

Provider Assessments, the Uninsured, and Uncompensated Care: Florida's Public Medical Assistance Trust Fund

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THE INCREASING NUMBER OF AMERICANS WITHOUT health insurance poses a serious and worsening dilemma for state and local governments. Recent estimates suggest that from 70 to 75 million persons were inadequately insured in 1994 (Short and Bantlin 1995). The size of this group, in conjunction with their extensive use of hospital emergency room services, explains in part why the financing and provision of health care to the medically indigent and underinsured has evolved into the "uncompensated health care crisis." An examination of the growth of hospital uncompensated care illustrates the magnitude of this crisis. Uncompensated care charges exceeded \$6 billion in 1982, doubled to nearly \$12 billion by 1986, and increased another 50 percent to \$17.2 billion by 1990 (American Hospital Association 1992). In real terms, uncompensated care charges grew by 29 percent between 1982 and 1990 (Dubay, Norton, and Moon 1993). Many policy makers contend that this crisis is the driving force behind recent efforts to reform the delivery of health care in the United States.

The burden of uncompensated care charges may be more problematic for hospitals now because of a complex set of political, social, and economic circumstances, some of which can be linked to earlier attempts to

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solve the problems of the health care system. Events of the early 1980s, in particular the economic recession, declines in private health insurance coverage, and limits on federal government spending, have all contributed to the current "crisis." This problem has been further exacerbated by more recent cost containment policies like Medicare's prospective payment system, the growth of policy strategies that are geared toward competition, and an increasingly competitive health insurance sector in which managed care plans pressure hospitals to provide discounted rates. As a consequence, many health care institutions have been forced to curtail access to care for individuals who lack health insurance (Wilensky 1988).

Some states recognized the serious social and economic ramifications of these changes and, during the late 1980s and early 1990s, enacted specific legislation to provide health care access to the otherwise uninsured and/or to alleviate the financial burden imposed on hospitals rendering excessive levels of uncompensated care. One of the more promising approaches to the latter problem is the establishment of revenue pools, funded in part by the imposition of provider taxes (Bartlett 1985). Dollars from this earmarked fund can be used to finance Medicaid expansions and other forms of coverage for the uninsured and/or to make lump sum payments to hospitals that serve a large proportion of indigents.

Surprisingly, despite widespread interest in this funding approach among policy makers, relatively little research exists documenting whether revenue pools generated via provider taxes are effective mechanisms for reducing uncompensated care and improving access through insurance coverage to the medically indigent and underinsured. The few exceptions include published studies by Thorpe (1987, 1988), Thorpe and Spencer (1991), and Thorpe and Phelps (1992) on the impacts of the New York revenue pool. The New Jersey program has been analyzed by Rosko (1990), Dunn and Chen (1994), and Gaskin (1996). Two other articles, by Jones (1989) and Brown (1993), have discussed the Florida revenue pool in the context of evaluating the political process of implementing health care reform in the state. Neither author, however, conducted an empirical analysis to document the effects of the Florida revenue pool on the uninsured and uncompensated care. Research on this subject is extremely important and timely, given recent updates indicating that a substantial portion of the population lacks adequate insurance coverage. Moreover, further research on this topic is clearly warranted in light of the number of states that have established revenue pools financed via provider taxes.

This study examines the situation in Florida and evaluates whether the initiatives financed via the Florida revenue pool, known as the Public Medical Assistance Trust Fund (PMATF), have improved access through its provision of insurance coverage and have mitigated the problem of uncompensated care. The Florida revenue pool, established in 1984 by the state legislature, merits analysis for a number of reasons: First, this policy mechanism is well established, as it was the second revenue pool to become operational; thus, its effects can be observed over a long period of time. Second, the funds generated from the provider tax are primarily used to increase access to the uninsured through Medicaid coverage and other state-sponsored indigent care programs. Only a small percentage of its revenue pool funds are allocated to make direct payments to hospitals that render high levels of uncompensated services. In contrast, nearly all the other states with revenue pools use their funds primarily for this purpose. Third, the provider assessment in Florida applies to all hospitals and four types of ancillary service facilities. The Florida pool, therefore, has a more extensive funding base than other states with revenue pools because their provider assessments are only imposed on hospitals.

In the present study, we analyze Medicaid enrollment and expenditure data, PMATF assessment and reimbursement data, and financial data on Florida hospitals to examine the following issues:

- the effect of the initiatives supported by the PMATF on the growth of uncompensated care
- the effect of the initiatives supported by the PMATF on the distribution of uncompensated care among hospitals by ownership status
- the effect of the PMATF on Medicaid enrollment and expenditures
- whether PMATF assessments collected from proprietary hospitals, which typically provide relatively little uncompensated care, exceeded reimbursements received from Medicaid expansions, direct subsidies, and disproportionate-share payments
- whether government and not-for-profit (NFP) hospitals, which typically treat a large number of indigents, received PMATF reimbursements that in aggregate exceeded PMATF assessments paid by these facilities
- whether the provider tax imposed on hospitals and ancillary facilities constitutes a stable source of financing for the revenue pool

The next section presents background information on the PMATF, followed by an examination of the growth of uncompensated care in Florida. We then describe the effects of the PMATF on access to care by the medically indigent and underinsured and go on to examine whether the PMATF has altered the amount of uncompensated care rendered by hospitals in the state. After a consideration of whether the provider assessment approach generates a stable source of financing for revenue pools, we present our conclusions and discuss the policy implications of this funding approach.

Revenue Pools and the PMATF

Perhaps one of the most noteworthy initiatives enacted to address the problem of the uninsured was the Health Care Access Act (HCAA) passed by the Florida legislature in 1984. As part of this legislation, a revenue pool was established to address the following circumstances: escalating health care costs; diminishing private health insurance coverage; limited availability of primary and preventive care; the failure to utilize federal funding opportunities; the concentration of poor patients; and the associated burden of indigent care among relatively few providers. The purpose of this revenue pool was to finance Medicaid expansions and other primary health care programs for the medically indigent and the underinsured.

Initially, the revenue pool funds were generated from both a hospital assessment and some state general appropriations. The provider assessment was set at 1.5 percent of the amount of revenue actually collected before expenses (net operating revenues) of all licensed hospitals in the state. In 1990, state lawmakers increased the cigarette tax by ten cents a pack and earmarked these revenues for the PMATF. In 1991 the Florida legislature expanded the fund base and imposed a 1.5 percent assessment on the annual net operating revenues of ambulatory surgical centers, clinical laboratories, freestanding radiation therapy centers, and diagnostic imaging centers. In 1992, the Florida legislature imposed a \$1.50 assessment for each patient day provided by nursing homes. The industry opposed this assessment and lobbied heavily to bring about its repeal in FY 1993–94.

The Florida pooling mechanism is regarded as a highly innovative approach toward ameliorating the economic and social problems linked

to the provision of uncompensated care for at least three reasons: First, revenue pools are designed to address inequities across hospitals in the provision of indigent care (Wilensky 1987). From 1987 through 1992 a portion of the revenue pool funds were distributed by a formula to hospitals that served a disproportionate share of indigent and uninsured patients. Thus, the redistributive revenue pools are considered more equitable than alternative sources of funding (i.e., excise taxes on alcohol and cigarettes) because the insured population, whether directly or indirectly, finances health care to the uninsured. Essentially, this mechanism formalizes the practice of cost shifting (Jones 1989). This approach seems most appropriate to accommodate the problems of states like Florida, where there are many hospitals, yet only a small proportion treat the uninsured.

Second, because the funds are partly generated from an assessment on hospital revenues and freestanding ancillary facilities, the financing of programs for the uninsured increases in accordance with the costs of care. This approach therefore avoids the problems associated with programs that depend extensively on state and local revenues for support. Extensive reliance on state and local funds tends to be problematic because during recessionary periods unemployment rises, state and local revenues decline, and the number of uninsured increases. In contrast, the assessment imposed on hospitals and health care facilities specializing in outpatient services constitutes a more stable source of revenue.

Third, many other states that finance uncompensated care through revenue pools (i.e., New York, New Jersey, Ohio, and Massachusetts) have used these funds solely to reimburse hospitals providing high levels of charity care. Because services rendered outside the hospital are not covered, allocating funds only to hospitals promotes overutilization of services rendered in the most expensive care settings (emergency room and other hospital-based facilities). More important, when lump sum payments are made to hospitals, there is no guarantee that they will be earmarked to provide services to uninsured persons. The Florida approach avoids this "leaky bucket" phenomenon (Thorpe 1988) because it allocates most of the funds to finance Medicaid expansions.

The PMATF is used to support several programs, all of which mitigate the problem of uncompensated care. First, the state expanded Medicaid coverage to targeted groups of uninsured persons (see table 1). Second, to compensate hospitals for Medicaid shortfalls, the state increased reimbursement levels for hospitals; physician fees were also in-

TABLE 1
Policy Changes Financed through the PMATF Since Inception

Year	Policy change
1984	<ul style="list-style-type: none"> • Hospital outpatient cap, the maximum amount the Florida Medicaid program will pay for each outpatient visit, was increased from \$100 to \$500 per recipient per year.
1985	<ul style="list-style-type: none"> • Ten million dollars was appropriated to fund county public health units; 18 of 67 counties were awarded. Free care for indigents with incomes below 100 percent of federal poverty level (FPL) and a sliding-fee scale for those with incomes between 100 and 200 percent of FPL. • Expanded Medicaid coverage to include married, pregnant women in income-eligible families; children up to age 21 in income-eligible intact families; income-eligible unemployed parents and children.
1986	<ul style="list-style-type: none"> • Medically needy program was established to provide services to categorically eligible persons with incomes at or below 133 percent of FPL.
1987	<ul style="list-style-type: none"> • Indigent Health Care Act expanded Medicaid coverage to include categories stipulated in SOBRA: pregnant women, infants, and children under two with family incomes at or below federal poverty level; elderly and disabled with family incomes below 90 percent of FPL. • Presumptive eligibility implemented for all pregnant women who attest their family income meets Medicaid eligibility. • Hospital outpatient cap increased from \$500 to \$1,000 per recipient per year. • Increased physician reimbursement for office visits, obstetric services, neonatal-perinatal services, dental services, and home health.
1988	<ul style="list-style-type: none"> • Expanded coverage to the elderly and disabled with family incomes between 90 and 100 percent of FPL. • Limit on inpatient hospitalization for infants in neonatal intensive care units increased from 45 to 120 days. • Extended coverage to children up to age five with family incomes up to 100 percent of FPL. • Extended coverage to pregnant women, infants, and children up to age one with family incomes between 100 and 185 percent of FPL. • Established a Medicaid disproportionate share program (DSH) to reimburse hospitals that treat a high percentage of Medicaid and indigent patients. To qualify for reimbursement, the sum of a hospital's charity care and Medicaid days must exceed 5 percent of its total adjusted inpatient days. The adjustment rate was equivalent to the number of Medicaid days plus 4.5 percent multiplied by the number of charity care days expressed as a percentage of total adjusted patient days. Hospitals with Medicaid inpatient utilization rates greater than one standard deviation above the statewide mean are eligible for DSH payments.

creased to raise participation rates. Finally, the state implemented a disproportionate share program (DSH) to assist hospitals that treat a large number of Medicaid and indigent patients. This program offered three advantages: First, it provided a federal matching of funds with a high degree of flexibility regarding eligibility requirements. Second, the results could be easily predicted because the adjustments were determined using prior year hospital financial records, yet payment was made for every Medicaid reimbursement in the current year. Finally, administrative expenses could be minimized because the DSH adjustments were added to the Medicaid payments received regularly by hospitals. After 1992, however, PMATF dollars were no longer allocated to fund DSH payments to hospitals. The programs and policy changes financed through the fund since inception are described in chronological order in table 1.

Uncompensated Care in Florida

Published estimates indicate that there were 2,242,000 nonelderly persons without health insurance in Florida in 1986; this represented 23.2 percent of the nonelderly population. The corresponding number and percentage nationally were 37,027,000, or 17.8 percent. Thus, in 1986, Florida's rate of persons lacking insurance exceeded the national average (Chollet 1988). By 1994, the proportion of the nonelderly population nationally lacking insurance declined slightly, to 17.4 percent (39,718,000 persons). The corresponding number and percentage for Florida in 1994 were 2,457,000, or 20.9 percent (U.S. Bureau of the Census 1996). Thus, Florida's rate of uninsured persons declined relatively more over this period, although in absolute terms the Florida rate still exceeded the national average. Some of the concern over the lack of health care coverage among the nonelderly population stems from the fact that uninsured patients generate significant dollar amounts of uncompensated care. Therefore, before considering the impact of the PMATF on the provision of uncompensated care in Florida, it is important to assess the severity of the problem in the state.

Table 2 presents information regarding the amounts of uncompensated care provided by Florida hospitals over the period 1983 through 1991. Although we report both nominal and real dollar amounts, our discussion focuses on real dollar changes. During this nine-year period, the real dollar increase in uncompensated care was \$553.6 million, or

TABLE 2
Uncompensated Care Dollars Provided by Florida Hospitals
from 1983 to 1991

Year	Uncompensated care in nominal dollars ^a	Nominal annual percent increase	Uncompensated care in real dollars ^a	Real annual percent increase	Uncompensated care as percent of revenue
1983	586.5	—	586.5	—	10.2
1984	813.5	38.7	771.1	31.5	12.9
1985	923.7	13.5	834.6	8.2	13.7
1986	1,126.8	22.0	982.8	17.7	15.9
1987	1,306.3	15.9	1,086.2	10.5	17.4
1988	1,365.7	4.5	1,065.2	-1.9	16.0
1989	1,489.4	9.1	1,089.9	2.3	16.0
1990	1,643.1	10.3	1,139.5	4.6	15.7
1991	1,734.4	5.6	1,140.1	.05	15.4
Increase from 1983 to 1991					
Actual \$	1,147.8		553.6		5.2
Percent	195.7		94.4		51

^aAll dollar values are expressed in \$100,000s.

about 94 percent. Although since 1983 the amount of uncompensated care statewide more than doubled in real terms, the trend slowed considerably after 1987. The growth of uncompensated care between 1984 and 1987 is not surprising, considering the limited nature of the Medicaid expansions and the implementation difficulties of extending health care access to the uninsured. In contrast, statewide uncompensated care in real dollars declined by almost 2 percent between 1987 and 1988. Concomitantly, uncompensated care dollars expressed as a percentage of revenues peaked in 1987 at 17.4 percent and declined thereafter to 15.4 percent in 1993. The dramatic slowdown in the growth of uncompensated care may be attributable primarily to the subsequent resolution of initial implementation problems in enrolling eligible persons, the mandates stipulated under the Sixth Omnibus Budget Reconciliation Act (SOBRA) legislation in 1987, and the establishment of the DSH program (Dubay, Norton, and Moon 1993). Although these trends are only descriptive, they provide some indication that extending access to the

uninsured has been instrumental in controlling the dollar volume of uncompensated care.

Previous research indicates that most uninsured patients are treated at teaching, public, and NFP hospitals, whereas investor-owned facilities serve relatively few of these patients (Wilensky 1984). To ascertain whether these associations exist among Florida hospitals, we examined the relation between ownership status and uncompensated care dollars. Table 3 shows that in 1983, most of the \$586.5 million of uncompensated care was provided by public and not-for-profit (NFP) hospitals, approximately 41.4 and 42.6 percent, respectively. Investor-owned facilities, in contrast, rendered a smaller share of uncompensated care, only \$93.8 million, or 16 percent of the statewide total. The expansions supported in part by the PMATF appear to have had negligible effects on the distribution of uncompensated care by ownership type among Florida hospitals. In 1991, the shares borne by NFP, government, and for-profit hospitals were 47.3 percent, 36.7 percent, and 16 percent, respectively. Given that the number of government hospitals decreased from 50 to 27 over the nine-year period, it is not surprising that NFP institutions experienced the largest increase in dollar volume of uncompensated care; their real dollar increase was 116 percent.

The financial burden imposed on hospitals that render substantial amounts of uncompensated care becomes more apparent when one examines uncompensated care dollars expressed as a percentage of total revenue. Government hospitals continued to bear an increasing share of uncompensated care over the period 1983 to 1991. Uncompensated care dollars as a percentage of total revenues increased from 20.4 percent to 54.6 percent, a 34.2 percentage point increase. (In relative terms this change represents an increase of 168 percent.) The share and absolute increase experienced by NFP facilities was much smaller. Among this ownership group, uncompensated care dollars as a percentage of total revenue increased from 9 percent to 19.5 percent; this 10.5 absolute percentage point change is equivalent to a 117 percent relative increase. Proprietary hospitals experienced a 110 percent increase in uncompensated care dollars as a percentage of revenue between 1983 and 1987 (from 5.3 percent to 10.6 percent). Yet between 1987 and 1991 this ratio declined from 10.6 percent to 9.2 percent. Hence, the net burden experienced by proprietary facilities over the period was a 3.9 percentage point increase (about 74 percent in relative terms).

TABLE 3
Uncompensated Care Provided by Florida Hospitals
by Ownership Type from 1983 to 1991^a

Ownership type	Total nominal dollars of uncompensated care \$ (%)	Total real dollars of uncompensated care \$ (%)	Uncompensated care dollars as percent of total revenue ^b
<i>Not for profit</i>			
1983	249.7	249.7	9.0
1987	561.5	466.9	19.4
1991	820.7	539.5	19.5
Change and % increase			
1983-87	311.8 (125)	217.2 (87)	10.4 (115.5)
1987-91	259.1 (46)	72.6 (15.5)	0.1 (.5)
1983-91	571.0 (229)	289.8 (116)	10.5 (116.7)
<i>Government</i>			
1983	243.0	243.0	20.4
1987	525.0	436.5	42.3
1991	637.0	418.8	54.6
Change and % increase			
1983-87	282.0 (116)	193.5 (80)	22.0 (107.8)
1987-91	112.0 (21)	-17.8 (-4.1)	12.3 (29)
1983-91	394.0 (162)	175.7 (72.3)	34.2 (167.6)
<i>Proprietary</i>			
1983	93.8	93.8	5.3
1987	219.8	182.8	10.6
1991	276.7	181.9	9.2
Change and % increase			
1983-87	126.0 (134)	89.0 (95)	5.3 (100)
1987-91	56.9 (26)	-.89 (-.5)	-1.4 (-13.2)
1983-91	182.9 (195)	88.1 (94)	3.9 (73.6)

^aAll dollar values are expressed in \$100,000s.

^bThe numbers in parentheses reflect the percentage increase in uncompensated care dollars as a percent of total revenue over each time period.

The evidence presented in tables 2 and 3 suggests that the medically indigent and the underinsured have received substantial dollar amounts of uncompensated care and thus have probably caused significant financial hardship for certain providers, especially government and NFP institutions. The descriptive findings also imply that both the absolute increase and the growth rate of uncompensated care slowed considerably

after 1987. To assess the implications of these trends, the effects of the PMATF on extending access to the uninsured and on hospitals rendering a disproportionate share of uncompensated care are evaluated below.

The Impact of the Medicaid Expansions and PMATF on the Uninsured

Table 4 presents aggregate statistics indicating the overall impact of the Medicaid expansions on the Florida Medicaid program. First, note that Florida experienced rapid population growth during the 1980s. Between FY 1984–85 and FY 1992–93 the population of Florida increased by 20 percent. Second, as anticipated, the expansions have extended health insurance to many previously uninsured persons. In FY 1984–85, before any significant expansions were enacted, only 494,118 individuals, or 4.4 percent of the state's population, qualified for Medicaid. Within eight years after the passage of the HCAA, the number of Medicaid beneficiaries increased by over 996,000 to its then current enrollment of 1,490,314 in FY 1992–93. This 200 percent increase in the number of enrollees means that Medicaid was providing health care insurance to nearly 11 percent of the state's population. Nevertheless, because the state's population has grown so rapidly, the number of uninsured has remained relatively constant and may have even increased.

TABLE 4
Comparison of Florida Medicaid Program before and after
the PMATF Expansions

Fiscal year	Total population	Number of eligibles	Eligible percent of population	Total expenditures (\$) ^{a,b}	Expenditures per capita (\$) ^a	Expenditures per eligible (\$) ^a
1984–85	11,322,300	494,118	4.4	913.6	81	1,849
1989–90	12,921,950	762,223	5.9	2,496.0	193	3,275
1990–91	13,196,000	922,038	7.0	3,174.5	241	3,443
1991–92	13,424,400	1,176,350	8.8	3,986.5	297	3,389
1992–93	13,608,600	1,490,314	10.9	4,852.4	357	3,256

^aAll dollars are expressed in nominal terms.

^bTotal expenditures are expressed in \$100,000s.

Source: Florida Medicaid Program, Agency for Health Care Administration.

Abbreviation: PMATF, Public Medical Assistance Trust Fund.

Table 4 also demonstrates that the Medicaid expansions resulted in significant increases in program expenditures. Overall expenditures grew from just under \$914 million in FY 1984–85 to around \$4.85 billion in FY 1992–93, a 431 percent increase in Medicaid program expenditures. The last two columns of table 4 show the effects of the Medicaid expansions on program spending per capita and expenditures per eligible. Per capita spending increased approximately 341 percent between FY 1984–85 and FY 1992–93, from \$81 to \$357. Expenditures per eligible increased by more than 76 percent, from \$1,849 in FY 1984–85 to \$3,256 in FY 1992–93. These expenditure increases were anticipated, however, as the Medicaid program significantly expanded both the categories of eligible persons as well as the range of services provided.

Table 5 presents details indicating how the composition of the Medicaid caseload changed over the study period. Except for initial caseloads, table 5 reflects the number of Medicaid eligibles at the end of each calendar year. The total number of Medicaid eligibles increased from about 500,000 to almost 1.6 million, or by about 218 percent between July 1985 and December 1994. Caseloads at the end of 1994 show that all of the targeted groups—categorically eligible, medically needy, pregnant women, children, the elderly, and the disabled—have been the primary beneficiaries of the expansions. Nonetheless, the expansions have also resulted in higher SSI and AFDC caseloads. While over 98 percent of the initial caseload was accounted for by persons who qualified for Medicaid under either SSI or AFDC, these two categories represented about 74 percent, or close to 1.2 million of the Medicaid population. Except for refugee assistance eligibles, the remaining 25 percent qualified for Medicaid under the expansions and federal mandates. Clearly, these Medicaid expansions have extended health care access to many previously uninsured Floridians.

The large increases in the AFDC and SSI populations document an unexpected consequence of the enrollment effort: the identification of a significant number of Medicaid eligibles who were also deemed to be eligible for cash assistance (AFDC or SSI). For example, the projected AFDC caseload without the medically needy expansions for FY 1988–89 was 99,776 families, or 276,380 persons (assuming average family size is 2.77 persons). The actual realized AFDC caseload was 113,646 families, or 314,799 eligibles, about 14 percent higher than projected. A similar phenomenon occurred among the SSI population. In FY 1988–89, the SSI caseload projected without Medicaid expansions was 187,660,

TABLE 5
The Effects of the PMATF Expansions and Federal Mandates on the Medicaid Caseload

Aid category	Beginning caseload as of date	Beginning caseload	Caseload as of				
			12/89	12/91	12/92	12/93	12/94
SSI	7/85	205,750	248,252	264,586	282,779	306,662	335,784
AFDC	7/85	291,205	408,996	490,548	621,242	795,755	841,599
Categorically eligible	7/85	379	7,960	9,255	35,246	69,952	62,448
Medically needy	7/85	177	11,233	15,099	9,300	8,922	20,935
Pregnant women	10/87	1,977	19,852	26,357	35,391	39,046	43,752
Children	10/87	713	33,944	62,179	107,277	182,097	207,440
Elderly and disabled	10/87	1,948	26,889	38,281	52,253	67,919	71,646
All refugee assistance	7/85	2,049	3,016	2,160	2,460	6,483	4,846
Total		504,198	760,142	908,465	1,145,948	1,476,536	1,588,450

Source: Florida Medicaid Program, Agency for Health Care Administration.

Abbreviations: AFDC, Aid to Families with Dependent Children; PMATF, Public Medical Assistance Trust Fund; SSI, Supplemental Security Income.

while the actual caseload was 201,771, or about 7.5 percent or 14,171 individuals above projections (Clarke 1989).

State officials did not anticipate that such a large proportion, about 60 percent of persons who enrolled in Medicaid during the expansions, would also qualify for cash assistance programs. Many potentially eligible persons who qualified for cash assistance were not enrolled previously because (1) they did not have access to information about cash assistance and Medicaid programs; (2) they perceived the application process as burdensome; (3) they failed to apply because of the stigma attached to welfare programs. The extensive efforts undertaken to reach persons residing in low-income areas and a streamlined eligibility process were probably the major reasons why administrative personnel were able to enroll a large number of persons who were not previously on the rolls. This evidence implies that extensive outreach efforts by state workers to enroll eligible persons in Medicaid can result in substantial increases in insurance coverage without changing any laws.

As shown in table 6, however, PMATF-funded eligibles represented a relatively small proportion of the population of Medicaid beneficiaries. In FY 1986–87, PMATF Medicaid eligibles accounted for less than 2 percent of all Medicaid beneficiaries. Yet, by FY 1988–89, there were almost 55,600 PMATF Medicaid eligibles, which represented about 8.5

TABLE 6
Comparison of PMATF Medicaid Eligibles Relative to Total
Medicaid Eligibles from 1984–85 to 1993–94

Fiscal year	PMATF Medicaid eligibles	Total Medicaid eligibles	PMATF eligibles as a percent of total eligibles
1985–86	1,502	513,443	.29
1986–87	9,436	547,432	1.72
1987–88	25,763	592,918	4.35
1988–89	55,585	655,742	8.48
1989–90	103,011	762,222	13.51
1990–91	161,745	922,038	17.54
1991–92	253,095	1,176,350	21.52
1992–93	384,793	1,490,314	25.82
1993–94	422,486	1,596,832	26.46

Abbreviation: PMATF, see table 4.

percent of the Medicaid population. In subsequent years the expansions had dramatic effects on enrollment. As of FY 1993–94 the number of PMATF Medicaid eligibles was close to 422,500, or only about 26.5 percent of all Medicaid beneficiaries. The Medicaid beneficiaries funded through the PMATF, however, accounted for almost 39 percent of the growth in Medicaid eligibles over the time period covering FY 1985–86 through FY 1993–94. The remaining 61 percent can be linked to congressional mandates expanding access to pregnant women and infants and state changes in AFDC eligibility requirements. Thus, while the HCAA and the PMATF reflect significant attempts to expand access to the uninsured, these efforts paralleled congressional mandates to extend medical care coverage.

Impact of the PMATF on Hospital Uncompensated Care

Revenues from the PMATF were earmarked to increase access to care for the uninsured and to mitigate the financial problems associated with the provision of high levels of uncompensated care. Information documenting the disbursements from, as well as the assessments contributed to, the PMATF by hospitals aggregated according to ownership category is reported in table 7. A careful examination of these dollar figures reveals that the Florida revenue pool appears to be achieving the second of its two objectives: leveling the playing field among hospital providers.

As expected, the largest share of the payments to hospitals for the Medicaid expansions was paid to NFP and public hospitals. NFP hospitals received in excess of \$560 million, or 55 percent, whereas the public facilities received close to \$318 million, or 31 percent of total disbursements for Medicaid expansions. In contrast, investor-owned hospitals received only 13 percent of the total PMATF revenues disbursed to hospitals for Medicaid expansions over the study period. Similar patterns emerge regarding the direct reimbursements to hospitals (i.e., the one-time PMATF redistribution in 1987 and the DSH payments). Since 1987, hospitals meeting specific criteria related to patient mix have received direct subsidies from the PMATF in excess of \$209 million. NFP and government hospitals have received the largest shares of these payments: 44.7 percent and 45.6 percent, respectively. Less than 10 percent of these subsidy dollars have been given to investor-owned facilities.

TABLE 7
 Summary of Expenditures Compared to PMATF Assessments, from July 1, 1984 (Inception) to September 30, 1991^a

Ownership type	Payments to hospitals for Medicaid expansions	PMATF redistribution and disproportionate share payments	Total payments to hospital	Assessments collected from hospitals	Payments to hospitals over/(under) assessments
Government	317,771,212	95,407,151	413,178,363	109,824,748	303,353,615
Not for profit					
Church	108,287,485	13,700,166	121,987,651	75,155,322	46,832,329
Other	452,174,053	79,778,871	531,952,924	284,040,909	247,912,015
Total	560,461,538	93,479,037	653,940,575	359,196,231	294,744,344
Proprietary					
Solely owned	7,322,311	1,739,639	9,061,950	16,269,024	(7,207,074)
Corporation	125,187,717	18,393,543	143,581,260	254,719,852	(111,138,592)
Total	132,510,028	20,133,182	152,643,210	270,988,876	(188,345,666)
All hospitals	1,010,742,778	209,019,370	1,219,762,148	740,009,855	479,752,293

^aIn dollars. Dollars are expressed in nominal terms.

Source: Florida Medical Program, Agency for Health Care Administration.
 Abbreviation: PMATF, see table 4.

These results suggest that the revenue pool may be working as anticipated. Overall, total disbursements from the PMATF to hospitals exceeded \$1.2 billion, whereas assessments collected from hospitals over this period amounted to \$740 million. Public hospitals appear to be the primary beneficiaries of the revenue pool, as these facilities contributed close to \$110 million, or almost 15 percent of total assessments, but received about 34 percent, or \$413 million, of total PMATF payments. The ratio of the excess of payments over assessments (\$303 million) relative to assessments for government-owned hospitals was 2.76. NFP and proprietary hospitals have fared less well. NFP hospitals contributed \$359 million, or roughly 48.5 percent, of total assessments and received almost \$654 million, or about 53.6 percent of PMATF distributions. The ratio of the excess of payments over assessments (\$295 million) relative to assessments collected for NFP facilities was .82. Investor-owned facilities contributed nearly \$271 million, or 36.6 percent, of total assessments, yet received just under \$153 million, or 12.5 percent, of the total PMATF disbursements. As a consequence, assessments on proprietary hospitals exceeded the payments these facilities received from the PMATF by more than \$118 million.

The major providers of uncompensated care were identified by examining hospital financial data. In 1983, the 16 major providers of uncompensated care rendered in excess of \$269 million, or about 46 percent of uncompensated care statewide. Despite the passage of the HCAA, the amount of uncompensated care provided by these seven government and nine NFP hospitals continued to escalate through 1987. A reversal of these trends, however, occurred between 1987 and 1988, when half of these 16 hospitals experienced a decline in uncompensated care dollars for the first time since 1983. Moreover, for each of the other eight hospitals, the incremental change in dollars of uncompensated care was the smallest in five years. Nonetheless, by 1991 these 16 hospitals still accounted for almost \$811 million, or close to 47 percent of uncompensated care dollars statewide. All 16 hospitals, however, have received more from the PMATF, either as payments for Medicaid services and/or as direct subsidies, than they have contributed in assessments. While this finding suggests that the PMATF disbursements have provided some monetary relief to the major providers of uncompensated care in the state, the existence of the revenue pool has not resulted in the financial burden of this care being redistributed away from these hospitals.

Provider Taxes as a Financing Mechanism for Revenue Pools

An important question to address is whether the provider assessments imposed on hospitals and four types of freestanding ancillary facilities constitute a stable source of financing for the PMATF. To evaluate this critical concern, we examine a breakdown of revenue sources and expenditures from the PMATF by fiscal year since inception. This cash analysis, presented in table 8, excludes the federal match and thus only reflects the state's allocation of revenues to and expenditures from the PMATF. The relative contribution of provider taxes as a financing mechanism can be evaluated by examining the share of total state PMATF revenues generated by assessments on hospitals and ancillary facilities. This relative share is expressed both with and without the beginning cash balance because large surpluses from the prior fiscal year tend to distort the relative contribution of revenues derived from provider assessments in calculations that include the initial cash balance.

The relative share percentages (excluding the initial cash balances) show that from FY 1985–86 through FY 1989–90 the provider assessments accounted for between 73.6 percent and 78.4 percent of state PMATF revenues. The percentages that include the initial cash balance amounts are somewhat smaller because during this time period the PMATF had relatively large prior year surpluses. After FY 1989–90, however, the initial cash balances were relatively small as increasing expenditures nearly exhausted state-generated PMATF revenues. In FY 1990–91, the state legislature recognized that expenditures on Medicaid expansions would exceed projected PMATF dollars generated through provider assessments and the \$30 million general revenue appropriation. In response, the legislature passed a ten cents per pack increase in the state cigarette tax, which yielded \$123.4 million and increased the PMATF general revenue appropriation to \$123.1 million. Although the actual dollar amounts generated by the provider assessments increased between FY 1990–91 and FY 1993–94, the share of PMATF dollars attributable to the assessments (excluding the initial cash balance) has remained relatively stable. Nonetheless, the cigarette tax increase has proved to be a declining source of revenue; the general revenue appropriation's share of PMATF funds has increased from 30 percent in FY 1990–91 to about 46 percent in FY 1993–94.

Regarding expenditures, most of the PMATF dollars are allocated to Medicaid expansions and state-sponsored primary care programs. Even though the one-time redistribution of \$69.5 million represented 39 percent of PMATF expenditures in FY 1988–89, the DSH payments made in each of the four subsequent fiscal years accounted for small shares of total state trust fund expenditures. DSH payments represented 16, 6.6, 1.3, and 2.7 percent of state PMATF dollars, respectively, in the four-year period beginning with FY 1988–89. Thus, in accordance with the original legislation, most of the PMATF dollars are used to extend health insurance coverage to previously uninsured persons.

Conclusions and Policy Implications

In recent years many states have implemented some form of provider tax in an attempt to address the problem of uncompensated hospital dollars stemming from services rendered to the medically indigent and underinsured. In this study we conducted descriptive analyses of one such revenue pool implemented by the state of Florida in 1984: the Public Medical Assistance Trust Fund. We recognize that descriptive studies are limited because they may only suggest associations and trends that may disappear if a more rigorous multivariate framework is employed. Nevertheless, because no prior study has evaluated the impact of the Florida revenue pool on uncompensated care and the uninsured, the insights that can be gleaned from such descriptive analyses of this unique financing mechanism are of particular value. First, the Florida approach provides policy makers with considerable discretion in the allocation of funds. Second, unlike other states with revenue pools, Florida targets most of the PMATF dollars toward extending medical insurance to the uninsured. The Florida approach, therefore, avoids the “leaky bucket” problem of most other existing revenue pools, which allocate the funds solely to reimburse hospitals for previous levels of uncompensated care (Thorpe 1987, 1988). When lump sum payments are made to hospitals that render high volumes of uncompensated care, it is unclear whether any of the monies are used to extend care to the uninsured. Moreover, under the Florida approach, funds are directed toward services provided in more cost-effective, primary care settings rather than in expensive hospitals.

TABLE 8
Cash Analysis of PMATF by Fiscal Year, in Millions of Dollars

	Fiscal year										
	1984-85	1985-86	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	
<i>Revenues</i>											
Beginning cash balance	0.0	27.2	99.3	180.5	162.3	125.5	7.4	24.9	80.1	135.0	
Hospitals assessments	24.1	74.5	106.6	117.1	130.8	144.1	148.8	183.4	179.9	231.3	
General revenue	17.6	20.0	20.0	30.0	30.0	30.0	123.1	197.3	257.5	348.6	
Cigarette tax							123.4	113.4	116.1	113.2	
Ambulatory facilities assessments								6.0		21.5	
Nursing-home assessments										27.0	
Interest earnings and other	0.3	3.9	8.3	12.0	13.5	10.6	4.5	5.2	7.1	15.0	
Total	42.0	125.6	234.2	339.6	336.6	310.2	407.2	530.2	640.7	891.7	
Percent share-provider assessments with beginning balance	57.4	59.3	45.5	34.5	38.9	46.5	36.5	35.7	28.1	31.4	
Percent share-provider assessments without beginning balance	57.4	75.7	78.4	73.6	75.0	78.0	37.2	37.5	32.1	37.0	
<i>Expenditures</i>											
Expanded Medicaid service	11.1 ^a	7.8 ^b	26.7 ^c	60.8 ^d	104.1 ^e	215.1 ^f	307.9 ^f	364.1 ^g	434.8 ^h	472.2 ⁱ	

Disproportionate share hospitals													
Administration	0.9	8.90	17.2	25.2	29.7	34.8	20.0	4.8	12.0				
Primary care	2.9	9.6	9.8	20.0	30.0	30.0	33.5	34.2	38.2	36.9	38.3		
Redistribution to hospitals				69.5			30.0	30.0	30.0	28.5	28.0		
Other				1.8			2.9	4.3					
Total	14.8	26.3	53.7	177.3	211.1	302.8	382.3	450.1	505.7	538.5			
Cash balance	27.2	99.3	180.5	162.3	125.5	7.4	24.9	80.1	135.0	553.2			

^aIncludes hospital outpatient cap increase from \$100 to \$1,000, and hospital inpatient.
^bIncludes hospital outpatient cap increase from \$100 to \$1,000, and categorical eligibles.
^cIncludes hospital outpatient cap increase from \$100 to \$1,000, categorical eligibles, and medically needy.
^dIncludes hospital outpatient cap increase from \$100 to \$1,000, medically needy, pregnant women and children to 100 percent of the federal poverty level (FPL), elderly, and disabled.
^eIncludes hospital outpatient cap increase from \$100 to \$1,000, medically needy, pregnant women and children to 100 percent of the FPL, elderly, disabled, and inpatient length of stay increase for neonates.
^fIncludes hospital outpatient cap increase from \$100 to \$1,000, medically needy, pregnant women and children to 100 percent of the FPL, pregnant women and children from 100 to 185 percent of the FPL, elderly, disabled, rural hospitals swing beds, and inpatient length-of-stay increase for neonates.
^gIncludes all in (f) and obstetric fee increase.
^hIncludes all in (f), obstetric fee increase and qualified Medicare beneficiaries.
ⁱIncludes all in (f) and qualified Medicare beneficiaries.
 Abbreviation: PMATE, see table 4.

While the merits of this funding approach are clear, opponents regard this mechanism as a "sick tax" because it imposes the costs of charity care on the providers who are subject to the tax. Another criticism is that most programs tend to compensate hospitals according to existing patterns of utilization, irrespective of whether such care is provided efficiently and effectively. A third potential shortcoming may arise if the assessment is only imposed on specific providers like hospitals. If so, the assessments may fail to generate sufficient funding to implement substantial extensions of insurance coverage to previously uninsured persons. Further, even though consumers regard such assessments as a tax on providers, critics also contend that these extra costs are eventually passed on to consumers as higher prices. Nonetheless, the ability of hospitals to raise prices in this era of managed care and intense competition for patients is quite limited. Clearly, alternative sources of funding, such as a general tax on health insurance premiums or income taxation, could generate substantial amounts of revenue. Yet these options are politically unpopular because consumers recognize that such taxes alter their consumption and savings behavior directly.

Our findings, although only descriptive, suggest that the PMATF has been at least partially successful at achieving its objectives. First, the PMATF has helped to provide insurance coverage to medically indigent and previously uninsured persons. The categorically eligible, the medically needy, pregnant women, children, the elderly and the disabled have been the primary beneficiaries of these expansions. While the HCAA and the PMATF represent significant attempts at increasing access to care for the uninsured, slightly less than 40 percent of the growth in Medicaid-eligible persons can be attributed to the PMATF. The other 60 percent can be linked to congressional mandates expanding access to pregnant women and children, as well as state changes in AFDC eligibility criteria.

Second, the PMATF appears to have partially fulfilled its goal of redistributing the financial burdens associated with the provision of uncompensated care services. Public hospitals appear to be the primary beneficiaries of the revenue pool, as these facilities contributed 15 percent of total hospital assessments but received 34 percent of PMATF disbursements (including Medicaid expansion reimbursements and DSH payments). In contrast, proprietary hospitals, which typically treat relatively few indigents, contributed 36.6 percent of hospital assessments, yet received only 12.5 percent of PMATF disbursements. Moreover,

those hospitals that rendered the greatest dollar amounts of uncompensated care have received disbursements (Medicaid reimbursements and DSH payments) that exceed their PMATF assessments. The direct subsidy payments, nonetheless, cover only a small share of prior year uncompensated care dollars generated by individual hospitals. In the future, these circumstances may be exacerbated as a result of the contractual arrangements that exist between state Medicaid programs and hospitals providing large volumes of care to Medicaid-eligible individuals.

Third, although the provider tax yields a stable source of financing for the Florida revenue pool, it does not generate sufficient dollars to keep pace with the rapid growth in expenditures associated with increases in Medicaid eligibles. During the period FY 1985–86 through FY 1989–90, the provider assessments accounted for 73.6 to 78.4 percent of state PMATF revenues. For the more recent four-year period (FY 1990–91 through 1993–94), the share of PMATF revenues (excluding the initial cash balance) generated via provider assessments was about 37 percent. Unfortunately, because anticipated expenditures exceed revenue projections generated by the provider assessments and earmarked cigarette tax dollars, the legislature has been forced to increase state general revenue appropriations to keep the PMATF viable. The fund has been gradually depleted because the monies generated from the assessment tax are not sufficient to cover the costs of programs enacted to alleviate uncompensated care. To reduce the need and reliance on increasing appropriations from state general revenues, policy makers must identify other sources of funding that can be earmarked to cover the costs of medical care for those with inadequate insurance.

Several revenue-generating mechanisms might be implemented to generate the additional funds. Since the state has already expanded the base of the assessment tax to ambulatory surgical centers, diagnostic imaging, clinical labs, and radiation therapy centers, one possibility is to extend the funding base even further by taxing other licensed health care entities such as home health agencies, nursing homes, and rehabilitation clinics. Moreover, as was proposed recently in Minnesota, the funding base could be further augmented by imposing assessments on physicians and dentists. A second alternative is to establish a state inheritance and estate tax. While the advantages of these potential revenue sources are evident, their political feasibility is nevertheless highly debatable.

The initiatives to expand coverage to uninsured persons in Florida have important implications for the recent movement to implement

universal health insurance nationally. It is widely recognized that the most difficult issue facing policy makers concerns how to finance such coverage. Clearly, Florida's approach of financing expansions in insurance coverage via a revenue pool merits serious consideration because the funds are earmarked for this specific purpose. The Florida experience demonstrates that the more difficult challenge concerns the underlying financing of the revenue pool itself. The provider tax appears to be a useful tool to generate the initial funding to expand health insurance coverage, yet if applied to only a few types of health care facilities, the assessments will not generate sufficient amounts of revenue to finance substantial change. If, however, the provider assessment were to be imposed on a wide range of facilities, and perhaps even certain types of health care professionals, it could generate significant amounts of revenue to finance substantial expansions of health insurance coverage. Otherwise, an increasing percentage of the revenue pool must be financed through general appropriations. While politically controversial, it appears that provider assessments imposed on a wide range of health care facilities, and possibly even certain types of health care professionals, may represent a viable approach to financing the expansion of health insurance to the uninsured.

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