

Faculty Scholarship

2010

Medicaid, Low Income Pools, and the Goals of Privatization

Laura Hermer

Mitchell Hamline School of Law, laura.hermer@mitchellhamline.edu

Publication Information

17 *Georgetown Journal on Poverty Law Policy* 405 (2010)

Repository Citation

Hermer, Laura, "Medicaid, Low Income Pools, and the Goals of Privatization" (2010). *Faculty Scholarship*. Paper 323.
<http://open.mitchellhamline.edu/facsch/323>

This Article is brought to you for free and open access by Mitchell Hamline Open Access. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of Mitchell Hamline Open Access. For more information, please contact sean.felhofer@mitchellhamline.edu.

Medicaid, Low Income Pools, and the Goals of Privatization

Abstract

This article examines the Bush Administration's attempts to transform certain supplemental payments, most notably Medicaid's Disproportionate Share Hospital (DSH) program, into a means of subsidizing private health coverage for Medicaid expansion populations. Greater private market involvement in the state disbursement of supplemental payments such as DSH makes it more difficult to fulfill Medicaid's original goals. It reduces the overall funds available specifically for care, provides beneficiaries with leaner benefit plans than those offered by the public system, and hinders beneficiaries from obtaining and retaining care. As such, it increases waste and inefficiency, rather than reducing them. At the same time, rather than improving access to overall medical care and provider choice, it instead prioritizes choice among private insurance products. This not only subverts the original goals of Medicaid, but also suggests a key shift in our conceptualization of what it means to access health care in the United States.

Keywords

Medicaid, Health insurance

Disciplines

Social Welfare Law

ARTICLES

Medicaid, Low Income Pools, and the Goals of Privatization

Laura D. Hermer*

The uninsured often use emergency rooms for primary care, which leads to suboptimal care and excessive spending. If this public spending were focused, in a budget-neutral manner, on helping the uninsured purchase private insurance, people would receive the care they need in more appropriate settings and at a more reasonable cost.

– Office of the White House, *Fact Sheet: Making Private Health Insurance More Affordable for Low-Income Americans*, February 23, 2007

Privatization of many government services has been a Republican goal since at least the Reagan years. Advocates of privatization would, in certain contexts, cease public responsibility for certain activities and services altogether. In other contexts, they would move the actual production of goods and services—for example, the manufacture of military uniforms, the operation of public transit services, the provision of daycare services, etc.—from the public to the private sector while maintaining public financing for them. Supporters of privatization claim that the private sector is more efficient and productive than the government and that competition lowers prices.¹ The profit motive is said to act as a powerful incentive to reduce waste and provide the best product for the lowest cost. Choice is touted as a substantial additional benefit. Surely, advocates argue, beneficiaries of government services would prefer to have the variety available on the private market than to have only one government option.

Yet it is far from clear that privatization yields the benefits that its proponents tout. While privatization may make sense in some contexts, it is less obvious that

* Laura Hermer, J.D., L.L.M., is an assistant professor of health policy and bioethics at the University of Texas Medical Branch, Institute for the Medical Humanities. Her current research interests include the law and policy of health coverage, with particular emphasis on coverage for lower-income Americans, and issues concerning tobacco control and public health.

I would like to thank Rodrigo Canales, Mark Hall, and Lars Cisek for their comments on this paper. Any errors remain my own. ©2010, Laura D. Hermer.

1. See, e.g., Stephen Moore, *Contracting out: A Painless Alternative to the Budget Cutter's Knife*, 36 PROC. OF THE ACAD. OF POL. SCI. 60, 63-64 (1987).

it does in others. Publicly-provided health coverage is one latter such area. The George W. Bush Administration sought to privatize the provision of health insurance to individuals who could not afford to purchase coverage on their own. It was responsible, only several months into its tenure, for prioritizing the use of private health insurance to cover certain Medicaid populations for states seeking § 1115 waivers from federal Medicaid requirements.² The Administration favored capping annual federal Medicaid expenditures and eliminating Medicaid's entitlement status—ideas that were ultimately killed by Congress, but which later found new life in changes made to a couple of states' programs. Further, the Administration supported Congress's 2006 amendments that allowed states, for example, to charge certain Medicaid beneficiaries more money for services and to require them to enroll in a health maintenance organization for their care.³

Many of these initiatives sought to transfer program administration to the private sector and to make features of the program more closely resemble those of private coverage. But now, such initiatives may be waning. In contrast to that of the Bush Administration, early indications suggest that the Obama Administration's priorities for Medicaid do not include favoring greater involvement of the private market in different states' programs.⁴ What, then, can we say about the value in privatizing formerly public sectors of the health economy, and our recent intense foray into greater privatization of Medicaid? How does it fit into the program's history? Who stands to gain, and what is gained from it?

This article will examine these questions in a very particular context: that of the Bush Administration's efforts to transform certain supplemental payments, most notably Medicaid's Disproportionate Share Hospital (DSH) program, into a means of subsidizing private health coverage for Medicaid expansion populations. I will argue that greater private market involvement in the state disbursement of supplemental payments such as DSH makes it more difficult to fulfill Medicaid's original goals. It reduces the overall funds available specifically for care, provides beneficiaries with leaner benefit plans than those offered by the public system, and hinders beneficiaries from obtaining and retaining care. As such, it increases waste and inefficiency, rather than reducing them. At the same time, rather than improving access to overall medical care and provider choice, it

2. CENTERS FOR MEDICARE AND MEDICAID SERVICES, HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) DEMONSTRATION INITIATIVE (2001). Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive compliance with federal Medicaid (or other program) requirements where the Secretary believes the state's proposed plan "is likely to assist in promoting [Medicaid's] objectives"—a variable standard, indeed. 42 U.S.C. § 1315(a) (2009).

3. See, e.g., *Fiscal 2007 Budget: Health and Human Services: Testimony before the S. Finance Comm.*, 109th Cong. (2006) (statement of Michael O. Leavitt, Secretary, U.S. Dep't of Health and Human Services); Teresa A. Coughlin & Stephen Zuckerman, *State Responses to New Flexibility in Medicaid*, 86 MILBANK Q. 209, 210-14 (2008).

4. For example, while much of the Medicaid information on the Center for Medicare and Medicaid Services' website remains the same as it had been during the Bush Administration, the page regarding Bush's HIFA waiver initiative was removed shortly after Obama took office.

instead prioritizes choice among private insurance products. This not only subverts the original goals of Medicaid, but also suggests a key shift in our conceptualization of what it means to access health care in the United States.

Part I will provide an overview of Medicaid's original purpose and selected issues with its implementation. Part II will examine the genesis of supplemental payment programs like DSH and, more recently, low-income pools. Part III will examine issues with low-income pools as instantiated in different states, and Part IV will more broadly evaluate the goals of privatization in this context.

I. MEDICAID'S ORIGINS

Medicaid—the means-tested federal/state entitlement program providing health care to approximately 55 million low-income members of certain demographic groups—was not the product of extensive legislative deliberation. Rather—despite its roots in the old Kerr-Mills program aimed at providing health care to impoverished elderly people—it came about as an eleventh hour legislative solution to a number of objections to the proposed Medicare legislation in 1965.⁵ Medicaid provided a means of affording health care to certain categories of the “deserving poor.”⁶ It accordingly satisfied the objections put forth by the American Medical Association (AMA) to enacting Medicare as a non means-tested social insurance program, and concerns of the Chair of the House Ways and Means Committee, Wilbur Mills, that Medicare might provide an entrée to universal, national health insurance.⁷

There is very little legislative history concerning Medicaid, which makes it difficult to determine Congress's original goals for the program.⁸ Some, such as Cindy Mann and Tim Westmoreland, maintain that Medicaid's present role as “a big, heterogeneous, responsive, ‘last-ditch’ insurance program” is “largely a policy accident, and would probably be quite a surprise to its original authors.”⁹ With the myriad of recent changes in the practice, financing, and delivery of medicine, and in our provision of welfare benefits generally, to say that the program's creators would have intended the program's current form would be

5. ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 43, 46-48 (Transaction Publishers 2003) (1974) [hereinafter STEVENS, *WELFARE MEDICINE*]; DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY: 1965-2007* 43-45 (Transaction Publishers) (2008).

6. The “deserving poor” included people such as such as widowed mothers and their children: those who, despite their best efforts and through circumstances beyond their control, needed assistance. It was meant to exclude vagrants and others whose lack of effort or moral continence ostensibly led to their problems. See, e.g., JOEL F. HANDLER & YEHEKEL HASENFELD, *BLAME WELFARE, IGNORE POVERTY AND INEQUALITY* 70-71 (Cambridge University Press) (2006); JONATHAN ENGEL, *POOR PEOPLE'S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965* 9 (Duke University Press) (2006).

7. See STEVENS, *WELFARE MEDICINE*, *supra* note 5, at 43, 46-48; SMITH & MOORE, *supra* note 5, at 43-45.

8. See SMITH & MOORE, *supra* note 5, at 45.

9. Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 417 (2004).

speculative at best. Yet, consider Medicaid as it was in its earliest years. Was it purely created out of expedience, as part of its history suggests, with little other thought as to intent? Was it meant as nothing more than a means of encouraging states to provide at least a baseline of coverage to certain low-income people? Or did the mandatory baseline eligibility requirements and the wide range of services required of participating states imply a grander vision for health care for the poor?

The original statute itself provides some indication. Its baseline eligibility and coverage requirements, which all state programs must meet in order to receive federal matching funds, stand in stark contrast to Medicaid's predecessor, the Kerr-Mills program. So do, for example, the requirements mandating the uniform implementation of programs within the states and prohibiting states from varying benefits among beneficiaries. Kerr-Mills contained no such mandates.¹⁰ Perhaps even more noteworthy was another provision:

The Secretary shall not make payments under the preceding provisions of this section to a State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self care.¹¹

Although later postponed and ultimately repealed, the provision would have required states to ensure that, within 10 years of Medicaid's enactment, most people who qualified for the program in fact were covered under it.¹² Kerr-Mills contained no such provision: this, in conjunction with its other deficiencies, contributed to its sparse and spotty application in most states.¹³

We have some indication of the Johnson Administration's goals for the program. The first handbook issued by the U.S. Department of Health, Education and Welfare (now the Department of Health and Human Services) on administering state Medicaid programs provides that Medicaid's

ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and States, in order to achieve its high purpose, will need to assume responsibility for

10. STEVENS, *WELFARE MEDICINE*, *supra* note 5, at 32-36; SMITH & MOORE, *supra* note 5, at 40-41.

11. Act of July 30, 1965, Pub. L. No. 89-97, 79 Stat. 350 (repealed) (current version at 42 U.S.C. § 1396a (2009)).

12. SMITH & MOORE, *supra* note 5, at 109-110.

13. *Id.* at 40-41.

planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.¹⁴

If we take this statement at face value, it implies that the Johnson Administration did not merely intend for states to ensure access to a set minimum amount of health care for Medicaid beneficiaries, but in fact aimed to endow states with an affirmative obligation to ensure comprehensive and high-quality care for all beneficiaries. Stevens and Stevens characterize these words as “impassioned optimism,” yet observe that at least some states assumed these words were “more than mere rhetoric” and expected the federal government to follow through with commensurate funding.¹⁵ There is, therefore, some evidence that the enactment of Medicaid was not simply the “policy accident” construed by some, but was actually conceived as part of a greater vision for access to health care for the country’s poor.

Upon implementation, the provision of “complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves” was pursued largely through “mainstreaming” the poor into the regular, private health care system.¹⁶ Previously, most poor people—to the extent such charity was available to them—relied on free or reduced-cost care provided by voluntary or municipal hospitals.¹⁷ As Smith observes, voluntary hospitals limited their care to the “deserving” poor, while public hospitals served the remainder of the indigent.¹⁸ However, with financial access to health care newly available through Medicaid, the poor could obtain the same medical services, offered by the same providers and in the same locations, as those enjoyed by wealthier Americans.¹⁹

However, Congress quickly discovered that providing such care was enormously expensive. Mainstream participation required mainstream reimbursement. Accordingly, there was an initial push to reimburse providers on the “cost” basis used by Medicare—and its model,²⁰ Blue Cross/Blue Shield—rather than

14. BUREAU OF FAMILY SERVICES, U.S. DEP’T OF HEALTH, EDUCATION, AND WELFARE, MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION SUPP. D (1966).

15. STEVENS, WELFARE MEDICINE, *supra* note 5, at 79-80.

16. “Mainstream” medicine refers to health care received by those with private health insurance, provided by private physicians in their offices and in private hospitals. Stevens and Stevens observe that “there was considerable discussion at the time of Medicaid’s passage emphasizing that the poor would receive the same care, from the same sources, as the rich: this was known as bringing Medicaid recipients into the ‘mainstream’ of medicine.” STEVENS, WELFARE MEDICINE, *supra* note 5, at xxxiv.

17. ENGEL, *supra* note 6, at 9-11; *see* DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 13 (University of Michigan Press) (1999).

18. SMITH, *supra* note 17, at 13.

19. *See* STEVENS, WELFARE MEDICINE, *supra* note 5, at 201-03; SMITH & MOORE, *supra* note 5, at 46, 81; Frank Sloan, Janet Mitchell & James Cromwell, *Physician Participation in State Medicaid Programs*, 13 J. HUM. RESOURCES 211, 211 (1978).

20. *See, e.g.*, THEODORE MARMOR, THE POLITICS OF MEDICARE 107 (Transaction Publishers 1970) (2000).

pursuant to a welfare fee schedule, as had been the case with previous welfare programs.²¹ This contributed to the almost fivefold escalation in physician costs in Medicaid between 1965 and 1969.²² Both states and the federal government were highly distressed by the rapid escalation of Medicaid costs. For Medicaid's first two decades, a number of states tried to control costs by changing their reimbursement structures, making care under Medicaid less like the care obtained under private health insurance.²³ Some states, like California, obtained waivers that allowed increased cost sharing with beneficiaries.²⁴ Others used fee schedules.²⁵ Eventually, many states turned to managed care programs: health systems aimed at controlling and reducing health care use through a system of gatekeepers, provider panels, and/or utilization review.²⁶ In the early 1980s, the federal government dropped the "reasonable cost"-based provider reimbursement requirement and made it easier for states to obtain waivers for using different financing mechanisms, including health maintenance organizations, fee-for-service, or partially capitated case management systems.²⁷ As reimbursement for Medicaid patients fell relative to that of patients with other third party sources of payment, doctors and hospitals increasingly sought to avoid caring for Medicaid beneficiaries.²⁸

II. THE GENESIS OF DSH AND LOW INCOME POOLS

In the 1980s, Congress became concerned with the ability of Medicaid patients to access care and with the precarious financial situations faced by public hospitals and other higher-volume Medicaid providers.²⁹ It therefore sought to increase the funds paid to disproportionate share hospitals: those that care for a "disproportionately high" number of low income and/or Medicaid patients.³⁰ DSH—the Disproportionate Share Hospital program—allows states to increase

21. Robert Stevens & Rosemary Stevens, *Medicaid: Anatomy of a Dilemma*, 35 L. & CONTEMP. PROBS. 348, 384 (1970).

22. STEVENS, WELFARE MEDICINE, *supra* note 5, at 191.

23. *Id.* at 267-69.

24. *See, e.g.*, Cal. Welfare Rights Org. v. Richardson, 348 F. Supp. 491, 495 (N.D. Cal. 1972).

25. ENGEL, *supra* note 6, at 177.

26. STEVENS, WELFARE MEDICINE, *supra* note 5, at 268-69; Maren D. Anderson & Peter D. Fox, *Lessons Learned from Medicaid Managed Care Approaches*, 6 HEALTH AFF. 71, 74 (1987).

27. ENGEL, *supra* note 6, at 68-69; Anderson & Fox, *supra* note 26, at 72-73.

28. STEVENS, WELFARE MEDICINE, *supra* note 5, at 201-02 (discussing physician Medicaid boycotts over payments in the early 1970s); Sloan, Mitchell & Cromwell, *supra* note 19, at 238-39 (finding that low Medicaid fee schedules and increased hassle in obtaining reimbursement were the most important factors in inducing physicians not to participate in Medicaid); Janet B. Mitchell, *Physician Participation in Medicaid, Revisited*, 29 MED. CARE 645, 648 (1991) (finding that the share of the average physician's Medicaid practice declined from 12.1% in 1977-78 to 9.5% in 1984-85).

29. ENGEL, *supra* note 6, at 184-85.

30. *See* H.R. REP. NO. 99-241, Part 1, at 2 (1985); GOVERNMENT ACCOUNTING OFFICE, GAO/HEHS-96-76R: STATE MEDICAID FINANCING PRACTICES 4 (1996), available at <http://archive.gao.gov/paprpdf/156091.pdf>.

Medicaid funding paid to hospitals that the state identifies as caring for large numbers of low income and/or Medicaid patients.³¹ By subsidizing such hospitals for the provision of care to lower-income populations, DSH helps those hospitals survive.³²

DSH has also inadvertently reversed the “mainstreaming” effect of Medicaid. By providing subsidies to disproportionate share hospitals, DSH has influenced where Medicaid and uninsured patients can receive care.³³ Mainstream providers, who primarily catered to wealthier and insured patients before Medicaid’s enactment, saw little benefit from DSH, which directs its payments only to hospitals.³⁴ Accordingly, the program has indirectly contributed to the strong pull of Medicaid patients back to charity and public hospitals.³⁵

The program not only improved disproportionate share hospitals’ finances, but also the finances of many states. Once states started implementing DSH, many saw the potential to increase its use, and thus the ability to draw more federal dollars without requiring more state dollars to be spent in the process. This resulted in some creative schemes.³⁶ Under federal law, each individual state was responsible for determining the formula used for increasing the payment rate within its borders.³⁷ If a state was so inclined, it could inflate the payment rate substantially. Some did.³⁸ Initially, these states used three different forms of revenue-generation for their share of DSH: donations, provider-specific taxes, and transfers of funds from one unit of government to the state government.³⁹ All three used a similar concept, an example of which is given by Coughlin and

31. 42 U.S.C. § 1396a(a)(13)(A)(iv) (2009); 42 U.S.C. § 1396r-4(a)(1), (b)(1) (2009).

32. NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS (NAPH), *AMERICA’S PUBLIC HOSPITALS AND HEALTH SYSTEMS*, 2008 ix (2009) (noting that DSH and graduate medical education (GME) payments covered nearly 45% of public hospitals’ uncompensated costs in 2008).

33. See, e.g., SMITH & MOORE, *supra* note 5, at 168-69; *Medicaid: State Financing Schemes Again Drive Up Federal Payments: Hearing Before the S. Finance Comm.*, 106th Cong. 1-2, 4-6 (2000) (statement of Kathryn G. Allen, Associate Director, Health Financing and Public Health Issues, Health, Education, and Public Health Division), available at <http://www.gao.gov/archive/2000/he00193t.pdf>.

34. 42 U.S.C. § 1396a(a)(13)(A)(iv) (2010); 42 C.F.R. § 412.106(a) (2010).

35. For example, in 2007, Medicaid accounted for nearly 25% of all discharges from public hospitals, but only 18% of private, non-profit hospitals and 21% of private, for-profit hospitals. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, 2007 NATIONAL STATISTICS, PATIENT AND HOSPITAL CHARACTERISTICS (2007) http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=1C14E7FCE1293582&Form=SelPAT&JS=Y&Action=%3E%3ENext%3E%3E&_InPatChar=Yes&_InHospChar=Yes&_HospChar=H_CONTRL. More starkly, in 2008, Medicaid patients accounted for 27% of outpatient visits and 36% of discharges at National Association of Public Hospitals and Health Systems members. NAPH, *supra* note 32, at 11.

36. GOVERNMENT ACCOUNTING OFFICE, *supra* note 30 at 1.

37. 42 U.S.C. § 1396r-4(a)(1), (2) (2010).

38. See, e.g., SMITH & MOORE, *supra* note 5, at 207-10.

39. JEAN HERNE, *MEDICAID DISPROPORTIONATE SHARE PAYMENTS 4* (Congressional Research Service) (2005), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/97-48301102005.pdf>.

Zuckerman.⁴⁰ A Medicaid provider would transfer funds—say, \$10 million—to the state in the form of a tax or intergovernmental transfer (IGT). The state would then pay the provider a \$12 million Medicaid DSH payment. If the state had a 50% match rate from the federal government, then the federal government would pay \$6 million to the state as its share of the \$12 million. At the end of the process, the provider would have a net gain of \$2 million and the state \$4 million. The federal government, on the other hand, would have a net loss of \$6 million.

Information concerning these state manipulations was not well received by the federal government. The government was particularly unsettled to learn that, in some instances, states were using a portion of federal DSH payments for general revenue purposes rather than for health care, and that some hospitals had DSH payments in excess of their uncompensated care costs.⁴¹ After taking a number of interim steps that helped reduce these kinds of excesses, Congress ultimately capped the total amount each state could receive in DSH funds from the federal government, and updated those caps in 2003.⁴²

Other forms of supplemental payment exist. Upper Payment Limit (UPL) arrangements are one such example.⁴³ Medicaid payments to providers have tended to be lower, sometimes much lower, than payments under Medicare.⁴⁴ The federal government caps the amount that Medicaid providers can be paid in a given state at, roughly speaking, the amount that Medicare would have paid for the same service.⁴⁵ In a UPL arrangement, a state pays far more than it otherwise would for a Medicaid service—though less than the cap.⁴⁶ It then seeks contribution at that rate from the federal government.⁴⁷ Finally, it recoups part or all of the excess payment from the Medicaid provider, often through an intergovernmental transfer.⁴⁸

Once again, the federal government allows these supplemental payment programs to continue because public hospitals and other institutions providing a substantial amount of charity care and care for Medicaid patients require support in order to continue their operations. It is an indirect way of helping to ensure that

40. TERESA A. COUGHLIN & STEPHEN ZUCKERMAN, STATES' USE OF MEDICAID MAXIMIZATION STRATEGIES TO TAP FEDERAL REVENUES: PROGRAM IMPLICATIONS AND CONSEQUENCES 11 (Urban Institute) (2002), available at <http://www.urban.org/publications/310525.html>.

41. Leighton Ku & Teresa A. Coughlin, *Medicaid: Disproportionate Share and Other Special Financing Programs*, 16 HEALTH CARE FIN. REV. 27, 27 (1995); GOVERNMENT ACCOUNTING OFFICE, *supra* note 30, at 1, 10-11.

42. Ku & Coughlin, *supra* note 41.

43. Teresa Coughlin, Stephen Zuckerman & Joshua McFeeters, *Restoring Fiscal Integrity to Medicaid Financing?*, 26 HEALTH AFF. 1469, 1470 (2007).

44. Anne Lenhard Reisinger, David C. Colby & Anne Schwartz, *Medicaid Physician Payment Reform: Using the Medicare Fee Schedule for Medicaid Payments*, 84 AM. J. PUB. HEALTH 553, 557-58 (1994).

45. Coughlin, Zuckerman & McFeeters, *supra* note 43, at 1470.

46. *Id.*

47. *Id.*

48. *Id.*

people who are in low-reimbursing public programs or who are uninsured can obtain at least some medical care. Yet, despite the various curbs imposed on the programs over nearly two decades, excesses are still perceived to exist.⁴⁹ Additionally, few people would argue that DSH and UPL constitute ideal mechanisms in the provision of health care to the poor.

Accordingly, the Bush Administration sought to obtain agreements with individual states to revise their DSH and/or UPL programs, by (1) capping federal supplemental payment matches,⁵⁰ (2) restricting the use of intergovernmental transfers,⁵¹ and (3) extracting agreements from states to allocate DSH and/or UPL funds to “low income pools.”⁵² Low income pools go by a variety of names—“safety net care pools” and “health opportunity pools,” among others—and are intended to partially defray the cost of care provided to the uninsured.⁵³ However funds from low income pools, rather than merely helping to subsidize hospitals’ uncompensated care costs, were to generally be used in devising more organized solutions to the problem of the uninsured. These solutions range from increasing the number of community health care centers and/or health care providers at such centers (as some counties in Florida have done) to subsidizing the purchase of private health insurance for the uninsured (as Indiana has done, California might do, and Texas and Louisiana have proposed to do).⁵⁴

The Obama Administration does not appear likely to continue this trend.

49. JAMES C. COSGROVE, REPORT TO THE RANKING MEMBER, COMM. ON FINANCE, U.S. SENATE, GAO-08-614, MEDICAID: CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS 37-38 (U.S. Government Accountability Office) (2008), available at <http://www.gao.gov/new.items/d08614.pdf>; KATHERINE IRITANI, REPORT TO THE RANKING MEMBER, COMM. ON FINANCE, U.S. SENATE, GAO-10-69, MEDICAID: ONGOING FEDERAL OVERSIGHT OF PAYMENTS TO OFFSET UNCOMPENSATED HOSPITAL CARE COSTS IS WARRANTED 27-28 (U.S. Government Accountability Office) (2009).

50. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., No. 11-W-00206/4, MEDICAID REFORM SECTION 1115 DEMONSTRATION (2005), available at http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf [hereinafter CMS].

51. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., No. 11-W-00189/7, IOWACARE SECTION 1115 DEMONSTRATION (2007), available at <http://www.ime.state.ia.us/docs/RevisedSTCsDraft101409.pdf> [hereinafter IOWACARE].

52. See, e.g., Letter from Kerry Weems, Acting Adm’r, Ctrs. for Medicare & Medicaid Servs., to E. Mitchell Roob, Sec’y, Ind. Family & Soc. Servs. Admin. (Dec. 14, 2007), available at <http://www.cms.hhs.gov/MedicaidStWaiProgDemoPGI/downloads/Healthy%20Indiana%20Plan%20Current%20Approval%20Documents.pdf>.

53. STATE OF CALIFORNIA, CALIFORNIA SAFETY NET CARE POOL 1-3 (2005), available at http://www.dhcs.ca.gov/services/medical/Documents/MCRedesignFinancing/CAFinalConAgmnt_062205.pdf; RICK PERRY & ALBERT HAWKINS, A WAIVER REQUEST, SUBMITTED UNDER AUTHORITY OF § 1115 OF THE SOCIAL SECURITY ACT, TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES 4, 13 (State of Texas) (2008), available at http://www.hhsc.state.tx.us/about_hhsc/TX1115Combined.pdf.

54. See, e.g., CMS *supra* note 50; Letter from Kerry Weems to E. Mitchell Roob, *supra* note 52; TEX. HEALTH & HUMAN SERVS. COMM’N, HEALTH SAVINGS ACCOUNT PILOT REPORT: COST-EFFECTIVENESS AND FEASIBILITY ANALYSIS (2008), available at http://www.hhsc.state.tx.us/reports/HealthSavings_0508.pdf; LA. DEP’T OF HEALTH & HOSPS., LOUISIANA HEALTH FIRST APPLICATION FOR § 1115 RESEARCH AND DEMONSTRATION WAIVER (2008), available at <http://www.dhh.louisiana.gov/offices/publications/pubs-349/CMS%20Federal%20Waiver.pdf>.

Information on the Health Insurance Flexibility and Accountability waiver—a prominent policy tool the Bush Administration used to induce states to introduce or expand private sector involvement in their Medicaid programs—quietly disappeared shortly after Obama took office. While the Obama Administration has not issued any statements of Medicaid § 1115 waiver policy, Obama’s CMS Medicaid Director, Cindy Mann, proposed a more systemic and arguably more centralized approach to Medicaid policy and planning in her writings while a professor of law at Georgetown.⁵⁵ Among other issues, she is opposed to waivers of federal Medicaid rules that “become a substitute for rulemaking or way to circumvent the law,” or that “push states into compromising financing arrangements.”⁵⁶ Certain public-private partnerships in the Medicaid program will likely continue under the Obama Administration,⁵⁷ but, for reasons discussed further below, we may not see an expansion of low income pools for the next few years.

This does not, however, mean we will not see their use again under future administrations. Why have low income pools been used, and how have they been affecting the Medicaid program and its beneficiaries? First, they have been used as a tool to limit Medicaid supplemental payments.⁵⁸ But additionally, under the most recent Bush Administration, and conceivably under future administrations, they have been used to alter the provision of care to the uninsured.⁵⁹ It is instructive in this context to return to our earlier discussion of the original purpose of Medicaid. While there is no definitive evidence indicating Congress’ intentions for Medicaid, it appears that Medicaid was meant to provide comprehensive care to particular groups of lower-income people, and in doing so to help mainstream them into the private health care system from which they had often been segregated.⁶⁰ To what extent, then, do these low income pools help further these purposes?

III. ISSUES IN THE IMPLEMENTATION OF LOW INCOME POOLS

Let us first look at some of the financial issues. The changes in Medicaid supplemental payments and the transition to low income pools that the Bush Administration proposed usually did not increase financing for care for lower-income people, but rather sought to reduce state use of “improper” financing

55. See Mann & Westmoreland, *supra* note 9, at 421-23.

56. *Id.* at 422.

57. See CAROLYN L. YOCOM, GAO-10-258R, MEDICAID AND CHIP: ENROLLMENT, BENEFITS, EXPENDITURES, AND OTHER CHARACTERISTICS OF STATE PREMIUM ASSISTANCE PROGRAMS (U.S. Government Accountability Office) (2010), available at <http://www.gao.gov/new.items/d10258r.pdf>.

58. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS. 11-W-00189/7, IOWACARE SECTION 1115 DEMONSTRATION 14-16 (2007), available at <http://www.ime.state.ia.us/docs/IowaCareFinalPackage04262007.pdf>.

59. See, e.g., *Post-Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns, Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 110th Cong. 13 (2007) (statement of Fredrick R. Cerise, Secretary, Louisiana Department of Health and Hospitals).

60. See *supra* notes 10-12, 14, 16, and associated text.

schemes.⁶¹ At least twenty-five states revised their supplemental payment formulas as a result of the Bush Administration's inquiries into state DSH and UPL programs when states sought plan amendments or waivers.⁶² Five states—Florida, Iowa, Indiana, California, and Massachusetts—have adopted low income pools in the process of obtaining Medicaid § 1115 waivers.⁶³

Because the funds that states receive through their supplemental payment programs are not sufficient to cover the cost of all necessary care for all low income people, it follows that low income pools are unlikely to provide care for all the uninsured. Indeed, none of the state plans in question were written with the presumption that they would. In Iowa, for example, the Kaiser Family Foundation estimated that 128,100 adults earning less than 133% of the federal poverty level (FPL) were uninsured in 2008.⁶⁴ Yet, in the same year, only 33,117 non-Medicaid-eligible adults earning less than 200% FPL were enrolled in IowaCare for at least one month.⁶⁵ In Florida, Kaiser estimated that 1,600,800 adults earning less than 133% of the federal poverty level were uninsured in 2007.⁶⁶ Yet, while Florida's Low Income Pool program allowed a number of counties to expand certain health care services for low income and uninsured people, those expansions could not possibly represent the total care needed by Florida's uninsured population.⁶⁷

61. *Inter-Governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?: Hearing Before the H. Energy and Commerce Comm. Subcomm. on Health*, 108th Cong. 20 (2004) (statement of Dennis G. Smith, Director., Ctrs. for Medicare & Medicaid Servs.).

62. SONYA SCHWARTZ ET AL., *MOVING BEYOND THE TUG OF WAR: IMPROVING MEDICAID FISCAL INTEGRITY* 15 (Nat'l Acad. for State Health Policy) (2006), available at http://www.nashp.org/sites/default/files/Medicaid_Fiscal_Integrity.pdf.

63. CMS, *supra* note 50; IOWACARE, *supra* note 51; CTRS. FOR MEDICARE & MEDICAID SERVS., CALIFORNIA DEMONSTRATION FACT SHEET: MEDICAL UNINSURED/HOSPITAL CARE (2009), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/California%20Medi-Cal%20Hospital%20Uninsured%20Care%20Fact%20Sheet.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., MASSACHUSETTS STATEWIDE HEALTH REFORM DEMONSTRATION FACT SHEET: MASSHEALTH (2009), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Massachusetts%20MassHealth%20Fact%20Sheet.pdf>; Letter from Kerry Weems to E. Mitchell Roob, *supra* note 52.

64. THE HENRY J. KAISER FAMILY FOUNDATION, IOWA: NONELDERLY UNINSURED, STATE HEALTH FACTS (2008), <http://www.statehealthfacts.org/profileind.jsp?ind=136&cat=3&rgn=17>. Kaiser changed its database to break down populations by those earning less than 100%, 100%-133%, and 134%-300% of the federal poverty level, rather than 200%; thus, only those earning 133% or less are included here.

65. PETER C. DAMIANO, ELIZABETH T. MOMANY, & KNUTE DEREK CARTER, *OUTCOMES OF THE IOWACARE PROGRAM 7* (Public Policy Center, The University of Iowa) (2009), available at <http://www.ime.state.ia.us/docs/DraftSecondEvaluationIowaCareoutcomes.pdf>.

66. THE HENRY J. KAISER FAMILY FOUNDATION, FLORIDA: DISTRIBUTION OF THE NONELDERLY UNINSURED BY FEDERAL POVERTY LEVEL (FPL), STATES (2007-2008), U.S. (2008), <http://www.statehealthfacts.org/profileind.jsp?rgn=11&cat=3&ind=136>.

67. The total amount given to hospital and non-hospital providers under Florida's Low Income Pool (LIP) program increased nearly \$370 million over the amount allocated before Florida Medicaid Reform began. AGENCY FOR HEALTH CARE ADMINISTRATION, FLORIDA MEDICAID REFORM: YEAR 3 DRAFT ANNUAL REPORT, JULY 1, 2008–JUNE 30, 2009 75 (2009), available at http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/reform_draft_annual_report_yr3_070108-063009.pdf. In FY 2006–2007, hospitals receiving LIP payments served about 22,500 Medicaid, uninsured, or underinsured patients, and non-hospital providers receiving LIP payments served about 18,100 such patients. NICCIE L. MCKAY,

Additionally, many individuals receiving care funded through a low income pool have only sporadic access to care, rather than the “continuous” and “comprehensive” care that Medicaid was originally intended to provide.⁶⁸ In Iowa, for example, IowaCare provides only inpatient and outpatient care, and a few other limited services, to participants through the state’s teaching hospitals and clinics.⁶⁹ Physician office visits, most prescription drugs, and most durable medical equipment are not provided.⁷⁰ Also, of the small percentage of uninsured individuals who enrolled in IowaCare in 2008, only 28% remained enrolled in the program for the full year.⁷¹ Instead, they most often enrolled when they found themselves needing inpatient or outpatient hospital care, and then dropped from the program.⁷²

To take another example, Florida’s Low Income Pool (LIP) program, while originally intended to foster more comprehensive and continuous access to care for lower-income patients, appears instead to have devolved into a largely standard supplemental payment system. Only 1.6% of payments go to non-hospital providers, and there has been little analysis or discussion of innovative programs developed to provide care.⁷³ Additionally, while Florida presently receives more funds for its LIP than it did under its prior supplemental payment system (approximately \$1 billion per year, as compared with \$667 million in FY2005-2006), the total amount it can draw down from the federal government is capped, and no provision exists to increase the cap if necessary during the five-year waiver period.⁷⁴

Because the intent of the programs is to curb improper means of drawing

EVALUATION OF THE LOW-INCOME POOL PROGRAM USING MILESTONE DATA: SFY 2005-06 AND SFY 2006-07 24 (University of Florida) (2008), available at <http://www.mre.php.ufl.edu/publications/Evaluation%20of%20LIP%20Using%20Milestone%20Data.pdf>. Yet, in Florida in 2007, there were nearly 3.6 million uninsured people in the state. U.S. CENSUS BUREAU, TABLE HI05. HEALTH INSURANCE COVERAGE STATUS AND TYPE OF COVERAGE BY STATE AND AGE FOR ALL PEOPLE: 2008, http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm.

68. See *supra* note 14 and associated text.

69. PETER C. DAMIANO, ET AL., FIRST EVALUATION OF THE IOWACARE PROGRAM 9-10 (Public Policy Center, The University of Iowa) (2008), available at <http://www.ime.state.ia.us/docs/FirstEvaluationoftheIowaCareProgramReportFINAL2008.pdf>.

70. *Id.*

71. PETER C. DAMIANO, ELIZABETH T. MOMANY, JEAN C. WILLARD, POLICY REPORT: OUTCOMES OF THE IOWACARES PROGRAM 2 (Public Policy Center, The University of Iowa) (2009), available at <http://www.ime.state.ia.us/docs/DraftSecondEvaluationIowaCareoutcomes.pdf>.

72. See generally PETER C. DAMIANO, ET AL., *supra* note 69, at 27, 35, 42-43 (finding that half of enrollees signed up because of health problems, nearly two-thirds of the surveyed enrollees reported that they used health services through IowaCare in the last six months, over two-thirds reported seeking emergency care and half reported needing urgent care in the last six months, and that nearly 70% of enrollees found out about the program through one of the two hospitals that serve as providers for IowaCare or from a Department of Health Services caseworker).

73. MCKAY, *supra* note 67, at 24, 26.

74. *Id.* at 2-5; JOAN ALKER, SUMMARY OF FLORIDA MEDICAID REFORM WAIVER: EARLY FINDINGS AND CURRENT STATUS 7 (Kaiser Family Foundation) (2008), available at <http://www.kff.org/medicaid/upload/7823.pdf>.

supplemental payments from the federal government, it is unlikely that most states will be able to provide more care under them than they otherwise would have—unless, for example, states manage to develop more efficient and cost-effective ways of caring for Medicaid and uninsured patients, or if they are both willing and able to increase supplemental payments by contributing more state funds. However, the context in which these changes are taking place is not encouraging. Traditional safety net providers are under increasing financial constraints. Some nonprofit hospitals are leaving the inner cities to suburbia in search of greater revenues, sometimes leaving lower income urban patients without sources of care.⁷⁵ Even public hospitals are seeking to “diversify” their income streams by tamping down on the number of low-income patients served in favor of private-pay patients.⁷⁶

It is particularly problematic, then, that the low income pool programs draw their funds from money that would otherwise be allocated to traditional safety net providers to provide reimbursement for otherwise uncompensated care. Most of the preceding discussion concerned plans that allocate funds directly from the state to disproportionate share providers. But what about plans such as Indiana’s Healthy Indiana Plan (HIP), where money is not allocated directly to disproportionate share providers, but rather is being used to help low income uninsured people purchase private health insurance plans?⁷⁷ The Bush Administration advanced such plans under the rubric of the “Affordable Choices” initiative during its final two years.⁷⁸ What improvements, if any, would they offer to patients and disproportionate share providers?

One might think, at least, that private plans would provide a better source of revenue for hospitals: rather than going through the convoluted exchange described earlier to obtain funding to cover some fraction of the costs of uncompensated care, a hospital would instead simply bill the newly insured patient’s private insurer. It is possible, as well, that provider reimbursement rates would be higher than the state’s usual payments under Medicaid. Indiana’s program, for example, pays providers at Medicare rather than Medicaid rates.⁷⁹ Higher rates may translate into improved access to providers for beneficiaries. If the reimbursement process were more streamlined and predictable, and reimbursement rates were increased, it appears that the use of low-income pool funds in

75. Barbara Martinez, *Nonprofit Hospitals Leave the City for Greener Pastures*, WALL STREET J., Oct. 14, 2008.

76. 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*, 27 HEALTH AFF. WEB EXCLUSIVE w374, w375-76, w378-80 (2008).

77. Letter from Kerry Weems to E. Mitchell Roob, *supra* note 52, at 2.

78. Press Release, The White House, 2007 State of the Union Policy Initiatives In Focus: Health Care, Affordable, Accessible, and Flexible Health Coverage (2007), available at <http://georgewbush-whitehouse.archives.gov/stateoftheunion/2007/initiatives/print/healthcare.html>.

79. INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, THE HEALTHY INDIANA PLAN § 1115. AFFORDABLE CHOICES DEMONSTRATION PROPOSAL 27 (2007), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Healthy%20Indiana%20Plan%20Historical%20Documents.zip>.

subsidizing the purchase of private health insurance for low-income populations would be more preferable to both beneficiaries and providers than the simple expansion of the coverage traditionally provided by Medicaid.

Or would it? One problem is that the Indiana plan does not necessarily eliminate, or even curtail, the provider taxes and intergovernmental transfers involved in DSH and other supplemental payment systems.⁸⁰ Some states, such as Iowa, have agreed to end IGTs as a condition for establishing their low-income pool; others have not.⁸¹ The Indiana plan simply changes the source of payment for otherwise uncompensated care: instead of getting a supplemental payment from the state to help offset all uncompensated care provided over a set period, the hospital or other health care provider instead would collect a payment from a private health insurer and from the patient himself or herself for each specific instance of care.⁸²

This would seem to be an improvement: hospitals and other providers would receive a set payment for specific services rendered to specific patients. Additionally, other providers besides hospitals—providers who often receive few if any supplemental payments—would be reimbursed for care that otherwise would have been uncompensated or simply not provided. Providers might see added income, as reimbursement rates would likely exceed the proportionate share of DSH or other supplemental funds they would otherwise have received. Finally, patients would have a more reliable and comprehensive source of coverage.

However, involving the private market in fact makes the matter more roundabout and, indeed, even more complex. First, DSH, UPL, and other supplemental payments are not eliminated; rather, those systems remain in place while adding private insurance to the mix.⁸³ As mentioned earlier, low income pools will not provide coverage to all or even most of the uninsured in any given state—hence the continuing need for supplemental payments.⁸⁴ Indiana, for example, contemplates covering approximately 127,000 of the state's estimated qualifying 560,000 uninsured individuals with its program.⁸⁵ Many people who have no coverage or insufficient coverage will of course still need health care, and many will turn to traditional safety net providers for it.

Yet now there is less money available to help offset those costs. First, Indiana disproportionate share hospitals agreed to forego a total of \$50 million in DSH

80. See generally INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 79.

81. See, e.g., LEGISLATIVE SERVICES AGENCY, IOWACARE MEDICAID REFORM ACT, EXECUTIVE SUMMARY, House File 841, at 2-3, 5 (2005), available at http://www3.legis.state.ia.us/noba/data/81_HF841_JS.pdf; MCKAY, *supra* note 67, at 25.

82. Letter from Kerry Weems to E. Mitchell Roob, *supra* note 52, at 1-2.

83. See, e.g., *id.*

84. See, e.g., *supra* notes 64-68 and associated text.

85. INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 79, at attachment 6, p. 8. Elsewhere, the document states that the State's goal is to cover up to 150,000 presently uninsured people. *Id.* at 5.

payments to help fund HIP, a sum amounting to 40% of the supplemental payments the hospitals would have received.⁸⁶ Second, rather than directly funding care, the money subsidizes a premium payment to a third party, which comes with its own administrative and marketing costs and profit margin to consider. Studies evaluating the cost-effectiveness of existing public versus private health coverage programs have found, in each case that the public programs cost less to administer—approximately 3% for Medicare and 3 to 5% for Medicaid, while administrative expenses for private insurance run approximately two and a half times as high as those of the public programs.⁸⁷ Lower administrative costs free up more money with which to pay for care.⁸⁸ This translates across borders: countries with single-payer coverage, such as Canada, for example, spend far less than the United States to administer their coverage systems.⁸⁹

The extra costs of private coverage translate into fewer people covered with less generous benefit packages that cost more money, as compared with simply providing coverage under the state's regular Medicaid plan. Indiana's HIP, for example, serves non Medicaid-qualifying parents and a limited number of childless adults earning up to 200% FPL.⁹⁰ HIP offers benefits "similar to the State of Indiana employee benefits plan" (though excluding maternity, vision, and dental benefits, among others), with a \$1,100 deductible for individuals, a maximum annual benefit of \$300,000, and a lifetime benefit of \$1 million.⁹¹ To help meet the deductible, participants are required to contribute between 2% and 4.5% of their gross family income to a health savings account, with the state paying the remainder.⁹² Indiana estimated that the cost to the state of providing HIP to a parent in the first year of the demonstration would be \$336 per month, with an additional 2 to 5% of the parent's gross income added to the sum

86. *Id.* at 41-42.

87. CARLOS ANGRISANO ET AL., ACCOUNTING FOR THE COST OF HEALTH CARE IN THE UNITED STATES 72-74 (McKinsey Global Institute) (2007), available at http://www.mckinsey.com/mgi/reports/pdfs/healthcare/MGI_US_HC_fullreport.pdf; see generally CONGRESSIONAL BUDGET OFFICE, CBO'S HEALTH INSURANCE SIMULATION MODEL: A TECHNICAL DESCRIPTION (2007), available at www.cbo.gov/ftpdocs/87xx/doc8712/10-31-HealthInsurModel.pdf.

88. See *Time for Change: The Hidden Costs of a Fragmented Health Insurance System: Testimony Before the S. Spec. Comm. on Aging*, 108th Cong. (2003) (statement of Karen Davis, President, Commonwealth Fund).

89. Steffie Woolhandler, Terry Campbell & David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768 (2003); ANGRISANO ET AL., *supra* note 87, at 70.

90. INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 79, at 18. The state planned to limit enrollment for childless adults at 11% of the total eligible population. *Id.* at 42. It reached the cap in June 2009. Shari Rudavsky, *Healthy Indiana Plan Quickly Hits Limit for Childless Adults*, INDY.COM, June 4, 2009, <http://www.indy.com/posts/healthy-indiana-plan-quickly-hits-limit-for-childless-adults>.

91. INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 79, at 25, 27. Coverage of up to \$500 is permitted below the deductible for preventive care. *Id.* at 11.

92. *Id.* at 30-31.

(between \$0 and \$85.83 per month).⁹³ Yet, to provide the parent with a much richer benefit plan under regular Medicaid, including maternity and vision care, and medical transportation costs, with only nominal out-of-pocket costs and no maximum annual or lifetime limits on coverage, would cost the state only \$359, according to its own estimates.⁹⁴ Thus, if one includes the parent's out-of-pocket expenses, in most cases it would cost less overall to provide the parent with the richer regular Medicaid benefit package.

Yet Indiana's actual experience has been even more extreme. According to the most recently available data, an average HIP enrollee who did not have a history of cancer, HIV/AIDS, hemophilia, organ transplant or aplastic anemia, cost the state \$412.54 per month between January and August 2009, as compared to adult Medicaid managed care enrollees, who each cost \$350.31.⁹⁵ HIP enrollees with cancer or another of the listed medical conditions cost far more: \$1,007.02 per month per patient, on average.⁹⁶ It is difficult to justify spending so much more for HIP coverage than it would cost to provide comparably more generous benefits under Medicaid, yet those were remarkably not the only costs expended under HIP: beneficiaries had to contribute up to 5% of their income to fund a health savings account intended to cover the \$1,100 deductible.⁹⁷ These costs may act as a barrier to participation for parents, though perhaps not so for childless adults: as of June 2009, only 18,017 parents had taken up coverage—less than half of HIP's target for the year—although enrollment for childless adults closed in March 2009, with 28,012 enrolled.⁹⁸

IV. MEDICAID AND THE GOALS OF PRIVATIZATION

Given the foregoing, it must be asked why a state would consider it worthwhile to cover expansion populations with leaner, private market coverage using taxpayer dollars, rather than providing richer yet less costly benefit packages through public means. Like the push toward greater personal responsibility

93. *Id.* at attachments 4 & 6.

94. *Id.* at attachment 6, p. 5; see also INDIANA OFFICE OF MEDICAID POLICY & PLANNING, INDIANA CARE SELECT PROGRAM DESCRIPTION AND COVERED BENEFITS (2008), available at <http://www.indianamedicaid.com/ihcp/CareSelect/content/documents/62atte.pdf> (describing services covered benefits under the Indiana Care Select program).

95. INDIANA OFFICE OF MEDICAID POLICY & PLANNING, QUARTERLY FINANCIAL REVIEW 7 (Indiana Family and Social Services Administration) (2009), available at http://www.in.gov/fssa/files/OMPP_August_QFR_FINAL.pdf.

96. *Id.*

97. INDIANA OFFICE OF MEDICAID POLICY & PLANNING, *supra* note 79, at 30-31.

98. INDIANA OFFICE OF MEDICAID POLICY & PLANNING, HIP MONTHLY DASHBOARD DRAFT (2009) (on file with the author). For studies examining the effect of subsidies on health insurance take-up rates by income and prior insurance status, see generally M. Susan Marquis et al., *Subsidies and the Demand for Individual Health Insurance in California*, 39 HEALTH SERVICES RES. 1547 (2004); David Auerbach & Sabina Ohri, *Price and the Demand for Nongroup Health Insurance*, 43 INQUIRY 122 (2006); Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, 19 HEALTH AFF. 72 (2000).

generally for welfare recipients, the move appears to be motivated by a belief that it might help beneficiaries lift themselves out of the habits, so to speak, of poverty.⁹⁹ The reasoning seem to be that, by offering coverage resembling that offered in the “mainstream” to the otherwise uninsured, a state could ostensibly push poor people toward greater independence from government assistance. If this belief were true, this change would seem to be a positive one not only for beneficiaries but also for society at large.

The problem is that funding health care for low-income people is not analogous to cash welfare. Unlike the stance taken in the cash welfare debate in the 1990s,¹⁰⁰ it is not generally argued that health care programs for the poor engender laziness or increased poverty, other than perhaps by providing beneficiaries with a disincentive to earn more than the relevant eligibility cutoff. In spite of this, support for privatization seems to rely at least partially on the premise that if we provide low-income, uninsured people with the trappings of “independent” existence, however meager or difficult to maintain those might be, they will start behaving more responsibly.¹⁰¹ The argument carries even less strength in the context of health care access than it does in the context of the cash welfare debate.

The reader will recall that Medicaid was intended by at least some of its original crafters to provide the poor with the same access to health care enjoyed by wealthier Americans. It was meant to mitigate reliance on public and charity hospitals while increasing access to regular doctors’ offices and associated comprehensive and regular care.¹⁰² Yet the concept of “mainstreaming” has evolved so that it no longer appears to pertain to the locus and nature of the care provided, but rather to the nature of coverage. The theory appears to be that if we move the uninsured into private health insurance plans we will have succeeded in bringing the poor into the fold, regardless of actual access to providers and adequate care. The goal of privatization, stripped down, is not for the poor to receive the same quality of health care that wealthier Americans enjoy, but rather to increasingly attenuate the visibility of the government’s role in paying for and providing that care, and to correspondingly elevate the prominence of the private market.

99. See, e.g., Lawrence M. Mead, *The Rise of Paternalism*, in *THE NEW PATERNALISM* 24 (Lawrence M. Mead ed., 1997).

100. See, e.g., *Welfare Reform: Testimony before the S. Finance Comm.*, 104th Cong. (1995) (statement of Lawrence M. Mead, Weinberg Visiting Professor, Princeton University); *Welfare Revisions: Testimony before the S. Finance Comm.*, 104th Cong. (1995) (statement of Charles Murray, American Enterprise Institute).

101. See, e.g., Dennis Smith, *State Health Reform: Converting Medicaid Dollars into Premium Assistance*, THE HERITAGE FOUNDATION, Sept. 16, 2008, <http://www.heritage.org/Research/Reports/2008/09/State-Health-Reform-Converting-Medicaid-Dollars-into-Premium-Assistance>; Dennis Smith, *Consumer Direction in Medicaid and Opportunities for States*, THE HERITAGE FOUNDATION, Nov. 13, 2008, <http://www.heritage.org/Research/Reports/2008/11/Consumer-Direction-in-Medicaid-and-Opportunities-for-States> (specifically discussing the effects of “self-direction” in Florida’s Medicaid long term care program).

102. See *supra* note 16 and accompanying text.

Reasonable minds can disagree about whether the policy is directed at fostering a respectable reliance on the private market, with its emphasis on individualism, self-help, and self-created prosperity, or whether ulterior interests are driving increased privatization. However, skepticism should be used in considering a policy that diverts a sizeable portion of scarce funds—funds that are not in themselves sufficient to cover the health care needs of the poor—away from providing actual care and improved access for our country's uninsured, and into the pockets of third parties—third parties who otherwise would not qualify for welfare of any kind.

Of course, following this line of skepticism eventually leads one to question some fundamental underpinnings of our health care system. The federal government indirectly subsidizes private coverage in a myriad of ways. These subsidizations most notably include tax exemptions for both employees and employers for employer-sponsored private coverage, totaling \$246 billion in 2007, and additional payments for Medicare Advantage plans that, if continued at their 2007 levels, would cost an extra \$54 billion from 2008 to 2012.¹⁰³ What are the goals of these subsidies—subsidies that obscure, rather than reveal, the source and quantity of health coverage costs? Are we, as the original founders of Medicaid may have intended, placing our emphasis on providing comprehensive, high quality care to everyone? Or are the coverage mechanisms of that care driving our policies? Surely we as a society wish to preserve and promote the good of care, not coverage; coverage ought to be nothing more than a means of helping to ensure access to care. As we review our Medicaid programs and consider the prospect of national health reform, we need to keep the correct goal in mind.

103. *Health Care Reform Financing Issues: Hearing before the S. Comm. on Finance Roundtable on Financing*, 111th Cong. 6 (2009) (statement of Robert Greenstein, Executive Dir., Ctr. on Budget and Policy Priorities), available at <http://www.cbpp.org/files/5-12-09health-testimony.pdf>; *The Medicare Advantage Program: Hearing before the H. Comm. on the Budget 16*, 110th Cong. (2007) (statement of Peter Orszag, Dir., Cong. Budget Office), available at <http://purl.access.gpo.gov/GPO/LPS83018>.