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No Miracle Remedies in Sight for Financing Health Care for the Poor

John M. Kuder, PhD*

How the nation finances health care for people under age 65 who are unable to pay for care themselves has long been the subject of vigorous criticism from analysts of all political spectrums. Current mechanisms that finance such care (charity, cross-subsidization, and a multitude of public programs at all levels of government) are expensive and have left many unfulfilled expectations. Changes in the current system are necessary to assure this population of good quality, accessible health care at an affordable cost. However, designing and implementing such a system that is both efficient and equitably financed is a difficult task.

Despite the proposal and implementation of a large number of experimental programs, none has satisfied all interest groups, mainly because each group has a different perspective regarding an efficient and equitable financing system. Although some general trends in reform programs are appearing, the near future of health care financing for the poor will likely continue to be characterized by experimentation and uncertainty.

While there are numerous approaches to these issues, only government-sponsored programs are reviewed and financial considerations emphasized herein. The many voluntary program options and nonfinancial issues are important subjects which merit lengthy discussion, and therefore will not be addressed.

"Although some general trends in reform programs are appearing, the near future of health care financing for the poor will likely continue to be characterized by experimentation and uncertainty."

Problems with the Medicaid Program

Much debate over reforms is based on perceptions of the Medicaid program which is intricately linked to government-sponsored welfare programs. The Medicaid program was designed to provide a mixture of federal and state financing for medical care to the poor. This federal program defines a minimum benefit package and a minimum eligible population. State governments at their own discretion can broaden both the benefits and the eligibility requirements with a guarantee that the federal government will pay a significant portion of the expenditures. Accordingly, each state has set up a different system. Many states have expanded the eligible population well beyond the categorically needy group, the minimum set by federal legislation. In addition, some state governments have expanded the benefit package to include services beyond the set minimum. Other states, however, provide only the minimum benefits and limit coverage only to those eligible for federal welfare assistance, primarily recipients of AFDC (aid to families with dependent children) and SSI (supplemental security income). Most states supplement Medicaid through independent state, county, and local government programs. These frequently include subsidies for public hospital systems which provide services to the medically indigent who are not eligible for Medicaid. As a result, each state has a different set of programs for financing care for the poor. Until recently, Arizona had refused to participate in the Medicaid program at all, but now contracts with the federal government under a limited experimental program.

Historically, one significant means of financing care for needy patients has been a form of cross-subsidization sometimes referred to as cost-shifting. Under such programs all or part of the hospital cost of treating patients who do not pay their bills may become reimbursable through a third-party payment system. Also, self-pay patients may be charged a price substantially above the cost of their treatment to cover the costs of charity care. Thus hospitals become agents for redistributing resources from the insured population, the tax-paying public, and self-pay patients, to those who lack the means to pay for their own hospital care.

This web of financing mechanisms has been more expensive than was anticipated when the Medicaid program was first implemented. In 1984 total Medicaid expenditures were over $34 billion (1). While the annual rate of increase in expenditures has been substantially below that of the Medicare program, in recent years Medicaid has been the fastest growing component of aggregate state spending and is growing faster than state revenues. Federal government officials are distressed by their inability to control Medicaid costs. Under the program the federal government has an almost open-ended commitment to match increased funding at the state level. This problem of cost containment is

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particularly difficult because, until very recently, most states reimbursed medical care providers through the mechanism originally used by Medicare—cost-based payment to hospitals and usual, customary, and reasonable fees for physicians. This method of reimbursement does not encourage provider efficiency. The 180% increase in Medicaid expenditures between 1975 and 1984 has led analysts and others concerned with government budget deficits to seek a cheaper, if not better, method of reimbursement (1).

Many critics point out that Medicaid expenditures are misunderstood. In 1984 43% of total Medicaid expenditures were for nursing home care. Only 25% of the total was for care of AFDC recipients, while 75% was for the aged, blind, and disabled. Only $8.5 billion were spent by the Medicaid program for persons not aged, blind, or disabled, and nearly half this amount, $4.08 billion, was spent for the care of children (1). Thus, the percentage of Medicaid expenditures was 20% for Wyoming and 72% for Massachusetts. In 1980 the proportion of poor children covered by Medicaid was 20% for Wyoming and 72% for Massachusetts. In 1982, only 13.2% had some form of employer-provided health insurance, and 49.3% had no public or private health insurance (2). Of those individuals in the Detroit area who had been unemployed for three or more months, Berki et al reported that 26% had lost their health insurance and that 75% of these households were not protected under Michigan's Medicaid program, despite eligibility standards more liberal than the average state (3).

Because state governments determine Medicaid eligibility and payment levels for AFDC families, standards vary widely from state to state (Table 1). In 1982 the ratio of Medicaid recipients to the number of persons below the poverty level ranged from a low of 0.29 in Wyoming to a high of 1.24 in Massachusetts. In 1980 the proportion of poor children covered by Medicaid was 20% for Wyoming and 72% for Massachusetts (4). In short, the Medicaid system, despite its substantial contribution to the improvement in health care, leaves large coverage gaps and permits substantial regional variations in health insurance coverage of the poor.

Hospitals, physicians, and other providers of health care to the poor all are critics of the current financing systems. Providers have long complained of low payment levels and the lack of adequate programs to pay for uninsured patients. The burden imposed on hospitals to care for the poor is unevenly distributed. Medicaid pays for approximately 10% of all hospital expenses across the nation, but many hospitals receive a much larger percentage of their revenue from Medicaid. About one-fourth of the university-owned teaching hospitals in this country are heavily dependent on the Medicaid program which provides over 20% of their revenue (5). Fewer than 10% of the nation's hospitals provide 40% of the nation's free care (6). At the other end of the scale, data from the Hospital Cost and Utilization Project of the National Center for Health Services Research indicate that nearly half of urban voluntary hospitals provide little or no uncompensated care (7).

"Medicaid reimburses physicians at rates below usual fee levels. This places a financial constraint on practitioners who serve the poor, and it is a disincentive for physicians to treat the poor with the same standard of care as for patients who pay higher fees."

Table 1
Ratio of Medicaid Recipients to Persons Below the Poverty Level, Top Five and Bottom Five States, Fiscal Year 1982

<table>
<thead>
<tr>
<th>State</th>
<th>Ratio of Recipients to Persons in Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hawaii</td>
<td>104</td>
</tr>
<tr>
<td>2. California</td>
<td>83</td>
</tr>
<tr>
<td>3. Rhode Island</td>
<td>77</td>
</tr>
<tr>
<td>4. Michigan</td>
<td>72</td>
</tr>
<tr>
<td>5. Massachusetts</td>
<td>69</td>
</tr>
<tr>
<td>45. Utah</td>
<td>21</td>
</tr>
<tr>
<td>46. Texas</td>
<td>20</td>
</tr>
<tr>
<td>47. Wyoming</td>
<td>20</td>
</tr>
<tr>
<td>48. Idaho</td>
<td>18</td>
</tr>
<tr>
<td>49. South Dakota</td>
<td>17</td>
</tr>
</tbody>
</table>

(From Health Care Financing Program Statistics, Analysis of State Medicaid Program Characteristics, 1984, Health Care Financing Administration, Publication No 03204.)

Table 2
Reported Usual Fees and Insurer Allowables for Office Visits by Physician Specialty, 1976 to 1977

<table>
<thead>
<tr>
<th>Specialty</th>
<th>All Primary Care</th>
<th>Specialty General Surgeon</th>
<th>Obstetrics-Gynecology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual fee</td>
<td>$14.80</td>
<td>$15.51</td>
<td>$18.28</td>
</tr>
<tr>
<td>Blue Shield</td>
<td>$12.97</td>
<td>$13.11</td>
<td>$15.34</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$9.00</td>
<td>$8.78</td>
<td>$10.33</td>
</tr>
</tbody>
</table>

Pressure is increasing to reform the current systems for financing medical care of the poor. Increasingly providers are forced by price competition, excess capacity, and payment programs based on diagnostic related groups (DRGs) to monitor and control their financial position. In addition, health maintenance organizations (HMOs) and other alternative delivery systems are extracting discounts from providers and increasingly are unwilling to pay the hidden tax of cross-subsidization. Thus hospitals have continually less opportunity to shift onto others the cost of treating the poor. Inevitably, hospitals respond with attempts to lower the volume of charity and discounted care they provide to the poor. Between 1980 and 1982 private hospitals in communities with large increases in poverty and decreased Medicaid coverage actually reduced the amount of free care they provided, while public hospitals in the same areas increased the amount of free care given (6). Under these conditions, policies that increase restrictions on eligibility, reduce benefits, and/or extract higher discounts from providers of services to the poor (without making changes in delivery system incentives) have a dire financial impact on providers. Thus, more restrictive policies can only reduce access to services for the poor. Clearly, providers committed to serving the poor must find a means to deliver high-quality services without incurring severe financial risk. Given current uncertainty about the future direction of financial programs, this mandate is proving difficult to accomplish.

"Experimental programs have trouble enrolling the poor voluntarily into alternative delivery systems. The poor are reluctant to give up uninhibited choice of a provider without receiving added program benefits."

What Shall We Try Next?

To examine alternatives to the current system, governments at all levels have entered a period of trial-and-error experimentation. A variety of issues are being addressed by a multitude of innovative approaches, but the thrust of these reforms can be characterized under four major topics: 1) seeking new sources of revenue, 2) becoming more prudent purchasers by limiting provider participation, 3) altering provider payment mechanisms, and 4) employing alternative delivery systems. The success or failure of each of these new approaches, as a response to criticisms of the current system, will provide the basis of future policies.

New sources of revenue

One new initiative for states is to seek new sources of revenue to pay for services. Florida enacted a 1.5% tax on hospital revenues, with the tax revenue to be used to support the Medicaid program. The effect of such a program is essentially to cross-subsidize care for the needy at the state level rather than at the hospital level. This approach has been criticized for not spreading the cost widely enough. It taxes the sick and insured and may impact various insurers and hospitals differently, especially those that have for-profit status versus those with not-for-profit status. West Virginia and South Carolina have recently enacted similar tax programs, and other states are considering this initiative.

Prudent purchasing programs

To reduce program costs, several state governments have attempted to create a more competitive market by limiting the number of provider contracts for care to the poor. California and Arizona have implemented such programs with selective contracts with hospitals. These contracts are awarded through a modified bidding process. Negotiated fee structures are important in determining which hospitals receive contracts and which do not. In both states the programs have saved large amounts of money without reducing the quality of care provided. Despite potential cost-savings from these programs, there is concern that they may foster a deterioration in quality of and access to service resulting in two-tier medicine, i.e., medical care in which different, usually inferior, care is given to the poor.

The effect of California's hospital bidding process is difficult to evaluate. The program was part of a package of sweeping reforms which included substantial changes in eligibility requirements and shifting of responsibility for much financing back to the counties. During the first year of the program, the state of California claims to have saved $235.4 million from the contracting program alone (9). However, hospitals reported a 22% increase in revenue deductions from bad debt, charity care, and contractual allowances during this period (9). If the contracting program is to be successful, it must not cut hospitals' abilities to provide services to the poor, and policymakers must be careful to avoid the adverse impact these cuts may have on hospitals which predominately serve low-income groups. In California the possible negative impact of these reforms was tempered by the Medicaid program, Medi-Cal, which has always been generous in terms of eligibility and benefits.

In Arizona the competitive bidding system seems to have contained costs and provided services at an acceptable level of quality during its initial two years. However, this program has been criticized for its narrow eligibility standards which impose significant access barriers to the large number of people who do not qualify for the state program (10). Although the new program may be an improvement for some, the plan has created problems for many county hospitals and the medically indigent ineligible for the program.

Innovations in provider payment

Another area of reform in many states is the mechanism by which the state pays providers for services. The system of cost-based payment for hospital services and usual, customary, and reasonable payment for physician services does not provide incentives for efficiency. Most states have moved toward some form of prospective payment system. Several states, including Kansas, Michigan, and Pennsylvania, have adopted DRG-based hospital payment schemes for their Medicaid programs, which are similar to the most ambitious prospective payment systems.

Reforming means-tested programs is more troublesome. The use of private insurance but does not work for many programs.

The basic concept behind programs is to pay each insurer a predetermined fee for the volume of services rendered, thereby decreasing the possibility of insurers increasing costs. Florida also shows how states can serve the poor without return for capital investment. The legislature in West Virginia and South Carolina have recently enacted similar tax programs, and other states are considering this initiative.

Alternatives to the current system

The current systems are not only troubled, but also seem to be creating more problems. The poor are reluctant to give up uninhibited choice of a provider without receiving added program benefits. Experimental programs have trouble enrolling the poor voluntarily into alternative delivery systems. What shall we try next?
are similar to those used in the Medicare system. Perhaps the most ambitious programs of hospital payment reform are the all-payer systems in Maryland, Massachusetts, and New Jersey.

Reforming hospital payment programs is difficult, but making meaningful changes in physician payment methods is more troublesome. One alternative is the use of fixed fee schedules. The use of some form of ambulatory DRGs has been proposed, but does not appear practical at present. The only payment systems that incorporate all services are the numerous experimental programs employing capitation methods.

The basic elements of the all-payer type of hospital payment programs are simple. In essence, all third-party payers agree to pay each hospital according to the same prospectively determined formula. The resulting rate incorporates consideration for the volume of uncompensated care the hospital provides. In theory, the formula eliminates cross-subsidization and the possibility of extracting discounts by individual insurance plans. It also should help maintain the financial viability of hospitals that serve the poor. The process for establishing hospital rates is different in each state trying this approach. However, in each case the rate has been established through a negotiation process, which results in a highly regulatory environment. Thus, in return for increased financial viability and payment for uncompensated care, hospitals have had to yield much individual autonomy. One problem with this all-payer approach is the failure to address the issue of paying for nonhospital services. There is debate about whether these programs are able to contain hospital costs sufficiently to offset their large administrative costs (11).

An alternative to the highly regulated approach of rate-fixing is to pay providers for treating the poor by a capitation method. Through this approach providers receive a fixed payment for each individual they accept for treatment during a specified period of time. Under capitation, the providers (hospital, clinic, or individual physician) accept some or all of the financial risk of caring for the enrolled patients. Capitation, which encourages cost-efficiency, has been the cornerstone policy of many successful alternative delivery systems such as HMOs and preferred provider organizations. With this approach, HMOs have demonstrated an ability to contain health care costs by reducing hospital utilization rates (12). However, capitation has many problems when it is applied to programs designed to finance care for the medically indigent.

**Table 3**

<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>100,394</td>
</tr>
<tr>
<td>Michigan</td>
<td>87,448</td>
</tr>
<tr>
<td>New York</td>
<td>22,065</td>
</tr>
<tr>
<td>Ohio</td>
<td>10,211</td>
</tr>
<tr>
<td>Arizona</td>
<td>8,909</td>
</tr>
<tr>
<td>All other states</td>
<td>120,352</td>
</tr>
<tr>
<td>Total all states</td>
<td>349,379</td>
</tr>
</tbody>
</table>

(From National HMO Census, 1984. Excelsior, MN: InterStudy, 1985.)

Alternative delivery systems and the poor

The capitation principle of provider payment involves enrolling the poor into existing or newly established alternative delivery systems and paying providers in those systems on a capitation basis. Two immediate problems present themselves. First, alternative delivery systems and other potential providers of care have been reluctant to accept the poor as major parts of their programs under risk contract (13). As yet, there is inadequate experience for setting capitation rates for this type of population. The ability to predict enrollee service needs, a requirement for setting capitation rates for these population groups, is very limited. Providers fearing adverse selection (the acceptance of too many very sick patients and too few healthy patients) are often unwilling to accept large scale capitation-based risk contracts at a price governments are willing to pay.

A second problem is that experimental programs have trouble enrolling the poor voluntarily into alternative delivery systems. The poor are reluctant to give up uninhibited choice of a provider without receiving added program benefits. In Pennsylvania an intensive program to enroll Medicaid recipients into HMOs enrolled only 12,000 recipients in over three years. If a capitation system is to resolve some of the problems of the current system, voluntary programs may have to give way to mandatory programs.

Existing HMOs have little incentive to enroll the poor, and the poor have been reluctant to join HMOs. In 1984 only 349,379 Medicaid beneficiaries enrolled in HMOs nationwide (14). This represents only about 1.4% of the estimated 25 million Medicaid recipients during 1984, a percentage approximately the same as in 1981 (Table 3). The majority of HMO Medicaid enrollment occurs in the three metropolitan areas of Los Angeles, Detroit, and New York.

Recently, several experimental programs which incorporate case-management or gate-keeper policies into programs to finance care for the poor have been initiated. A gate-keeper program requires that individual enrollees choose a primary care physician or clinic as their case manager. The primary care physician must arrange all needed medical care, including referrals to specialists and admissions to the hospital. The patient must obtain all provided services except emergencies through the primary physician. The use of existing provider arrangements is one advantage of this type of program. Although there is little evidence about the performance of gate-keeper systems, advocates argue that 1) the quality of care is enhanced by improving the continuity of care; and 2) patient care cost is lowered by reducing unnecessary referrals, hospital admissions, and use of the emergency room (15).

The experience of one of the first gate-keeper systems, the SAFECO plan, indicates that the program may not lower patient-care cost unless the case-managers have a strong incentive to ration care (16). A Medicaid experimental program in Philadelphia places the case-manager at financial risk for most patient-care expenditures via a capitation-based payment program. A similar program in Boston failed to gain widespread support among either providers or the poor. The Philadelphia program attempts to avoid inadequate participation by making beneficiary enrollment mandatory. These small experimental...
programs are being carefully watched before prepaid case-management plans are implemented on a large scale.

Significant problems with all the HMO and case-management approaches result from the fluctuating population eligible for most Medicaid and indigent care programs. Moving in and out of employment and other eligibility categories makes it difficult to enroll this population long enough to take advantage of measures for reducing health care costs. Few states seem willing or financially able to fund health care during transition periods in a person's eligibility status.

"Concerned policymakers must not ignore that the poor population is more often sick and more difficult to treat effectively than the nonpoor."

Vouchers and geographic capitation

The use of vouchers is another proposal discussed by critics of the current system. Under this proposal vouchers would be issued to the poor to purchase health insurance in the private market. The plan is designed to increase competition and contain costs without direct government intervention. No voucher plan has gained enough political support to go beyond the proposal stage, but if political conservatives continue to gain power in Congress such a plan may be anticipated.

Recently, a reform proposal called geographic capitation has been proposed in the federal government. Rather than a fundamental reform, geographic capitation appears to be a plan to put at financial risk state governments and the intermediaries administering public insurance programs. Block-grant funding for public health insurance programs could reduce the federal government’s open-ended commitment to state Medicaid programs and bring federal expenses under firm budgetary control. Geographic capitation programs would change the current system very little but would transfer much of the financial risk to state governments and to the private administrators of public programs.

Discussion and Conclusions

At present there appears to be no consensus regarding the direction that should be taken to reform the system. There is, however, growing political consensus that reform is indeed required. As a result, the current pattern of innovation and experimentation is likely to continue. If today's trends do continue, future initiatives will aim at establishing programs that incorporate some form of restrictive purchasing policies, competitive bidding, or some other type of selective contracting. Innovative approaches to incorporate the successful components of alternative delivery systems should continue. In addition, we can expect measures to assist specific hospitals no longer able to support care for the poor through cost-sharing. Special taxes to support indigent care programs will likely be adopted in many states.

Although we are learning a great deal from these initiatives, many operational, economic, and political issues must be resolved. Paying for physician services is one of the most pressing problems. Solutions that do not restrict the patient’s choice nor reduce participation by providers have been elusive. Also, whether the public is willing to accept policies that result in two-tier medicine has not been resolved.

Finally, there are serious concerns that cost-reduction programs will adversely affect quality of care. The high cost of treating the poor has been attributed to the financing system which failed to encourage efficiency. However, concerned policymakers must not ignore that the poor population is more often sick and more difficult to treat effectively than the nonpoor. For example, poor children are 75% more likely to be admitted to a hospital in a given year, have 40% more days absent from school, and suffer from many more chronic ailments (17). Therefore, policymakers cannot expect two equally efficient systems delivering the same quality of service to incur similar patient-care costs if one is treating a poor population and the other a nonpoor population.

Balancing the public commitment to provide medical care for the poor with the political mandate to restrain the cost of publicly financed programs presents difficult problems to government, to providers of medical care, and to the low-income population. Although each new program is proclaimed the panacea for our financing and delivery problems, such statements are at best premature and at worst fraudulent.

References