of the Massachusetts health reform was retargeting existing public funds from health care facilities to individuals so that they could afford health insurance coverage, thus reducing uncompensated care at hospital emergency rooms.[33]

30. "Illinois: Total Medicaid Spending, FY2006," Henry J. Kaiser Family Foundation, StateHealthFacts.org, at *http://www.statehealthfacts.org/profileind.jsp?ind=177&cat=4&rgn=15* (August 22, 2008).
31. *Ibid.*
32. Greg D'Angelo and Edmund F. Haislmaier, "Health Care Reform in Massachusetts: Medicaid Waiver Renewal Will Set a Precedent," Heritage Foundation *WebMemo* No. 1979, July 2, 2008, at *http://www.heritage.org/Research/HealthCare/wm1979.cfm*.
33. For a description of this crucial component of the Massachusetts health reform, see Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs*, Vol. 25, No. 6 (2006). See also Nina Owcharenko and Robert E. Moffit, "The Massachusetts Health Reform: Lessons for Other States," Heritage Foundation *Backgrounder* No. 1953, July 18, 2006, at *http://www.heritage.org/Research/HealthCare/bg1953.cfm*.

In 2008, however, the state faced a nearly $150 million deficit in the program. Yet CHA and BMC continued to receive nearly $200 million per year in subsidies as a result of a political deal that clearly violated the intent and spirit of the health reform. Worse, Massachusetts' political leaders have pressured Washington to help to cover their cost overruns.[34] Clearly, if the state had chosen to reduce or eliminate these subsidies for CHA and BMC, it would have enough to cover its costs and insure even more of the state's low-income residents, further reducing the burden of uncompensated care on all state hospitals, not just CHA and BMC.

What State Policymakers Should Do

Federal regulatory changes and authorizations have encouraged several states to enact reforms. To its credit, the Bush Administration has begun to crack down on how states pool dollars to apply for federal matches of Medicaid supplemental funds.[35] Recent audits have led nearly 30 states to dial back controversial financing practices.[36] The Congressional Budget Office estimates that instituting more formal rules prohibiting certain intergovernmental transfers and payback arrangements would save taxpayers and the Medicaid program nearly $18 billion over five years and more than $42 billion over 10 years.[37] However, Congress has twice blocked implementation of these regulations.

Beyond these proposed rules and state rollbacks, state officials need to look for alternative ways to ensure that patients receive personal, portable, and private health insurance coverage. Two major policy options could refocus reform on patient care instead of buildings.

OPTION #1: States could transform Medicaid supplemental funding into a fund for personal health insurance coverage.

By tying federal and state funding for the health care of low-income and uninsured Americans to public institutions, officials drain resources away from real health care protection, missing the opportunity to expand health insurance coverage. Tying supplemental dollars to patients instead of places would:

- **Increase access to quality care.** Medicaid patients not only visit health care providers more frequently than privately insured patients, but also access this care in less efficient ways. A Centers for Disease Control and Prevention study showed that Medicaid beneficiaries are twice as likely as privately insured patients to receive care in a hospital setting. Uninsured patients are three times more likely.[38] Further, Medicaid and SCHIP patients are more likely than self-paying patients to visit emergency departments for non-urgent or semi-urgent care.[39] By extending private insurance to moms and kids on Medicaid, states would enable them to choose locations of care that meet their unique needs, eliminating the current one-size-fits-all model of public hospitals.
- **Promote fairness in the allocation of public dollars.** The current financing of Medicaid is unfair. Inequalities exist within and among states, with many of the country's poorer states subsidizing more generous benefit plans in wealthier states. As noted, supplemental funds are concentrated at a few public hospitals in each state, often for political reasons. Whether or not states choose to capitalize on current waiver authority to redirect supplemental Medicaid dol-

34. D'Angelo and Haislmaier, "Health Care Reform in Massachusetts."
35. For more information on recent regulations, see Nina Owcharenko, "The Medicaid Regulations: Stopping the Abuse of Taxpayers' Dollars," Heritage Foundation *WebMemo* No. 1911, May 2, 2008, at *http://www.heritage.org/Research/HealthCare/wm1911.cfm*.
36. Coughlin *et al.*, "Restoring Fiscal Integrity to Medicaid Financing."
37. Editorial, "Medicaid Money Laundering," *The Wall Street Journal*, May 19, 2008, p. A14, at *http://s.wsj.net/article/SB121115735476802403.html* (August 20, 2008).
38. Schappert and Rechsteiner, "Ambulatory Medical Care Utilization Estimates for 2006," p. 11.
39. O'Shea, "The Crisis in Hospital Emergency Departments," p. 10.

lars toward premium support and private insurance expansion, Congress should put all states on a level playing field in Medicaid and DSH allocations. This means eliminating special deals for individual states—including New York, which collects nearly $3 billion annually in hospital provider taxes that federal officials count as the state contribution.[40] These practices virtually ensure that no state general appropriations are used toward the increasing subsidies to prop up public hospitals. Congress could give states a transition period to adjust to a new financing arrangement that provides more equitable funding to states, such as through defined contributions on a per-enrollee basis.

- **Improve the patients' quality of health care.** The most important reason to move supplemental Medicaid dollars away from institutions and toward individuals is to improve health care in America. Compared to people on public programs, individuals with private insurance have better access to health care and receive better quality care.[41] By extending the advantages of private insurance to moms and kids on Medicaid, who are relatively healthy and low-cost in the first place, policymakers could ensure that their health care will not be disrupted by budget cuts or restricted to a particular building that may not fit their personal or medical needs. Starting with moms and kids would also help to create a healthier and more affordable insurance market for all citizens in the state. Further, redirecting supplemental subsidies from institutions to patients and other health consumers would give public hospitals the opportunity and incentives to reform their processes and services to compete for privately insured patients who bring along higher reimbursement rates.

OPTION #2: States could take advantage of federal waivers to create premium assistance for private health coverage.

Created in 2001, the Health Insurance Flexibility and Accountability (HIFA) initiative encourages states to experiment with health insurance coverage alternatives. This Medicaid Section 1115 waiver project allows states to demonstrate coverage alternatives, including limiting enrollment, modifying benefit structures, and increasing beneficiaries' cost sharing.

Under HIFA, many states have expanded private insurance coverage via premium assistance programs. By leveraging public dollars to give low-income uninsured or Medicaid patients access to private health coverage, the government creates greater ties between the public and private sectors and strengthens the risk pool, especially when adding moms and kids.

Several states—including Idaho, Kentucky, Maine, and New Mexico—have secured HIFA waivers that focus on this premium assistance element. For example, New Mexico enacted a State Coverage Initiative in which the state works with private health plans to create commercial insurance products that businesses, particularly small businesses, can purchase and offer to their low-income employees or that individuals can buy on their own.[42] While these states received waivers to spend their existing Medicaid dollars on the premium assistance programs, Maine enacted a similar initiative but financed the programs by redirecting its DSH allocation away from hospitals and toward individuals.[43]

These HIFA programs have been largely successful. By December 2005, the 10 state HIFA demonstrations resulted in more than 300,000 newly privately insured individuals.[44] In Illinois, Michi-

40. Robert E. Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," National Health Policy Forum *Background Paper*, September 14, 2004, p. 11, at *http://nhpf.org/pdfs_bp/BP_MedicaidDSH_09-14-04.pdf* (August 4, 2008).

41. John S. O'Shea, "More Medicaid Means Less Quality Health Care," Heritage Foundation *WebMemo* No. 1402, March 21, 2007, p. 2, at *http://www.heritage.org/research/healthcare/wm1402.cfm*.

42. Teresa A. Coughlin, Sharon K. Long, John A. Graves, and Alshadye Yemane, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs Web Exclusive*, Vol. 25, No. 3 (April 25, 2006).

43. *Ibid.*

44. *Ibid.*

gan, and Maine, private insurance coverage expansions have reportedly reduced the burdens on safety-net providers, allowing these institutions to compete for all types of patients, including those that formally used the facilities on a government-reimbursed or uncompensated basis.[45]

Building on the early success of HIFA, a new wave of state Medicaid demonstration projects offer tiered benefit packages to enrollees. Florida, Iowa, Massachusetts, and Vermont have opened the traditional one-size-fits-all Medicaid benefit package to offer different choices to beneficiaries depending on their unique needs and backgrounds. For example, Florida has moved from a defined-benefit program to a defined-contribution program that allows beneficiaries to choose among different, competing managed care plans.

Additionally, state officials allow recipients to choose more generous and unique benefit packages. Cost-sharing is usually capped at 5 percent of family income. For a family of four at 150 percent of poverty, this amounts to $133 per month out of a monthly income of $2,650.[46]

Even the traditional Medicaid program has been shifting to a model of choice. More than 60 percent of the Medicaid population is enrolled in managed care arrangements that provide beneficiaries more choice than is available under traditional Medicaid.[47] The majority of these enrollees are low-income children and parents or caretaker relatives, who generally rely on Medicaid to cover their acute care needs—the same type of care that can be accessed through private insurance.

While the move to managed care and models of choice within the Medicaid program is a positive development on balance, many of these plans still lock beneficiaries into the old-fashioned one-size-fits-all public institutions, and the plans' benefits are still tightly controlled by bureaucrats. The low-cost moms and kids could easily be moved to more flexible and appropriate private insurance plans. Specifically, the funds used to subsidize their care through public facilities could be redirected to these individuals via premium assistance programs that allow them to decide where they receive care. Certainly, public institutions could compete for these newly privately insured persons, as would every other health plan, because these relatively low-health-risk and low-cost patients are ideal for insurers and hospitals.

Recognizing the opportunity to empower patients over institutions, in 2007, the Bush Administration proposed the Affordable Choices Initiative, which would allow states to redirect DSH payments and other Medicaid supplemental dollars away from hospitals and toward the purchase of private health insurance for low-income people. Such flexibility would provide healthy options to states during fiscal crunches, promote efficiency within public institutions, and protect patients' freedom of choice. Regrettably, Congress has not enacted such reforms.

Conclusion

Public safety-net hospitals are critical to health care access in America. Complaining about a lack of funding for these institutions will not eliminate health disparities or access issues. Even if additional public dollars could be redirected to these institutions, this would only further institutionalize a two-tiered health care system that places America's most vulnerable populations at a disadvantage.

The claims on public resources for health care, national defense, entitlement spending, energy, and other purposes greatly exceed the available funding. Eventually, the money will run out, and public safety-net hospitals will be forced to close or drastically cut services with little warning. Worse, the uninsured patients who rely on these facilities will become sources of uncompensated care for other facilities.

Just as they adapted in the 1960s, public hospitals can maintain their missions and learn to operate in the 21st century of American health care. In fact,

45. *Ibid.*

46. Data based on personal interview with Dennis Smith, former Director, Medicaid and State Operations, U.S. Department of Health and Human Services, July 22, 2008.

47. Marion E. Lewin and Raymond J. Baxter, "America's Health Care Safety Net: Revisiting the 2000 IOM Report," *Health Affairs*, Vol. 26, No. 5 (September/October 2007).

by competing for patients, these hospitals can evaluate services and programs and streamline those that make the most sense for the population that they serve.

Most state officials sincerely want to improve health care access and quality for their residents. The most effective means of achieving the goal of health care equality is to enable their residents, including low-income individuals and families, to access superior private health insurance coverage instead of depending on substandard public programs or obtaining routine care in hospital emergency rooms. By transferring Medicaid dollars to help poorer individuals and families access solid private coverage and thereby reducing the overcrowding in America's emergency rooms, innovative state officials can begin to change the broader health care system in America.

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