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Commentary

Linking Health Care For The Poor To Health Care For Profit
by Jay Wolfson, Peter J. Levin, and William J. Brock

New linkages between the private sector and government are needed in tackling the problem of ensuring adequate, cost-effective health care for the indigent. More than 21 million people were Medicaid recipients in 1984. As many as 35 million people may be uninsured during the year. In 1986, the nation’s health care providers lost at least 6.5 percent of their gross patient revenues to uncompensated care. As these numbers show, the financing and management of the nation’s indigent care services are at best a poor-man’s compromise that is forcing out the proprietaries and not-for-profits, locking public hospitals into a no-win marketplace, and sentencing the nation’s indigent and uninsured to an explicit, separate tier of health-care.

The economic and social fallout from this dilemma is forcing government and private industry to create innovative ways to finance indigent and uncompensated care, and to induce the health care marketplace to provide cost-effective, mainstreamed services to the indigent. Part of the solution may lie in linking the providers’ ongoing need for capital and working capital with the provision of health care services to indigent populations, and financing the venture with a combination of the public securities markets and a commitment of Medicaid funds at the state level.

An Investment Model For Financing Indigent Care

Rationale. The existing health care delivery system—public, not-for-profit, or proprietary—financed directly or indirectly by tax dollars alone, has not effectively delivered health care to the poor. Monies, other than from direct tax sources or government reimbursement programs, must be incorporated into a solution that provides tangible benefits to providers, patients, and government alike. Providers must be

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able to realize a financial benefit, and patients must be able to gain access to the health care delivery system.

Conflicting forces are at work on providers of health care. Indigent and uncompensated care usually result in no realized revenues, or in revenues that are far below costs, to say nothing of charges. As such, this care is a revenue-reducing force on the provider. At the same time, health care organizations need capital to acquire and upgrade assets. With increasing frequency, capital is used for purposes that may better be classified as working capital (organizational restructuring, creation and management of alternative delivery systems, or current liabilities management). Capital and working capital are, therefore, revenue-producing forces for providers. If access to low-cost capital and working capital for providers could be tied both to the provision of indigent care and to guarantees of reimbursement for the cost of these services, then the amount of uncompensated care dollars could be reduced, access to needed care may be improved, and the financial burden on the government for indigent care could be mitigated.

**Linking capital to indigent care.** This model (Exhibit 1) calls for the issuance of tax-exempt bonds by municipal authorities, to be marketed in a public sale. Bond proceeds would be used to establish three separate funds. The first fund would be used to establish an indigent care pool.

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**Exhibit 1**

Paradigm For Financing Indigent Care

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**Issue tax-exempt bonds**

**Capital and working capital pool fund**

**Indigent care pool fund**

**Investment fund**

**Medicaid**

**Employed uninsured**

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*Arrows represent dollar flow.*
The second fund would be a pool for participating hospitals’ working capital and other capital needs. The third fund would be established to earn investment income to provide additional money for paying debt services on the bonds. Authorities issuing these municipal bonds would have to be empowered to issue tax-exempt bonds for working capital purposes by their legislatures. The existing federal tax code would have to be modified, or provisions waived for purposes of a demonstration project, for the investment and reinvestment of funds proposed in this model.

Financing for working capital and other capital expenditures would be available to any financially qualified health care provider at very attractive, highly competitive rates of interest. A participating health care provider could be either a proprietary, not-for-profit, or public hospital. Additional revisions or waivers in the federal tax code would be required to permit proprietary hospitals to use tax-exempt bond proceeds beyond present limitations. Statutory changes in the tax code are justified by the government’s compelling interest in addressing the indigent care issue and in creating incentives for the private sector to share in the provision and financing of care. Reinhardt argues that there is an “apparent unwillingness of society’s well-to-do to pay for the economic and medical maintenance of the poor,” and that the public sector, through the taxation mechanism, is unwilling (and thereby unable) to pay the bill. However, the U.S. has a long history of using the power to tax (or to exclude from taxation) as an incentive to private industry to produce products or services for the public good. Witness the early land grants to the railroad industry, tax exemptions for educational and health care institutions and even insurance-type organizations, such as Blue Cross/Blue Shield plans. The products of these organizations have been deemed of sufficient public value that the income to the government that would otherwise have been generated through full taxation has been eliminated or considerably reduced.

This point is very important, because the Internal Revenue Service (IRS) and Health Care Financing Administration (HCFA) statutory amendments are central to our proposal. Tax law amendments, either on a demonstration project basis or as a matter of general policy, have historically been employed by the federal government as an explicit mechanism to affect the distribution of income, wealth, and access to certain services. Subsidies and exemptions are designed to encourage specific behaviors. The deductibility of mortgage interest from personal income taxes, for example, is a subsidy to encourage home purchasing. And in the area of private goods and services, the government has a plethora of tax-exemption or subsidy systems in place, such as the sale of enriched uranium to utilities at about 30 percent of the amount charged by private firms; the sale of water for agricultural irrigation at about one-
sixth the cost; and charges for grazing rights on federal lands of between one-fifth and one-half of market value, to name a few.  

Returning to our model, capital would be made available through loans to health care institutions from the working capital/capital pool fund. Investment earnings from the fund and loan repayments would be applied to the debt service payments on the bonds. As a condition of receiving loans from the capital pool fund, providers must agree to deliver a certain percentage of health services to indigent patients. The interest rate on the loans can be tied to the percentage of indigent care provided; that is, the more indigent care a participating hospital agrees to provide, the lower the interest rate will be on its loan from the capital pool, creating a reciprocal subsidy. The benefits to public policy and to health care providers are, therefore, integrated.

The indigent care pool would be used to reimburse each hospital for a portion of the indigent care it provides. Providers would be encouraged, where possible, to deliver these indigent care services via managed care arrangements, preferably through the health maintenance organization (HMO) and preferred provider organization (PPO) systems in which they participate. Providers will be paid a fair-market capitation rate for each indigent person enrolled in their managed care plan. This care should be delivered at the county level to persons who are eligible through county residence and financial criteria.

As a demonstration project, all Medicaid-eligible recipients would be enrolled in managed care programs that are run by providers who are also participating in the capital pool. Medicaid beneficiaries enrolled in a provider's managed care program should be charged a larger cost-sharing amount for nonemergency care sought at a provider other than the one in which they are enrolled. Providers not participating in these pools may deliver services to Medicaid eligibles who are not enrolled in any managed care program under one of two conditions: these providers agree to accept the prevailing rate of reimbursement for Medicaid services as established by the state Medicaid program, or they agree to provide managed care services to these persons according to the same financial conditions established for providers participating in the program. Medicaid-eligible beneficiaries not enrolled in any provider's managed care program should be charged a deterrent level of cost share if they do not agree to participate in such a plan. Basic safeguards can be put in place to ensure that Medicaid beneficiaries do not enroll in more than one plan at a time and do not transfer into and out of plans indiscriminately.

Persons who are employed but not offered health benefits at work may also be allowed to participate in this program. Their premium contributions could be based on average wages, and incentives may be created for employers to contribute. The indigent care pool could make up the difference between premium contributions and actual total
premium requirements. This could further enhance the cash flow into the fund, afford uninsured persons a basic standard of health benefits, and address a part of the uncompensated care issue for providers.

**Financial viability.** This model assumes that a portion of the Medicaid stream spent at the county level will be pledged to the payment of debt service on the bonds. The amount of pledged Medicaid money can be determined on the basis of actual Medicaid expenses for health care services historically incurred by the county. State Medicaid funds placed in the indigent care pool would not be subject to withdrawal by the state at the end of each fiscal year if any surplus exists, but should remain in the pool and be used for its defined purposes.

The portion of the bond proceeds deposited in the investment fund should be invested in a manner that yields a reasonable but secure return. In addition to loan repayments being used for debt service payment on the bonds, arbitrage on all funds, but primarily the investment fund, would be applied to the payment of debt service.

### Benefits And Incentives

**Providers.** Health care providers in all sectors of the economy would benefit in two ways from this model. First, they would receive guaranteed, capitated payment for services they provide to indigent patients. Therefore, their revenues and cash flow would increase, and their bad debt and uncompensated care amounts decrease. Collection costs, account management expenses, and other related costs of doing business would be reduced. Second, access to low-cost capital and working capital provides the basis for organizational restructuring and the development of alternative delivery systems, which have been identified as the emerging capital and working capital needs of health care providers. Therefore, health care providers would have access to low-cost, “revenue-enhancing” features of the indigent and uncompensated care financing provisions.

**Consumers.** Targeted health care consumers would benefit by gaining access to a broad range of health care services in their county of residence. These persons would have access to health care in a cost-effective, quality environment at little cost to themselves. One of the provisions of this model involves limited cost sharing by all health service users who participate. The cost sharing should take the form of limited monthly premium payments, deductibles, or copayments. The amount of this cost sharing would be based on family size and income, and designed to be very low, but effective as a deterrent to unnecessary, discretionary utilization. Limited, but universal, cost sharing that is scaled by family size and income has been demonstrated to have no detrimental effects on the use of medically needed services.
Investors. Potential investors would be given the incentive of tax-exempt income on their interest payments on the bonds. To make the bonds marketable, some form of credit enhancement would be necessary. A federal or state government guarantee of the bonds, which in turn would be secured by letters of credit or third-party insurers, would provide the necessary market enhancement.

Government. The financial burden to the federal, state, and local governments associated with indigent and uncompensated care will be directly offset by the program, eliminating the loss of tax revenue argument espoused by governments related to the issuance of tax-exempt debt. If the program is managed properly, the rate of increase in state Medicaid expenditures should also decline. The greatest advantage to federal, state, and local governments, however, is that indigent citizens would be guaranteed access to health care services in their county of residence.

A number of mechanical issues remain in developing and implementing this model as a demonstration project. For example, the bond’s tax-exempt status, use of proceeds, access to Medicaid funds, and the long-term financial viability of the program are significant. However, the viability of the model in the health care marketplace is enhanced by two recent events. In 1986, California began to use the municipal bond market as a basis for creating a liability insurance pool. More relevant, however, is New York State’s pilot program to sell $14 million in bonds to construct housing for homeless people. The bonds are backed by a letter of credit from a major investment banking house and are expected to receive the AAA rating from Moody’s—thereby greatly enhancing their attractiveness to investors. The goals of the model are to ensure that health care providers will be able to realize a net financial gain from participation; that indigent persons can have access to needed, mainstream health services; and that public expenditures can be reduced or stabilized.

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NOTES

6. Ibid., 249.