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How tax-and-match, a federal program designed to help states subsidize hospital care for low income patients, came into existence and how it was overexploited is recent history Mainers should pause to consider. Woodward traces Maine's tax-and-match experience from its inception in 1991 to its repeal in 1995 and in doing so illustrates a set of larger issues related to the integrity of federal-state relations, the difficulties in developing fiscally sound health policies in a resource tight environment, and the political machinations that can lead to quick-fix solutions over long-term policy resolutions. With federal block grants looming in the future, Woodward suggests that if Maine is willing to learn from its recent tax-and-match experience, then perhaps Maine is poised to do the right thing when it comes to developing fiscally sound health policies for the future.

A. Mark Woodward

Introduction

When the legislature went home in June, 1995, it concluded a period in Maine history that was among the most active for the executive and legislative branches on health issues. In the fall of 1994 and the spring of 1995, Maine government debated and adopted healthcare statutes that expanded the professional capabilities of nurse practitioners and optometrists, killed a state-run health plan for the working poor, and eliminated the oversight functions of the Maine Health Care Finance Commission, which had monitored and regulated hospitals for more than a decade. From the interwoven perspectives of policy, political machination, and state financing, however, no single issue was more complex, contentious, and potentially divisive than the state's repeal of "tax-and-match," a program that funneled federal Medicaid dollars to Maine, as well as 30 other states, to assist them in subsidizing hospital care for low-income patients.

The name tax-and-match derives from a formula where for every $1 taxed from Maine hospitals approximately $2 was generated in federal matching funds. The study of tax-and-match, how it came to be as well intentioned policy, and how it suffered from over exploitation by financially strapped state governments, is instructive because it illustrates the interrelatedness of policy, politics, and fiscal concerns in shaping the public agenda.

While tax-and-match has been resolved in Maine, the experience has possible implications for the medium and long-term as this state responds to the phenomenon of block grants from the federal government. Will states that proved so calculating in their pursuit of federal matching money as a source of revenue to shore up weakened general fund accounts (often at the expense of the intentions of the policy), make responsible policy choices when money from Washington comes to their capitals in a lump sum, with few or no strings?

States are under more, not less financial pressure to fund highways, education, and welfare programs. The history of tax-and-match reflects, in the not-too-distant past, how difficult it will be for these jurisdictions to make decisions that are financially sound and promote responsible public policy.

A Policy Evolves From Poverty: The Indigent and Needy States

It was a desperate year, 1991, when the legislature arrived in Augusta. The economy was in a structural recession. The paper industry was shrinking. The defense budget was getting smaller and Maine's infrastructure of federally supported bases and shipyards was threatened. The state stared at a substantial revenue shortfall; the high estimate was $1.2 billion.

Despite the failing economy and shriveling of tax receipts, the institution of state government continued to expand, as it had since 1978, at the rate of 2,000 employees every four years. Late in 1991, the Special Commission on Government Restructuring issued a report on reengineering the Augusta bureaucracy, providing a blueprint to make it smaller. The governor and legislature ignored its recommendations and subsequently passed the largest tax increase in Maine history, $350 million. Even that wasn't enough.

The politicians were unwilling to confront directly the need for fundamental solutions, but were inventive and resourceful. As a result, 1991 became the epitome for gimmickry in state government finance, with payroll checks deferred into the next fiscal year, furlough days for state employees and "smoke and mirrors" obscuring the truth about the financial flow through the state treasury. It was the year Maine capitalized on what became known as the "tax-and-match" scheme that was tied to the federal Medicaid program.

Nationally, tax-and-match began in 1987. The federal government offered states an opportunity to expand services to the poor by capitalizing on new interpretations of earlier Medicaid formulas (which are financed by a blend of federal and state funds). To encourage investment in care for the indigent, Washington said it would add 63 cents to every 37 cents a state contributed--a nearly 2-1 match. In addition, the new tax-and-match interpretations allowed states to get federal funds to cover patients in state psychiatric hospitals--a population excluded from the original Medicaid program. A number of states, New Hampshire and Louisiana were among the first, leaped almost immediately at the opportunity.

By 1990, participating states had demonstrated that the program could be an effective revenue generator, with money flowing directly into general fund budgets. It was obvious that many states were diverting the federal match to purposes other than care of the indigent. "Everyone understood what it was," recalls Bruce J. Rueben, president of the Maine Hospital Association (MHA). Maine would "get hospitals to put up a pot of money that would be used to attract federal dollars, and then use the federal dollars for other purposes."

By 1991, federal policy makers also were well aware of what was going on. A program that was intended to generate funds for healthcare for the poor had suddenly become wildly popular. "Too much money was being raised too quickly," Rueben explains, and it was obvious to federal officials that states were using the program "to finance their general fund budgets." Washington

was moving to shut down the program over the objections of participating states and their congressional delegations. However, Maine was financially needy. Undeterred by the change in federal attitude, in 1991 Maine decided to join the 30 other states that were already participating.

Every state had a different gimmick for redistributing the wealth. Norman Ledwin, chief executive officer of Eastern Maine Medical Center (EMMC), was in Pennsylvania during the heyday of the tax-and-match experience there. That state established a foundation to serve as a collection and disbursement agent. He remembers hospitals wiring their money to the state foundation one day and having it sent back the next day with the increased federal contribution.

It worked that way in Maine the first year--an actual transfer of money--but the state quickly shifted to a one-on-one arrangement between hospitals and the Department of Human Services (DHS). Instead of cash reimbursement for tax payments, based on a formula designed to reward institutions with a high percentage of Medicaid-eligible patients, tax-and match became an accounting device that would allow benefit to accrue to state treasuries. To provide the financial stimulus Washington wanted, the state imposed a six percent tax on the gross patient service revenues of hospitals. This was the "tax" part of the formula. The federal government was unwilling to allow states to indemnify individual hospitals for their tax contributions. But under the match, the state promised to give back to hospitals, collectively, at least as much as they paid.

"We never saw the money," recalled Dennis King, president of Bangor’s Acadia Hospital, who described how the tax, as a financial number, went from the hospitals to the DHS through the state system and back again. On the return route, the facility’s gross patient revenues were adjusted by the Maine Health Care Finance Commission to compensate for the tax. The objective was a neutral bottom line. It was apparent from the beginning that some medical institutions, especially those with a high percentage of Medicaid clients, would benefit directly from the program. Others would lose.

The state was able to load up its Medicaid bill with poor, mental-health clients to help bail out both its mental health institutes. Bangor Mental Health Institute and Augusta Mental Health Institute became big beneficiaries of tax-and-match. The balance that didn’t go to Maine’s psychiatric and acute-care institutions went back into the state’s general fund.

How the tax worked, what it was intended to accomplish, who it might hurt, and how it registered on the scale of responsible government policy was relevant but not pursued and resolved by its architects in Maine. Only the motivation was understood clearly. It was described candidly by Representative James Donnelly, R-Presque Isle, as "an attempt to snag federal dollars." A handful of institutions lost from the beginning. A combination of changes in federal rules and continuing financial slippage of more than a dozen Maine hospitals, especially those in rural areas, resulted in tax-and-match becoming untenable for state policymakers. Looking back, says Rueben, "It really began to unravel almost as soon as it started."

Tax-and-Match in Practice: The Problem of Disproportionate Share

The unevenness of the application of the tax and subsequent redistribution of the funds was one negative by-product of the policy, which was intended to assist hospitals with a disproportionately high share of Medicaid patients. The disproportionate share regulation "had been around forever," explains King. Thirty years ago, the Medicaid program built in the mechanism to give economic assistance to hospitals with a legitimate problem: they were bottom heavy with financially needy clients. However, the new scenario created by tax-and-match--the assessment on all hospitals, the inclusion of mental-health facilities and the uneven redistribution of the federal contribution--gave disproportionate share new meaning.

Before 1991, (Acadia didn't open its doors until 1992), only four Maine hospitals, EMMC in Bangor, Maine Medical Center in Portland, Aroostook Medical Center in Presque Isle, and Jackson Brook Institute in South Portland, had the mix of patient economics and demographics and service-area geography to recover federal funds under the disproportionate share formula. After 1991, when all hospitals were being assessed under the tax-and-match program, nearly everybody qualified for disproportionate share. The reason was simple. The state reduced by half the threshold for eligibility, from 15 percent to 7.5 percent Medicaid recipients. Although all hospitals paid a tax of six percent on their gross patient service revenues, the more Medicaid-eligible poor the institution served, the more money eventually flowed back into it through what were called Disproportionate Share Hospital (DSH) payments.

However, for some hospitals the program was never a benefit and the tightening of federal regulations in 1994 was painfully disproportional. The Aroostook Medical Center in Presque Isle and the Cary Medical Center in Caribou without help from the legislature would have incurred a $9 million combined levy in the original budget for 1996-1997. In fact, of 42 Maine hospitals (40 are acute care) it was the two psychiatric hospitals, Jackson Brook Institute in South Portland and the Acadia Hospital in Bangor, that continued to gain from the program beyond 1995, largely because they served a disproportionately large clientele of poor, Medicaid-eligible patients. The same biennial budget that would have taken close to $9 million from two Aroostook County hospitals would have sent $15.4 million to Acadia Hospital alone.

Positive Outcomes, But Poor Timing

Despite unresolved issues with disproportionate share, there were some early positive outcomes associated with tax-and-match. Historically, hospitals have been inadequately reimbursed for patients covered by the two big federal medical programs. The Medicare/Medicaid shortfall, the gap between what hospitals contend are their real costs and what the federal government actually pays for services rendered, has been a chronic condition. Along with charity care, it creates a huge hole in a hospital's revenue picture. To break even, they shift costs to the other two groups of patients, those who self-pay or are insured.

When tax-and-match became an aggressive state policy, Maine's total Medicare/Medicaid shortfall was approximately $75 million a year ($60 million Medicare and $15 million Medicaid). By taking advantage of the more flexible 1987 interpretations, the state was able to provide fresh federal dollars to partially replenish the revenue side of the books of Maine's

hospitals. They, in turn, were able to reduce their charges to self-paying and insured patients. Using the tax-and-match device to keep the shortfall low, the entire system was able to practice "pain avoidance," according to King.

As a result, not only were the early beneficiaries in Maine the state treasury, the two state mental health institutes, and a majority of hospitals (which in the first two years netted an aggregate $49 million), but also self-paying and insured patients as well as the state's private insurers who benefited from less cost shifting.

Unfortunately, Maine's timing was poor. Just as it was becoming dependent on tax-and-match, the rules were changing in Washington, which had fiscal problems of its own. Congressional representatives, allied with their home-state governments and hospitals, were losing the fight to delay tougher regulations on the program during the Bush administration. In 1992, the feds capped states' DSH payments, setting Maine's limit at $165 million total.

The federal government also told state governments it would not participate in any program that attempted to hold harmless individual hospitals. This meant states could not target their general funds and the revenue streams of some hospitals for help, and protect the books of hospitals who would lose under the disproportionate share formula. If states persisted in exploiting tax-and-match they would have to continue to tax all their hospitals, and they were on notice: they would have to bail out losing hospitals with other resources.

The Repeal of Tax-and-Match

By late 1994 and early 1995, the new federal rules had pushed 29 of Maine's 42 hospitals into the red in their tax-and-match accounting. Without action to repeal the tax, the state in fiscal 1996 would siphon money from all but the Westbrook Hospital, Mount Desert Island Hospital, Jackson Brook Institute, and Acadia Hospital, which had very high proportions of poor, Medicaid-eligible or, as was the case with the latter two facilities, poor, mental health clients.

It was projected that by 1999, the total shortfall in DSH payments would top $90 million for a single year. The program was creating tension and hardship within the industry and political pressure for repeal in Augusta. In the spring of 1995, it was clear that unless something was done to modify or eliminate the tax, Maine's non-psychiatric hospitals would be a string of losers, north to south.

Changes in federal policy had turned upside down the trickle-down impact of tax-and-match policy. Because patients would be paying the six percent tax in their bills while hospitalized for being ill, breaking a leg, or having a baby, and a lesser amount of money would flow back from the state to the hospitals to reduce their charges, the program was given a new name and public image. It became the "sick tax." In Aroostook County, for example, the math was simple and the bottom line carried a strong political message. Representative Donnelly argued at the time that the $9 million that would be paid in total by the two facilities in the central Aroostook area, spread among the 40,000 people served there, "amounts to a $225 tax each year on every person."

Looking ahead four years, an independent study prepared by the accounting firm of Ernst & Young for the Maine Hospital Association projected that Maine people would pay an added $269 million more for hospital care as a direct result of the sick tax. The roll call of unintended victims was compelling: $155 more for family Blue Cross coverage, $5 million in added Medicare copayments for Maine's elderly, an average 10 percent increase in hospital rates, and serious jeopardy for the continued survival of 15 hospitals in nine Maine counties.

The conflict had arrived. Maine's experience had been brief, but profitable. In four years (through June 1995), tax-and-matched sluiced $350 million down the Medicaid pipeline from Washington to Augusta. The 40 acute-care hospitals, collectively, after an impressive first two years, had netted a $15 million surplus. For the psychiatric hospitals, Jackson Brook Institute and Acadia Hospital, because of their high Medicaid patient load, the program had paid $38 million to cover care in keeping with the original intent of the program.

However, when the legislature's Appropriations Committee unanimously endorsed a $3.5 billion biennial state budget on June 23, 1995, tax-and-match was a cornerstone of the agreement. Hospitals next year will still pay the tax on gross patient service revenues, but will be allowed to bill it as part of Medicaid. In the next stage, the tax will be reduced from six percent to 3.5 percent before finally being phased out. They will have to deal with near-term shortfalls the way they will deal with the future, by shaving expenses, shifting emphasis to less expensive outpatient and home-based-service models, and by entering into managed-care agreements.

Other states may continue to participate in tax-and-match until it is eliminated or replaced by block grants. Maine opted to end its involvement with the program, which was intended to address financial problems associated with caring for the indigent and enable states to raise the level and quality of services to the poor. Those healthcare issues and challenges remain. The lingering question is whether this was only an exercise in short-term fiscal pain avoidance, or an experience through which policymakers in Maine gained insights and lessons.

Tax-and-Match in the National Dynamic

Late in June, medical ethicist Emily Friedman of Chicago challenged the Maine Hospital Association to defend Medicare and Medicaid against congressional budget reformers and budget cutters. "We cannot allow [the cuts] to happen," Friedman exhorted her audience of hospital officials at Rockport's Samoset, "There are no ifs, ands, and buts. When a person needs healthcare, it has to be available."

Friedman's statements probe the heart of the larger healthcare cost and policy issues for Maine hospitals. They are institutions with a strong sense of community and social obligation that far exceeds requirements to provide charitable care. But at the bottom line, they are businesses that are vulnerable to the consequences of bad management--their own or government's.

Unwavering in her belief in the social principles on which Medicare and Medicaid are built, and their intrinsic value--they "kept the United States from becoming a Third World health system," Friedman, a noted industry analyst, is one in a chorus of critics of tax-and-match. In a September interview she described the program as a "scam" and "a shell game" seen by the federal

government for what it is, "an act of predation upon its finances as well as a manipulation of its statutes."

Friedman is among those who believe the program probably is doomed, but it continues to be exploited by some states, and "there are a lot of hospitals that are losing their shirts on Medicaid and indigent care." Federal policymakers, she argues, "are not going to feel any great need to protect" a program that had the potential to help the medically needy poor, but which has been so abused by the states. Instead, Washington will load it up with restrictions and eventually, led by new-wave conservative members who "have no qualms about making destructive cuts in Medicare and other programs [Congress] will get rid of it entirely." Maine got in late, but is disengaging just in time.

For Friedman, the deliberate milking of tax-and-match is not "a big moral issue," but a painful, practical one that has negative consequences for the poor and sick and troublesome implications for the future of public policy. The tax-and-match scam exposes a fundamental dishonesty in some federal-state relationships--one in which morality and trust become inoperative in the hunt for a balanced budget--and reveals a weakness in the social contract between some state governments and their needy. In this sense, the experience with tax-and-match may provide a glimpse of the future if Congress eventually redistributes the nation’s wealth through federal block grants to the states for food stamps, welfare, childcare, and education.

Friedman is concerned when she looks at the history of tax-and-match. When the leveraged Medicaid checks arrived in the mail, the impact was tantamount to state government winning the lottery or suddenly being the beneficiary of another source of revenue outside its historic capacity to tax. She sees three policy issues.

First, a state becomes addicted to the easy wealth. If the money is cut off quickly, it leaves a gaping hole in the state’s healthcare budget, which she says "can be lethal to the care of poor and chronically ill and the low-income elderly."

In Maine’s case, as federal rules tightened on tax-and-match, hospitals claimed they collectively faced $116 million in excess tax payments over the two years beginning July 1, 1995, and a boost in overall hospital costs of $269 million over four years. Blue Cross and Blue Shield of Maine estimated the impact of tax-and-match on insureds through Maine businesses at $62 annually in higher premiums for individuals and $155 for family coverage. The costs were high because losing the money was a triple whammy for hospitals, which were still being taxed six percent on gross patient service revenues while losing out on the match and reimbursement, but still obliged to provide care to indigent patients.

By bringing closure to its tax-and-match experience, Maine sets itself up to do the right thing on Friedman’s second point: expand the Medicaid program, with proper funding, and do it deliberately as a matter of public policy. No scheming, says Friedman. It should be the product of honest debate. If a state wants to extend healthcare benefits for the poor, she argues the more "courageous and moral thing to do is make it part of a public policy discussion." In that wide-open scenario, in which healthcare issues are brought out from under the table, the poor could be

winners. American people historically have supported expanded access and financial support for healthcare for the indigent. Maine's experience is consistent with this.

Openness also avoids a serious down side for hospitals, illustrated by Maine's tax-and-match experience, and what Friedman colorfully refers to as "guerilla funding for healthcare." When programs are constructed in honest public-policy debates, and given adequate funding, providers don't get stuck making up the difference between the cost of care and the limited funds that trickle down to the poor. Similarly, when the commitment and funding are products of a proper public policy process, the true costs are not buried in healthcare insurance premiums.

Which brings us to Friedman's third concern, that "some states never got around to distributing all the money where it should have gone," into improved healthcare services for the poor. "It's just too tempting to have Medicaid subsidizing roads and schools and tax cuts." Tempting, says Friedman, but "dead wrong. It ends up helping nobody."

Maine was unabashedly premeditated. This state's entry into tax-and-match was not motivated by genuine concern for the poor and the sick, or even by its hospitals' annual $75 million shortfall in the Medicare and Medicaid programs, but by the need to balance the state budget. Driven and desperate, Maine did the wrong thing for the wrong reasons. It will be buying its way out of the problem for the next four years.

"I strongly support innovation in Medicaid," Friedman explained, "when it expands access and quality, and changes in welfare programs when they expand access to jobs, self-image and self-esteem." Tax-and-match, however, cynically exploited by a majority of states after Florida and West Virginia discovered the Medicaid gold mine, has disturbing implications for the future of federal-state partnerships and the value of services that will be received by citizens under the funding device of choice for many conservative Republicans: the block grant. If a state will tax a hospital to leverage federal dollars for the elderly poor and divert the money to cover the cost of, say, paving a road, what hope is there for responsible distribution of a block grant for welfare mothers or food stamps for children?

Post-tax Policy: Learning From the Experience

Maine, despite its tax-and-match experience, has a history of high per capita investment in human services and treatment for the mentally ill, and a reputation for good character. Other states are squeaky clean. They have a tradition of good government, responsibility, and sharing the load. "I'm not going to stay up at night and worry about Minnesota," says Friedman, but "other states, I wouldn't trust with the poor fund from the local church."

States like Mississippi, and more recently California are likely to be especially troublesome in the way they distribute block grants. Given what she describes as the former's poverty and "atrocious history of treatment of its non-white poor," and political pressure in the latter against immigrants and minorities, "can you share my concern," asks Friedman, "that not all of that block grant will be responsibly distributed?"

Add to that proposed state-share formulas, such as Senator Bob Dole's requirement that states continue for two years to meet just 75 percent of their 1994 obligation in order to receive the block grants and a bleak outcome is extrapolated from the tax-and-match experience. "It's an idiotic way to make policy," is Friedman's succinct assessment.

Maine's decision in June 1995 to phase out tax-and-match and beat the feds to the punch ended what had been a lucrative one-way arrangement. It came almost on the 30th anniversary of the establishment of Medicare and Medicaid programs. They are only a year younger than the Civil Rights Act of 1964. Like a majority of states, Maine did what it felt it had to do to get money to balance the state budget. However, in the scramble for federal handouts nationally there was a troublesome lapse of collective conscience by state chief executives and program administrators. Governments themselves showed disrespect for the potential value of government in improving the quality of the lives of needy citizens. They cheapened their own processes.

But from the perspective of social liberals and fiscal conservatives, the experience with tax-and-match and the advent of block grants may be beneficial. They may mitigate against the future likelihood that another combination of tight budgets and non-program-specific transfers of revenue from Washington to the states will wind up tearing at social programs, or that undedicated federal checks will be diverted into rat holes in state treasuries.

EMMC's Ledwin, who in late summer predicted the resignation of Senator Robert Packwood would delay but not derail the shift to the block-grant concept favored by the Oregon Republican, is one of those who believes block grants have the potential to enforce honesty and discipline on the system, whether the program is Medicaid or Women, Infants, and Children (WIC), a federally financed, state administered nutritional program for women, infants, and children.

One lesson of tax-and-match is that the federal government can help states make responsible, even wise choices in how they structure programs and spend money by encouraging them to confront their financial situations candidly. In theory, if block grants are given to a state with a $1.2 billion shortfall between revenue and spending (as Maine had in 1991), and it has no loopholes to manipulate and no complicated gimmicks to exploit, it is forced to be honest with itself and its people. That's the right foundation for good public policy.

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