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Financing indigent health care—medical treatment for patients unable to pay—is a major problem for hospitals and other health care providers, worsened recently by loss of private health insurance and Medicaid coverage.

Financing Indigent Health Care

The financing of indigent health care is a growing and far-reaching problem for health service providers and state and local governments. Uncompensated hospital care, of which indigent care is a portion, has risen since 1978—at an estimated average annual rate of 10.2 percent—to a total of $6.2 billion in 1982.

Loss of private health insurance coverage precipitated by high rates of unemployment in recent years, federal cutbacks in Medicaid eligibility, and the erosion of Medicaid eligibility at the state level have all contributed to an increase in the number of people unable to pay for health care. Medicare's refusal to pay a prorated share of hospitals' uncompensated care, as well as increased competition among hospitals for privately insured patients, have limited the ability of hospitals to shift uncompensated costs to Medicare or to privately insured payors.

As more states begin to address the problem of indigent care, many related issues may receive renewed attention. One such issue is ERISA's preemption of state regulation as it applies to self-insured employer health plans.

This *Issue Brief* examines the magnitude and apparent causes of the growing problem of financing care for the medically indigent, and the recent increase in noncoverage across the population. The legal responsibilities of state and local governments to pay for indigent health care are explored. Finally, this *Issue Brief* reviews efforts undertaken by the states to finance indigent care, including the state revenue pools now operating in Florida and New York.

◆ Uncompensated Care: A Growing Problem

Financing indigent health care—health care for patients unable to pay—has become a major problem for hospitals and, to a lesser extent, other health care providers in the United States. The problem has worsened in recent years due to the convergence of several factors: the loss of private health insurance precipitated by high rates of unemployment, federal cutbacks in Medicaid eligibility, the erosion of Medicaid income eligibility at the state level, and Medicare's refusal to pay a prorated share of hospitals' uncompensated care, including charity, or indigent, care.

In short, hospitals are confronted with more patients unable to pay for care, while their ability to shift unpaid costs to other large payors—especially Medicare—has been sharply curtailed. Greater competition for private, group-insured patients in the form of preferred provider organizations (PPOs) and negotiated discounts to insurers and employers probably also contributes to the urgency of the indigent care problem. These arrangements limit the degree to which hospitals can shift costs to privately insured patients to finance indigent care and other bad debt.

◆ What Is Indigent Care?

Uncompensated care, as a hospital accounting term, encompasses both charity care and bad debt, including bad debt associated with charges not covered by private insurance or Medicare, such as deductibles and copayments. In accounting practice, the distinction between bad debt and charity care is imprecise, and the terms are not uniformly applied. As a result, measuring the amount of indigent care provided by hospitals is difficult.[1] In general, indigent care is all charity care provided by hospitals plus the portion of hospital bad debt associated with care provided to the medically indigent.

The medically indigent are defined in statutory language simply as the poor, or "persons unable to support themselves" (in New Hampshire), as "persons unable to meet the full cost of hospital care" (in Georgia), or in terms of income or eligibility for federal assistance (in Arizona, Indiana, New Mexico, and Oklahoma, for example).[2] Medical indigency is implicitly defined in federal law as eligibility for Medicaid benefits.

◆ How Big Is the Problem?

Although data on the volume of uncompensated care provided by hospitals are scarce, estimates suggest that the figure is large and growing rapidly. Using Gross National Product data, Sloan *et al.* estimate that uncompensated hospital care has risen since 1978 at an average annual rate of 10.2 percent, to a total of $6.2 billion in 1982.[3] Sloan *et al.* estimate that the real (inflation-adjusted) value of uncompensated care provided by hospitals has been rising at an average annual rate of about 4 percent.

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The burden of uncompensated care is unevenly distributed among hospitals. Reports from many states and municipalities indicate that public hospitals bear a disproportionate share of the indigent care burden. For example, Florida estimates that the state's public hospitals provided 12 times as much indigent care (measured as a percent of gross patient revenue) in 1983 as proprietary (profit-making) hospitals, and 25 percent more than voluntary (not-for-profit) hospitals.[4]

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[1] "Few hospitals rigorously distinguish between bad debt and charity care, and fewer still are likely to implement the same set of procedures for . . . bookkeeping allocations," as observed in Suzanne Mulstein, "The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options," *Inquiry* 21 (Fall 1984): 219.

With this caveat, Sloan *et al.* estimated that charity care accounted for only $1.7 billion of the $6.2 billion in uncompensated care provided by hospitals in 1982. Frank A. Sloan, Joseph Valvona, and Ross Mullner, "Identifying the Issues: A Statistical Profile." Paper presented at Vanderbilt University (April 6, 1984), as summarized in Mulstein, p.220.

[2] Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Health Care: Executive Summary," *Access to Care for the Medically Indigent* (Washington, DC: Academy for State and Local Government, 1985), p. 21.

[3] Frank A. Sloan, Joseph Valvona, and Ross Mullner, "Identifying the Issues: A Statistical Profile." Paper presented at Vanderbilt University (April 6, 1984), as summarized in Mulstein, p. 220.

[4] Bob Graham, "Florida Blends Competition with Regulatory Safety Net in Landmark Legislation," *Business and Health* 1 (September 1984): 50.

Using 1982 annual survey data from the American Hospital Association (AHA), Sloan *et al.* concluded that teaching hospitals also shoulder a significantly larger share of charity care and bad debt than other hospitals relative to their share of total charges. In 1982, teaching hospitals provided more than one-third (36 percent) of all uncompensated care provided by hospitals in the United States, but accounted for only 27 percent of hospital charges. State and local public teaching hospitals (representing 19 percent of teaching hospitals) provided one-half of the uncompensated care delivered by all teaching hospitals. The remaining uncompensated care is provided by voluntary nonteaching hospitals (42 percent), nonteaching public hospitals (17 percent), and proprietary hospitals (5 percent).

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Various hospital and billing characteristics suggest principal sources of uncompensated care. Based on 1982 AHA survey data, Sloan *et al.* found higher rates of uncompensated care among hospitals with high percentages of revenue billed to "self-pay" patients—those with neither public nor private health insurance coverage. In the South, where Medicaid qualifying income levels are generally lower, hospitals had higher shares of both charity care and bad debt than did hospitals in other regions. These findings suggest that people without insurance coverage from public or private plans are less likely to be able to finance their health care. Furthermore, regional patterns in uncompensated care suggest that erosion of Medicaid eligibility standards at the state level may have significantly contributed to noncoverage.

The relationship between levels of uncompensated care and service mix identified by Sloan *et al.* suggests the health service use patterns of people unable to pay for routine health care. Hospitals with a high proportion of beds in obstetrics, neonatal intensive care, intermediate care, and burn care have, on average, higher levels of uncompensated care. Hospitals that obtain a high proportion of their total revenue from outpatient care—primarily emergency care—also have high levels of uncompensated care. Sloan *et al.* did not find that higher levels of uncompensated care were significantly related to hospital closings, despite the greater difficulty that private hospitals with high levels of uncompensated care might have competing in capital markets.

◆ The Problem of Noncoverage

Noncoverage—that is, coverage from neither a private health insurance plan nor a public plan such as Medicaid or Medicare—poses an important barrier to obtaining health care. Research evaluating the effect of insurance coverage on health care use has found that levels of health service use among uninsured people are much lower than among insured people, even after adjusting for health status. A study of health care use patterns in 1977 found that people who had continuous insurance coverage throughout the year used nearly twice as many hospital days as uninsured people.[5] Insured people also used 54 percent more physician care than people without insurance; among people who reported fair or poor health, the disparity in physician use was even greater. Other research has linked lower rates of health service use with higher mortality rates, in general, and higher rates of infant mortality, in particular.[6]

For hospitals, noncoverage signals a substantially greater risk of bad debt. Consequently, many hospitals routinely refer, and actually transfer, patients without insurance or public coverage to other hospitals, often public hospitals—a practice called "dumping." Alternatively, hospitals may require a substantial cash deposit from uninsured patients before providing nonemergency care.

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[5] K. Davis and D. Rowland, "Uninsured and Underserved: Inequities in Health Care in the United States." *Health and Society* 61 (Spring 1983): 149-176.

[6] M. Grossman and F. Goldman, "The Responsiveness and Impacts of Public Health Policy: The Case of Community Health Centers." Paper presented at the 109th Annual Meeting of the American Public Health Association (November 1981).

Despite professional guidelines intended to avoid transfers that are hazardous to patients' health,[7] a recent study of patient transfers from private hospitals in a California community concluded that, in at least some cases, the practice of transferring unprofitable patients probably jeopardized the health of those patients.[8] Of 458 consecutive transfers to a large California public hospital in 1981, 63 percent were uninsured; 21 percent and 13 percent, respectively, had Medicaid and Medicare coverage. Although one-half of the patients transferred had traumatic injuries, 91 percent had been transferred by private hospitals with full emergency services. Based on reviews of 103 transferred patients' records, the study concluded that nearly one-third of the patients were medically jeopardized by the transfer. Not included among the 33 at-risk patients were five obstetrical patients transferred from the site of the area's high-risk obstetrics center. An earlier study (1970) of 18,000 patient transfers to Cook County Hospital in Chicago indicated that 50 patient deaths had resulted; similar claims have been made about patient transfers to public hospitals in other cities.[9]

Because employer plans are important providers of health insurance coverage, unemployment commonly precipitates loss of coverage among unemployed workers and their families.

Table 1
Distribution of Nonelderly Persons by Source of Health Insurance Coverage, 1982–1983[a]

Source of Health Insurance	1982 Number of Persons (millions)	1982 Percent	1983 Number of Persons (millions)	1983 Percent
All Persons	195.6	100.0	197.7	100.0
Private Coverage	148.1	75.7	147.5	74.6
Employer Plan	131.2	67.1	130.3	65.9
Other Plan	24.8	12.7	24.3	12.3
Public Coverage	25.2	12.9	25.2	12.7
Medicaid	15.7	8.0	16.0	8.1
Medicare	4.4	2.3	4.3	2.2
CHAMPUS[b]	6.5	3.3	6.1	3.1
No Coverage	30.3	15.5	32.6	16.5

Source: EBRI tabulations of the March 1983 and 1984 Current Population Surveys (U.S. Department of Commerce, Bureau of the Census).

Note: Detail may not add to totals because of coverage from more than one source during the year, and because of rounding.

[a] Includes persons under age 65, except those employed in agriculture or the military, or members of their families.

[b] Civilian Health and Medical Program of the Uniformed Services.

◆ Trends in Noncoverage

The rate of noncoverage across the population has been rising since the mid-1970s and continues to rise. The Social Security Administration estimated that as much as 13 percent of the nonelderly population had no private or public insurance coverage in 1976.[10] EBRI tabulations of the Census Bureau Current Population Survey (CPS) indicate that about 14 percent of the nonelderly population were without coverage from any source in 1979. That proportion rose to 15.5 percent in 1982 and 16.5 percent in 1983.

Rates of coverage from various private and public sources in 1982 and 1983 are presented in table 1. Although 1982 was a severe recession year with record rates of unemployment, the rate of employer coverage among the nonelderly population was apparently higher (67 percent) than in 1983 (66 percent), a year of significant economic recovery. Nearly one million fewer people were covered by employer plans in 1983 than had been covered the previous year.

[7] Board of Directors, American College of Emergency Physicians, "Patient Transfer Guidelines: A Position Paper," *Journal of the American College of Emergency Physicians* 6 (1966): 10. See also: American Hospital Association, AHA Bill of Rights; and Joint Commission on Accreditation of Hospitals, JCAH Standard on Emergency Services, both quoted in M.R. Mancini and A.T. Gale, *Emergency Care and the Law* (Rockville, MD: Aspen, 1981), p. 106.

[8] David U. Himmelstein, M.D., *et al.*, "Patient Transfers: Medical Practice as Social Triage," *American Journal of Public Health* 74 (May 1984): 494-497.

[9] P. de Vise, "Cook County Hospital: Bulwark of Chicago's Apartheid Health System," *The New Physician* 20 (1970): 394. See also: S.J. Meltzer, letter to *The New England Journal of Medicine* 304 (1981): 232; and E. Friedman, "Special Report: The Dumping Dilemma," *Hospitals* 56 (1981): 51-56 (Sept. 1) and 75-84 (Sept. 16).

[10] Social Security Administration, "Private Health Insurance Plans in 1976: An Evaluation," *Social Security Bulletin* 41 (September 1978).

Because employer plans are important providers of health insurance coverage, unemployment commonly precipitates loss of coverage among unemployed workers and their families, despite state laws giving employees the right to continue group medical coverage after separation from service. In the 23 states with continuation laws, these laws apply only to insured plans. On average, employers in these states must offer continued coverage for as long as 29 weeks.[11] The continuation of employer coverage, however, assists mainly short-term unemployed workers. Long-term unemployed workers are more likely to either exceed the continuation period or to be unemployed from a job that provided no health benefits at all.[12]

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In 1975, the average qualifying level of income for Medicaid was only 67 percent of the federal poverty standard. By 1984, it had eroded to ~~38~~ 45 percent.

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Although *short-term* losses of health insurance coverage are a generally recognized result of economic recessions, these transitional noncoverage periods may in fact be the lesser effect. Economic recession may also generate *long-term* loss of insurance coverage, if unemployed workers move into jobs that do not offer health insurance as a benefit.

Recent economic recessions have accelerated the growth of service-industry employment relative to employment in manufacturing and other nonservice industries.[13] Since the rate of benefit coverage in the service sector is much lower than benefit coverage in other more unionized, higher-wage industries, permanent job loss or slower employment gains in nonservice industries tends to reduce aggregate coverage rates. Economic recovery, therefore, may not restore coverage to prerecession levels.

The changing industrial composition of employment suggests that a gradual decline in private insurance coverage may continue in the absence of an incentive for expanded employer-provided health insurance benefits.

◆ Medicaid and the Poor

Medicaid is a state-based insurance program for low-income people in specific need categories. By federal law, the elderly, disabled, and single-parent families with dependent children are categorically eligible for Medicaid benefits. States may define additional categorically eligible groups within federal guidelines (for example, all financially eligible children under age 18 and persons in two-parent families with dependent children where the principal earner is unemployed). The 1984 Deficit Reduction Act (DEFRA) expanded Medicaid entitlement to (1) first-time pregnant women who would be eligible if the child were born; (2) pregnant women in two-parent families with an unemployed principal earner; and (3) all financially eligible children under age 5.

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Many of the poor are without health insurance coverage from an employer plan. Without access to either employer-provided coverage or Medicaid, a large proportion of persons with family income below the federal poverty standard are without health insurance of any type.

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In addition to *categorical* eligibility criteria, state-determined *financial* eligibility criteria must be met. In most states, qualifying income for Medicaid is set well below the federal poverty standard. No state automatically indexes the qualifying income level for Medicaid.

Failure by states to fully index qualifying levels of income for Medicaid eligibility has resulted in a substantial erosion of those standards relative to the federal poverty standard. In 1975, the average qualifying level of income for Medicaid was only 67 percent of the federal poverty standard. By 1984, that had eroded to 45 percent of the federal poverty standard. One-half of all states set the income standard for Medicaid eligibility at less than 43 percent of the federal poverty standard. These data are included in table 2.

[11] Hewitt Associates, *Continuation of Group Medical Coverage—A Study of State Laws* (Lincolnshire, IL: Hewitt Associates, 1985).

[12] Among family members of the long-term unemployed (workers unemployed for 13 weeks or more) in 1979, only 49 percent reported coverage from an employer health plan at any time during the year, and only 58 percent reported coverage from any private source. Rates of employer coverage by duration of unemployment are presented in "Health Insurance for the Unemployed," *EBRI Issue Brief* 22 (September 1983).

[13] Emily Andrews, *The Changing Profile of Pensions in America* (Washington, DC: Employee Benefit Research Institute, forthcoming).

Table 2
Qualifying Income for Medicaid Eligibility by State, 1984, and as a Percent of the Federal Poverty Standard, 1975 and 1984

State	1984 Annual Income Standard for Medicaid Eligibility[a]	Qualifying Income as a Percent of the Federal Poverty Standard	
		1975	1984
Alaska	$9300	65	91
California	7500	76	74
Wisconsin	7344	88	72
Minnesota	6996	84	69
New York	6792	87	67
Vermont	6816	80	67
Hawaii	6552	108	64
Washington	6528	81	64
Connecticut	6384	88	63
Michigan	6456	87	63
Massachusetts	5340	66	52
Oregon	5352	90	52
Maine	5160	76	51
North Dakota	5244	76	51
Montana	5100	50	50
Rhode Island	5052	70	50
Iowa	5028	78	49
Nebraska	5040	72	49
New Jersey	4968	78	49
Utah	4992	67	49
Colorado	4896	58	48
New Hampshire	4920	75	48
Pennsylvania	4812	76	47
Kansas	4620	77	45
District of Columbia	4392	65	43
Illinois	4416	69	43
South Dakota	4332	72	42
Wyoming	4260	59	42
Idaho	4140	75	41
Oklahoma	4188	57	41
Delaware	4032	63	40
Ohio	4116	55	40
Maryland	4020	53	39
Indiana	3924	69	38
Mississippi	3924	60	38
New Mexico	3756	52	37
Virginia	3660	68	36
Missouri	3540	81	35
Florida	3276	37	32
Nevada	3264	50	32
West Virginia	2988	54	29
Georgia	2856	50	28
Kentucky	2820	51	28
Louisiana	2784	34	27
South Carolina	2748	47	27
North Carolina	2652	44	26
Arkansas	2292	62	22
Texas	2136	31	21
Tennessee	1848	47	18
Alabama	1764	30	17
State Average	$4586	67	45
State Median	$4416	69	43

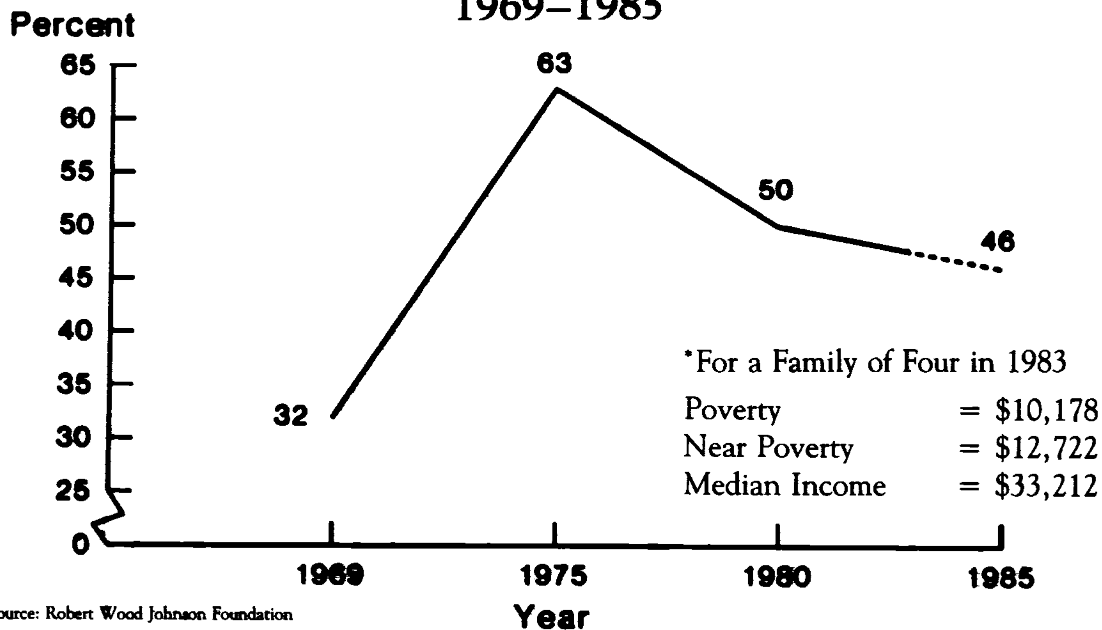
Source: U.S. House of Representatives, Committee on Ways and Means, *Background and Materials on Programs Within the Jurisdiction of Ways and Means* (Washington, DC: U.S. Government Printing Office, February 22, 1985); and the U.S. House of Representatives, Committee on Appropriations, *Data on the Medicaid Program: Eligibility, Services, Expenditures for Fiscal Years 1966-1977* (Committee Print 95-10), 1975.

[a] Qualifying income for a family of four. Families qualify for Medicaid and other public assistance benefits on the basis of monthly income; here, monthly qualifying income levels have been annualized.

The erosion of state qualifying income standards, as well as federal reductions in eligibility for income assistance programs that carry Medicaid entitlement (in particular, Aid to Families with Dependent Children, or AFDC), have reduced the proportion of the poor who qualify for Medicaid coverage. In 1983, only 40 percent of the noninstitutionalized population under age 65 with income below the federal poverty standard qualified for Medicaid coverage (table 3). Even among persons with income less than one-half the federal poverty standard—approximately the median qualifying income across states—only 44 percent qualified for Medicaid.

Moreover, estimates from Medicaid and Census Bureau data indicate that the proportion of the poor and near-poor (including the elderly) who qualify for Medicaid benefits has declined dramatically during the last decade, from 63 percent in 1975 to an estimated 46 percent this year. Estimates of changes in Medicaid coverage rates are presented in chart 1.

Because most persons in poverty are nonworkers, have fragmented employment patterns, or work in low-wage sectors or small firms, many of the poor are without health insurance coverage from an employer plan (table 4). Without access to



either employer-provided coverage or Medicaid, a large proportion of persons with family income below the federal poverty standard are without health insurance of any type.

Most indigent care statutes leave substantial discretion to the agency that administers the program. Few expressly define "indigent" or the services that must be covered.

In 1983, 35 percent of all poor persons, as defined by the federal poverty standard, were without health insurance coverage of any type throughout the year. Among low-income persons with family income above the poverty line (but within two times the federal poverty standard), higher rates of employer-provided coverage (54 percent) reduce the noncoverage rate to 26 percent. In aggregate, the poor are nearly three times as likely to have no insurance coverage as are the nonpoor, despite significant public-sector spending for income assistance and health insurance programs.

◆ Public Liability for Indigent Care

In most states, the state or local governments are legally obligated to provide health care for the poor and uninsured.[14] Under these laws, state and county governments may be sued to reimburse health service providers for the cost of treating indigent patients. Court enforcement of these statutes may

[14] The information presented in this section summarizes material presented in: Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Care," *Access to Care for the Medically Indigent* (Washington, DC: Academy for State and Local Government, 1985), pp. 13-44.

become more common as hospitals and private-pay patients are less willing to absorb the cost of indigent care. Under such a statute, the Nevada Supreme Court recently awarded a local hospital more than $300,000 for indigent patient medical care costs in a suit against Washoe County.[15]

Patterns of statutory responsibility differ among states. The state government alone is liable for financing indigent care in 14 states, the counties are liable in 18 states, and towns are liable in 2 states. The responsibility is shared by counties and the state in 5 states, by counties and towns in 4 states, and by towns and the state in 4 states. Three states apparently impose no obligation on any governmental unit for general indigent health care, although all states authorize various levels of government to provide some health and medical services for their residents through the operation of public hospitals or by direct payment for, or contract with, health care providers.

Most indigent care statutes leave substantial discretion to the agency that administers the program. Few expressly define "indigent" or the services that must be covered. The legal obligation of state and local governments to provide for indigent care has been interpreted by many courts so as to preserve administrative discretion. The language of some statutes, however, has accommodated broad court interpretation, obliging the responsible agency to pay for extensive services under the indigent care statute.[16]

Table 3
Medicaid Coverage by Family Income as a Proportion of Poverty Income, Nonelderly Persons, 1983[a]

Income as a Proportion of Poverty Income	All Persons (millions)	Medicaid-Eligible Persons (millions)	Medicaid-Eligible Persons as a Percent of All Persons
Total:	197.7	16.0	8.1
0 – 0.49	12.2	5.4	44.0
0.50 – 0.99	17.3	6.6	38.1
1.00 – 1.49	18.3	2.0	11.0
1.50 – 1.99	19.5	0.9	4.4
2.00 – 2.99	40.7	0.7	1.8
3.00 or more	89.8	0.4	0.5
Summary:			
0 – 0.99	29.5	12.0	40.5
1.0 – 1.99	37.8	2.9	7.6
2.00 or more	130.5	1.2	0.9

Source: EBRI tabulations of the March 1984 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

[a] Includes all noninstitutionalized persons under age 65, except for persons employed in agriculture or the military, and members of their families.

Table 4
Percent Distribution of Nonelderly Persons With Coverage From Selected Sources by Family Income as a Proportion of Poverty Income, 1983[a]

Income as a Proportion of Poverty Income	Private Coverage		Public Coverage		
	Employer	Other	Medicaid	Medicare	No Coverage
Total	65.9	24.3	8.1	2.2	16.5
0–0.49	8.4	9.0	44.0	1.2	39.1
0.50–0.99	21.8	9.4	38.1	3.6	32.9
1.00–1.99	53.9	14.1	7.6	3.3	25.8
2.00–2.99	74.5	12.6	1.8	2.3	13.4
3.00 or more	83.4	12.4	0.5	1.5	7.8
Summary:					
0–0.99	16.3	9.2	40.5	2.6	35.4
1.0 or more	74.6	12.8	2.4	2.1	13.2

Source: EBRI tabulations of the March 1984 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

Note: Detail may not add to total due to rounding and coverage from more than one source.

[a] Includes all noninstitutionalized persons under age 65, except for persons employed in agriculture or the military, and members of their families.

◆ State Programs to Finance Indigent Care

Many states have instituted programs in addition to Medicaid that address the problem of indigent care.[17] These programs vary between two models: (1) those that provide health in-

[15] Washoe County v. Wittenberg, 676 P.2d 808 (Nev. 1984).

[16] Welburn Memorial Baptist Hospital v. County Dept. of Public Welfare, 442 N.E.2d 372 (Ind. App. 1982), was decided under former law, the provisions of which are substantially identical to current law.

[17] The information presented in this section summarizes material presented in: Lawrence Bartlett, "State Level Policies and Programs," *Access to Care for the Medically Indigent* (Washington, DC: Academy for State and Local Government, 1985), pp. 54-74; and *State Programs of Assistance for the Medically Indigent* (Washington, DC: George Washington University, Intergovernmental Health Policy Project, April 1985).

surance coverage for persons who are uninsured; and (2) those that address the financial burden imposed on providers of uncompensated care.

Programs in the first group include state and local general and medical assistance programs for persons categorically ineligible for federal income assistance or Medicaid. State and local medical assistance programs may cover basic health care expenses; recent statutes (in Oklahoma and South Dakota) specifically address payment of providers for catastrophic health care expenses incurred by residents. Other states (Alaska, Maine, Minnesota, and Rhode Island) have long-standing catastrophic health insurance programs. These programs primarily serve near-poor or middle-income persons. Persons served by these programs may have insurance (90 percent in Rhode Island), but have health expenses that exceed the limit of their plan. However, only one-quarter of Maine's program beneficiaries and few of Alaska's catastrophic program beneficiaries have other insurance coverage.

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Florida and New York recently implemented revenue pools to redistribute the financial burden of indigent care. As experience with these pools evolves, revenue pools may be adopted by other states.

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State programs that address the provider burden of financing indigent care are varied. Under federal law, some programs seek to enhance Medicaid reimbursement for hospitals that serve a "disproportionate number" of low-income patients. No more than 10 states have acted to increase reimbursement levels to hospitals serving large numbers of low-income patients, although approximately 20 states have adopted new Medicaid hospital reimbursement systems since the passage of the 1981 federal Budget Reconciliation Act (P.L. 97-35), which authorized greater state flexibility in reimbursing under Medicaid.

State revenue pools are a relatively new approach to resolving the inequitable distribution of indigent care costs among hospitals. Florida and New York, for example, recently implemented revenue pools to redistribute the financial burden of indigent care. Florida finances its revenue pool by a 1-percent tax (to be raised in 1986 to 1.5 percent) on hospitals' net revenues, supplemented by state general revenues. New York finances its eight regional pools from a surcharge levied on hospital charges.

Use of the funds from these revenue pools differs. In Florida, the funds will in part be used to finance Medicaid benefits for the *medically needy*—categorically eligible persons who financially qualify for Medicaid based on their *net* income, after health care expenses. The funds also are being used to extend Medicaid eligibility to certain children and pregnant women, and expand outpatient services and primary care provisions. In New York, where Medicaid eligibility standards are already broad, the funds are redistributed among hospitals within the state's all-payor rate setting program to offset charity care losses. Under New York's program guidelines, however, public hospitals reported receiving only a 6- to 8-percent offset for the charity care they provided, as opposed to the 48-percent offset reported by other New York hospitals.

Since revenue pools can, by their design, address inequities among hospitals in providing indigent care, similar proposals have received recent attention in other states, including Alabama, Kentucky, Ohio, and Washington. As experience with the Florida and New York programs evolves, revenue pools may be adopted by other states to address the problem of financing indigent care.

It is likely, however, that these pools will draw attention to a wide range of peripheral problems in publicly financing health care outside the Medicaid program. The preemption of state regulation under the Employee Retirement Income Security Act (ERISA) may, in particular, come under much greater scrutiny as a result of state problems with financing indigent care.

Under ERISA, self-insured plans are exempt from state legislation and regulation affecting insurance. Insured plans are not. ERISA's preemption may impede the ability of states to finance indigent care on a broader basis than the Florida and New York plans. The financing of these plans has been characterized by some critics as a "sick tax," since the plans raise charges to users of hospital care. However, state efforts to spread the burden of indigent care over a larger population (all persons with insurance coverage) and to finance nonhospital services for indigent patients may be hindered by ERISA, since self-insured plans could choose not to participate.

◆ Conclusion

Uncompensated care accounts for a growing portion of the nation's health care bill. Medicare's adoption of prospective payment and the increasing frequency of negotiated discounts for employer plans limit the ability of hospitals to finance indigent care by shifting costs to public and private payors. As a result, indigent patients may be barred from obtaining needed health care, and hospitals that are large providers of indigent care (relative to their total revenues) are put at a competitive disadvantage.

The need for a funding source will lead state and local governments to look for new ways to finance indigent health care. State revenue pools offer a glimpse of the type of innovation the future may hold as the need for a financing solution becomes increasingly urgent.

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