FINANCING CHARITY CARE IN AN ERA OF COMPETITION

by Lawrence S. Lewin and Marion Ein Lewin

Prologue: The clarion call for health care reform in the 1980s from many quarters has been replacing what Stanford Professor Alain C. Enthoven has labeled “cost-unconscious care” with market-driven price competition. Because competition systematically attacks the traditional cross subsidies within hospitals that have financed indigent care in the past, though, the movement has had a decided impact on access to care among uninsured people. In this paper, Lawrence Lewin and Marion Ein Lewin discuss this dynamic and explain how medical care can be financed for uninsured people in this new era of price competition, Lawrence Lewin, who holds degrees from Princeton and Harvard University is president of a Washington, D.C.-based consulting firm that bears his name. He has been a fixture on the Washington health policy scene for well over a decade, first serving as vice-chairman of the McNemey Task Force on Medicaid and Related Problems in 1969-1970. Lewin and his organization have been at the forefront of educating federal, state, and local officials about how health services research can be employed to address public policy problems facing the several levels of government. Working under the auspices of the National Center for Health Services Research and Health Care Technology Assessment, Lewin and his firm have convened some fifty workshops with government officials for this purpose. Lewin has also consulted with many state governments on the development of cost-containment strategies and has worked closely with many private organizations as well, including academic health centers, hospitals, insurance companies, pharmaceutical and medical device manufacturers, and alternative delivery plans. Marion Ein Lewin is director of the Center for Health Policy Research at the American Enterprise Institute (AEI). She has been the editor of and has contributed to three AEI health policy books. Previously, she worked as associate director of the National Health Policy Forum and as a health legislative assistant to Rep. James H. Scheuer (D-N.Y.).
For most of the 1980s, the health care industry has been in the throes of a major effort to see whether the market discipline of price competition can lead to a more cost-effective and responsive health care system. Few predicted that the road would be a smooth one, and, in recent years, the problem of financing charity care has emerged as a major threat to support for competition in the minds of employers as well as elected political officials.

As more and more Americans confront difficulty in gaining access to and paying for care, a backlash against further development of market forces is emerging. There is growing talk of mandating insurance benefits and of renewed interest in proposals for some type of national health insurance. In addition, attempts to further deregulate the health care industry are being challenged as inappropriate until charity care financing and access problems are ameliorated. While earlier efforts in state legislatures to adopt an all-payer rate setting as a solution appear to have abated, the indigent care issue has obstructed efforts in several states to curtail Certificate of Need.

In an effort to reduce hospital costs, payers are moving from paying charges as billed to paying negotiated rates. The cost of charity patients, and those with large uncompensated charges, thus is spread among fewer payers. In such an environment, hospitals committed to serving the uninsured poor are forced to increase their charges, while those with low or declining charity care burdens can gain a significant price-competitive advantage solely by avoiding charity care. The result has been an erosion of the genteel arrangement of cross-subsidies (cost shifting) that historically allowed hospitals to provide charity care without serious financial penalty or competitive handicap. As the pressures of competition among hospitals and prudent purchasing by payers squeeze those providing charity care, some have begun to reduce or limit their commitments. Indeed, Feder and Hadley documented such actions as early as 1980. An even more serious shortfall exists in primary and preventive care.

Efforts to avoid charity care cases did not, of course, begin with the advent of price competition. Patient dumping and skimming are by no means new phenomena, nor are the disproportionate charity care roles played by teaching and public hospitals. What is new is that the tendency to shift uninsured patients to public hospitals or to severely limit charity care has accelerated where competitive forces have escalated. The pressure to reduce unsponsored care has also intensified as hospitals in general have developed an increased preoccupation with producing “bottom lines” or total margins. In the past, most nonprofits were content to set charges to break even. Now, hospital executives and their trustees worry about producing large enough margins (profits) to retain favorable bond ratings and thus low-cost access to capital, and to ensure that they will have sufficiently deep pockets to ride out the storm of
declining demand and tough competition, the result is a tension between margin and mission that is manifesting itself in hospitals’ attitudes toward charity care.

Public Or Private Responsibility?

Although some support shared public-private responsibility for financing charity care, the popular view seems to be that it is first and foremost the responsibility of government. This view, which is particularly popular among the most ardent advocates of competition, poses some ironic and painful twists for its proponents and has some serious flaws.

First, the call for expanded public responsibilities runs counter to prevailing conservative thinking that government’s role in the domestic economy, and especially the health care sector, is already too large, and that big government leads inevitably to increased regulation. This view also runs counter to the Reagan administration’s efforts to strengthen voluntarism as a viable alternative to government. Ironically, the position that the government should be responsible for the indigent care problem provides strong support for national health insurance and similar approaches that rely on mandates and regulations.

Second, as a practical matter, increased government spending on a scale that would “solve” the charity care financing problem is highly improbable given the present federal deficit and the requirements of the Gramm-Rudman Act. In this climate, the proponents of a substantially larger federal financial role appear either naive or disingenuous.

Third, the call for increased government financing of charity care provided by hospitals suggests that the highest priority for new tax revenues should be to increase hospital income, when the more serious health care problem may not be uncompensated hospital care, but unrendered or deferred primary and preventive care. The problem is not that there are too few dollars in the health care system for hospitals to provide charity care, but rather that the unequal distribution of the charity care burden is creating competitive handicaps for those serving the uninsured poor, forcing providers to either curtail their commitments or risk pricing themselves out of the market.

Fourth, arguments in favor of expanding government responsibility also ignore the long-standing and predominantly charitable character of the hospital industry. A recent public opinion poll conducted by Cambridge Reports, Inc., for Health Management Quarterly, reported that the vast majority of the American public (85 percent of those sampled) believes that hospitals “should provide care to everyone regardless of patients’ ability to pay.” One of the underlying historical purposes of tax-exempt status is to attract and preserve capital for those nonprofit
institutions providing vital social services that government otherwise would have to provide or finance. Those who currently enjoy the benefits of tax exemption should carefully consider the financial and political consequences if the government should take over the provision or financing of hospital-based charity care.

Finally, arguments to rely primarily on government financing imply that there are no other ways to bring about fair competition, to retain medical care resources already in place, and to improve access to primary and preventive care. As this article seeks to prove, this is assuredly not the case. There are already in practice a number of approaches that are not only feasible, but, given the larger goals of the health care system, more appropriate and realistic than a major shift to government financing would be. In general, the financing of charity care can be improved in three ways: (1) expanded private and public insurance; (2) increased support for public hospitals and clinics and other programs aimed at underserved priority groups; and (3) an equitable sharing of the financial burden of providing charity care.

### Expanding: The Reach Of Insurance

Altered federal policies, changes in the labor force, and a more competitive, price-oriented health care environment are rapidly rending the fabric of public and private health insurance coverage. Both Medicaid and Medicare are the targets of increased cost-control efforts by federal and state governments, leaving vulnerable groups—low-income mothers, children, and the elderly—without needed coverage. In the private sector, businesses are shifting insurance costs, especially for dependents, increasingly to their employees. The mounting out-of-pocket costs that result may be encouraging workers to drop their dependents from the insurance rolls. In 1982, 36.3 percent of uninsured children lived with parents who had insurance. Changing trends in the labor force will place the insurance problem into sharper view, as high-paying, value-added manufacturing jobs give way to a service economy with fewer fringe benefits, lower wages, and more part-time workers.

Broadening the reach of insurance is viewed by many as one way to improve access to care. At least twenty states have expanded their Medicaid programs, with federal support. Congressional budget acts of 1984 and 1985 expanded eligibility to pregnant women in two-parent families that meet Aid to Families with Dependent Children (AFDC) income resource requirements even when the principal breadwinner is employed, as well as to children under five years old in two-parent families otherwise eligible for AFDC. The 1986 budget reconciliation bill (SOBRA) extended Medicaid optional eligibility still further to include pregnant women and young children up to 100 percent of the...
poverty level.

States, providers, and private employers have found it in their interest to support Medicaid expansion. For states, the program funds are matched by at least a 50 percent federal contribution. For providers, Medicaid covers services that in most cases would end up as charity or bad debt. And for employers, financing care of the indigent through Medicaid also spreads the burden across the business community through state taxes; the tax rate businesses pay is far below the amount they pay through cost shifting.

In spite of these efforts, however, Medicaid coverage for the poor remains inadequate. Proposals are under consideration to make Medicaid eligibility standards uniform, perhaps at 50 percent of the poverty level; currently, thirty-four states have eligibility levels below 50 percent of poverty. Recommendations also have been made to allow the low-income uninsured to buy into Medicaid on a sliding premium scale.

Another target group in the expansion of insurance are those without insurance who are employed. Urban Institute data show that three-fourths of the 37 million in this country who lack insurance are either employed or dependents of employed persons. Many of these work for small businesses, which are not required to provide insurance benefits. Such benefits for small employers often are more costly and less comprehensive than are products marketed to larger groups. To address these problems, efforts are under way nationwide to develop insurance products for this segment of the population. These products, which are now being developed in states such as Florida, Utah, Washington, and Wisconsin, have three main objectives: (1) to offer a meaningful benefit at a reasonable price (premiums within the range of $40-$70 per month); (2) to manage the care provided and to negotiate discounts with providers; and (3) to keep high-risk employees from being screened out of the market. States such as Wisconsin are investigating the feasibility of permitting small employers to place high-risk employees into a statewide risk pool, to which the employers would contribute an amount equaling the amount they pay for other employees' health benefits.

Improving access to health insurance appears to be of growing interest to Congress and public policymakers. The 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provisions require that employers' coverage be extended to certain groups of people—laid-off workers, widowed beneficiaries, divorced or Medicaid ineligible spouses and their dependents—for up to eighteen or even thirty-six months at a cost to the individual of 102 percent of the average cost for other group members. Last year, the House Ways and Means Committee proposed legislation to create incentives for states to establish state health insurance risk pools for the medically uninsurable. Although it did not pass, momentum for the concept is sure to carry over into the
100th Congress. Currently, ten states have such programs; seventeen others are considering the option.

While these voluntary efforts are important, their effectiveness in helping the low-income uninsured has yet to be proved. Good health insurance has become a costly commodity, one that middle-class workers in large companies receive at a highly subsidized, tax-favored rate. Small companies can match this benefit only at greater expense. It is doubtful that even requiring small employers to provide health benefits will prove economically feasible without some form of subsidy.

**Increasing Institutional Support For Dedicated Providers**

Public hospitals and clinics bear a disproportionate share of the burden of care for low-income uninsured persons. In many cities, they represent the principal source of inpatient care for the indigent and the only source of primary and preventive services. Direct institutional support in the form of grants and special appropriations to cover resulting deficits have come from federal as well as county and municipal (and less commonly state) governments. In cities such as New York, Chicago, Albuquerque, and Los Angeles, direct financial support of these hospitals and clinics has assured medical care to millions of uninsured poor who, as a result, do not necessarily lack access to care.

Why not, then, simply increase the funding for these public programs as a means of assuring access to care for the medically indigent? In many cases, doing so would be a productive response, and may be the only sensible solution. But overreliance on this option also has its shortcomings. Public hospitals are not always easily accessible, especially to persons in rural areas; such hospitals tend to serve primarily the poor and thus result in a two-class system of care. Also, the history of public hospitals, although replete with examples of dedicated service and distinguished quality (especially for public teaching hospitals), is also filled with evidence of fiscal penury that stands in sharp contrast to the amenities, equipment, and staffing levels of most community and proprietary hospitals. This is especially true of ambulatory care facilities, which are few in number.

Sadly, our public institutions have fallen behind in the adequacy of both physical and human resources. As a result, forcing the medically indigent to rely increasingly on public hospitals and clinics without making a major commitment to upgrading these facilities is tantamount to institutionalizing a two-class system of care. Additionally, a greatly expanded commitment not only seems improbable given today's budget crisis, it also appears wasteful given the excess capacity that exists in the private system. Improved access to, and efficient use of, the resources already in place seems a more sensible approach.
There is, however, one respect in which institutional grants to providers committed to indigent care can be preferable even to improving access via expanded insurance coverage: their ability to provide specific services to target populations. Private practice physicians accustomed to providing medical services to primarily middle-class persons are ill-equipped to cope with the management demands posed by some patient groups, such as low-income children and low-income pregnant women. Thus, the nearly four-to-one cost-effectiveness ratio claimed for early prenatal care suggests that it is economically and clinically sound to finance such care through specific programs dedicated to providing these services to an otherwise underserved population.  

Direct grants to dedicated caregivers, rather than the traditional fee-for-service market, succeed more often in providing the appropriate type of care (often both medical and social services) to seriously underserved populations. This seemingly contradicts the conventional wisdom that improved access via expanded insurance is always the preferred approach. But given the very low physician payment rates in most state Medicaid programs, increasing access for specific target groups would almost certainly require increasing payment levels for all physicians to make treating already underserved patients more appealing. While this may be justified in theory, it is most unlikely to occur in practice.

Sharing The Burden Equitably: Indigent Care Funds

In the absence of universal coverage or a secure, stable public-sector safety net, some segment of the population will continue to be uninsured. While most local governments operate or support public hospitals, clinics, health centers, and related programs that serve the uninsured, usually based on income, one-third of the nation’s largest cities lack a publicly mandated, tax-supported provider of care for the poor. As a result, some level of uncompensated hospital care and unrendered primary care will remain for the foreseeable future. 

In efforts to preserve and increase resources for indigent care, and to promote fair competition, a number of states have looked at indigent care funds or pools as a way of ameliorating the problem of unsponsored charity care, at least for the present, until more systematic financing reforms can be implemented. Indigent care funds as an approach have generated a great deal of attention and debate. Such programs already have been established in New York, New Jersey, Massachusetts, South Carolina, and Florida. What follows will attempt to explain and to clarify some aspects of the pooling strategy that seem to be frequently misunderstood and misinterpreted. Most of the discussion focuses on Florida’s experience, since it has attracted a great deal of attention, and because it illustrates how the pooling mechanism relates to a competitive rather
than a regulated health care marketplace.

What is an indigent care pool? An indigent care pool collects funds from a variety of possible sources and redistributes them primarily to those who bear a disproportionate share of the uncompensated charity care burden. Its basic objectives are: (1) to forestall the erosion of the system of cross-subsidies that has traditionally financed a significant portion of hospital-based charity care; (2) to prevent those who avoid charity care from thereby gaining an advantage in price-competitive markets; and (3) to permit a targeting of resources on indigent care, especially for primary and preventive care. Indigent care funds can take a variety of forms, differing in who pays into the pool; the nature and extent of federal, state, and local financial participation; how the funds are to be used (for example, to expand Medicaid, to reduce hospital uncompensated care, to fund primary care programs, to support high-risk insurance pools, and so on); and how and by whom the pool is administered.

Florida’s Medically Indigent Fund was established by that state’s Health Care Access Act of 1984 to accomplish two goals: first, to finance an expansion of Florida’s Medicaid program (at the time, rated as one of the five most restricted in the nation); and, second, to promote fair competition among Florida’s hospitals so that differences in the level of charity care would not, by themselves, produce competitive advantages or handicaps. Indeed, it was the latter goal that originally attracted then-Governor Bob Graham and his Task Force on Competition and Consumer Choice in Health Care to recommend the indigent care fund approach. While the final legislation differed from the task force’s recommendations in several important respects, a description of the statute’s provisions and omissions illustrates how an indigent care fund might look in a non-rate-setting state. Its key elements were as follows.

First, a levy of 1.5 percent was imposed on each hospital’s net patient revenues payable in cash into a fund administered by the Florida Hospital Cost Containment Board (HCCB). In the first year, the hospital levy was set at 1.0 percent and increased to 1.5 percent thereafter.

Second, the state was obligated to contribute $20 million per year to the fund. The task force had recommended a county assessment, which the legislature dropped because it would have had to amend the county millage cap and felt that to do so would have doomed the bill.

Third, the principal use of the fund’s proceeds was to provide the nonfederal match for an expansion of the Florida Medicaid program. This expansion, phased over a three-year period (the task force had recommended immediate implementation), included adding optional categories of women and children, and adopting a Medically Needy Program for persons otherwise categorically eligible for Medicaid but above the state’s income eligibility level (then, as now, at about 33
percent of the poverty line). The Medically Needy provision excluded nursing home care.

Fourth, the legislature directed that $10 million of the fund be used in the first year for grants to county public health units. These grants, which were awarded on a competitive basis, were intended for the provision and brokering of primary and preventive care in underserved areas. Funds were also set aside for two surveys designed to refine budget estimates for the Medically Needy Program.

Recognizing that the additional revenues from Medicaid expansion would still leave a significant amount of unequally distributed uncompensated care, the task force considered, but believed it premature to recommend, an additional levy on hospitals that could be used to bring all hospitals to within a defined variance (for example, 2 percent) from either the statewide or a regional charity care average. A 1985 Secretary's Task Force on Deregulating Certificate of Need (CON) did urge the adoption of this “equilibrium” approach, which would move dollars from very low to very high charity care providers, thereby narrowing the range of variance in uncompensated charity care without reducing the aggregate level beyond what the Medicaid and county programs would accomplish. Both the “equilibrium” and the CON deregulation proposals were rejected by the legislature-in-part because the governor and the legislative leadership demanded that they be linked.

According to the task force’s calculations, with the Medicaid expansion fully implemented, the hospitals would have contributed $50 million per year, the state $20 million. An estimated $43 million of these funds would have generated an additional $55 million in federal Medicaid match (a total of $98 million), yielding an estimated $62 million in new hospital Medicaid revenues as compared to the $50 million contributed by the hospitals directly. Politically, the proposal had appeal. The hospital community as a whole would gain, as would other providers. The state legislature saw a significant leveraging of state general revenue funds. Employers could anticipate a reduction in cost shifting, which falls most heavily on charge payers. At the same time, business would experience only a nominal offsetting tax bite for their small share of the state Medicaid match.

Unfortunately, in Florida’s case, this potential “win-win” situation was frustrated by the manner in which the state implemented the program. A major problem arose because the Medicaid expansion was implemented very slowly and federal/state revenues from that source were slow to materialize. The modest increases in caseload fell far short of initial task force estimates and those of a special Louis Harris and Associates survey conducted for this purpose, suggesting that outreach efforts were insufficient. Florida’s low-income eligibility level was also considered an obstacle to moving charity cases onto the Medicaid rolls.
Despite these enrollment shortfalls, the state collected the hospital levies on schedule, producing large unused balances in the fund, which the state allowed to accumulate. The result was that even the nonprofit and teaching hospitals that had supported the indigent care fund and that had considerable charity care burdens now found themselves paying far more into the fund than they were receiving. This situation could easily have been remedied by placing the fund on an annual reconciliation, rather than on a cash basis, but the problem remains and, as of December 1986, the fund had a cash surplus of $110 million.

Other pools have different objectives and have taken somewhat different form. In New York and Massachusetts, both rate-setting states in which Blue Cross dominates the hospital market and where there is little self-insurance, a direct tax on health benefits is feasible and serves as the principal source of financing. New Jersey's newly established plan taxes hospitals directly, as does Florida's. Like Florida, South Carolina also has linked private and public support to maximize indigent care financing. A 1985 law established a pooling program that draws $7.5 million each from hospitals and the counties to pay for unsponsored hospital care. At the same time, the state agreed to raise Medicaid eligibility from 27 percent to 50 percent of the poverty line. These differences reveal the flexibility states have in shaping the pooling approach to meet their specific needs.

Implementation difficulties aside, pooling as a strategy to reallocate financial resources and level the playing field continues to be a subject of debate and controversy. The following are questions asked about this concept.

Isn't this really a sick tax by another name? While the pool assessment is in reality a form of taxation, it is not a new tax. The so-called sick tax has always been with us in the form of the cost-shift mechanism, which is a kind of implicit cross-subsidy. The effect of the pooling mechanism is to preserve these funds in the system, but to distribute them more fairly in the form of a rational, explicit cross-subsidy. In fact, in an efficient market where price competition is really effective, this “tax” can prove to be budget-neutral. That is, the higher net levies on low charity providers that are passed on to the insurer should be offset by the reduction in charges by high charity providers who benefit from the pool. Unless the intent is to generate new dollars, the pool will not necessarily result in a net increase in total premiums.

Moreover, the term “sick tax” suggests that this tax is levied only on those who go to the hospital. In reality, the tax is primarily through, more than on, hospitals and is effectively a tax on health benefits, since hospitals that pay more into the pool than they receive from it will have to raise their charges, which in turn will require the insurer or third party administrator to increase premiums unless there are offsetting reductions.
from other hospitals. Thus, as is the case in any insurance plan, the increased premium costs, if any, are spread among all members, not just those who go into the hospital.

**Why not just tax benefits directly?** It would be highly desirable to tax insurance benefits directly as many health economists have urged. Doing so, however, would mitigate the positive incentive the pooling mechanism offers hospitals to provide charity care in order to avoid a net tax. Unfortunately, the federal Employee Retirement and Income Security Act (ERISA) of 1973, as currently written, expressly prohibits states from exercising tax or regulatory jurisdiction over self-insured plans. In Florida, for example, more than 30 percent of health benefits were self-insured and thus exempt under ERISA; an attempt by the state to tax the remaining nonexempt plans would probably prove counterproductive since the number of self-insureds would be certain to increase dramatically to escape such taxation.

Since the ERISA exemption prohibits a direct tax on benefits, the indirect tax via the pool is the next best choice. Not only does it extend to health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which are major factors in eroding the implicit cross-subsidies, but it offsets the preference these plans might otherwise have for hospitals that avoid charity care. Finally, there is an equity rationale for even indirectly taxing health benefits given the more than $40 billion in federal income tax deductions that recipients of these benefits and their employers enjoy.

**Why should funds taken from hospitals be used to pay for physicians’ services?** Little is known about the amount-and distribution of charity care by physicians in the 1980s. The few studies that have been done suggest that most physicians do provide at least some charity care, and that it is unevenly distributed. Nevertheless, a large portion of the uninsured poor rely heavily on hospital emergency rooms and public clinics rather than physicians’ offices for much of their care.

Physicians could be required to contribute to an indigent care fund, especially if it sought to improve access to their offices. The simplest method might be to assess all physicians in active practice (including those employed by hospitals and HMOs) a surcharge on their annual licensing fee. For a state with 15,000 active physicians, a $400 surcharge would contribute $6 million annually to an indigent care fund.

There is, however, good reason to use the pool’s proceeds for other than hospital services whether or not physicians contribute directly. The most important reason is that access to primary and preventive care services appears to be especially problematic. In addition, our studies have shown that uncompensated outpatient services make up a large proportion of total uncompensated care in many states, especially for the high-burden hospitals. In one city, for example, uncompensated costs for
Medicaid and other outpatient services were found to be more than twice as high as for inpatient care.

**How does pooling avoid propping up inefficient providers?** By itself, the pooling mechanism cannot accomplish this important objective. Strategies that include Medicaid managed care systems, such as California's selective contracting and Pennsylvania's experimental “Buy Right” program, among others, are more direct means for improving the efficient purchase of health care for the medically indigent. However, the flexibility available to those administering the fund makes it possible for them to take advantage of these tools. In addition, pooling makes it more difficult for providers to mask their inefficiency through lower prices by avoiding charity care, compared to efficient providers who would have to charge higher prices if they have high charity care burdens.

**Won’t state and local governments use the tax on providers to replace public appropriations?** It is true that an improperly constructed statute permits all levels of government to view the pooling arrangement as a replacement for public funds. In Florida, taking note of the unexpended balance in the indigent care fund, the governor’s fiscal year 1986 budget message called for a reduction in state spending on Medicaid. The legislature quickly forced the governor to restore the cuts, but the message was not lost to opponents of the pool approach, and the governor’s attempt was featured in anti-indigent fund rhetoric around the nation. This problem could easily have been avoided had the legislation contained language linking the level of government contributions to those of other contributors.

A more complicated issue is whether to require maintenance of effort at the county or municipal level, where there is a potential for significant displacement of local government contributions to public hospitals and clinics. The issue arises because public general hospitals usually receive a large share of the fund’s disbursements. Because the financing of these facilities accounts for a large share of local government budgets, it may be appropriate to allow for a limited amount of displacement of these funds. If limits on such displacement are deemed desirable, there are two approaches that might be useful. The first would be to cap the amount of disbursements specific public hospitals or clinics could receive from the fund, as New Jersey does, leaving the amount above the cap as a county or municipal responsibility. The other would require any local government in a position to reduce its level of financial support to allocate a designated percentage of this amount to primary and preventive care projects in its jurisdiction or adjacent areas.

**Isn’t this procompetitive approach regulation in disguise?** No disguise is intended; the pooling arrangement is a form of regulation as is any form of taxation designed to redistribute income or create incentives for economic or social purposes. Where the pooling approach differs from
other forms of taxation is that it keeps the proceeds within the health care system and that it explicitly seeks to promote fair competition, not just competition per se. In this regard, the pooling approach is in the tradition of many regulatory activities in our society that are designed to preserve the integrity and viability of the market system while protecting valued social goals.

Advantages Of Pooling

In summary, the pooling approach, although not without its risks, does have three major advantages. First, if the problem in a state or a regional market is less one of access to hospital services by the medically indigent, and more one of unfair competition because of unequal distribution of charity care, the fund permits a leveling of the playing field without raising general revenue tax funds to do so. That is, it can accomplish this goal not by reducing the total amount of uncompensated hospital care, but simply by redistributing dollars among hospitals to neutralize the competitive advantages and handicaps that result from these differences. By avoiding the need for new general tax revenues for this purpose, it frees those dollars to meet more serious needs such as primary and preventive care. Second, pooling offers flexibility in how funds are raised: who contributes to the fund and the conditions of participation. For example, to avoid the timing and cash flow problems that have plagued Florida’s program, a fund could operate on reconciliation, using cash transactions only periodically to reconcile accounts, and retaining only enough cash in the fund to operate the program. Funds can be used to support Medicaid expansion, offset uncompensated care differences, subsidize high-risk pools or small employer insurance programs, support primary care grants, and pay for special studies, among others. Finally, pooling offers flexibility on the delivery side, permitting choice among many options as to the kinds of services to fund, whether to operate statewide or in a regional market, whether to use direct purchase of services, grants, contracts, and so forth.

In a world of universal health insurance and assured financial access, halfway technologies such as the pooling mechanism should be unnecessary. But, as this article has suggested, we are, and for some time are likely to remain, some distance from these worthy goals. Until we reach them, we must find ways of allowing competition and improved access for our nation’s medically indigent to coexist. The indigent care fund may not be an appropriate solution for all communities, but it deserves careful consideration by many.
NOTES

4. Data from Southern Regional Task Force on Infant Mortality, a joint project of the Southern Governors’ Association and the Southern Legislative Conference.