The New Jersey Policy Forums on Health and Medical Care

THE UNINSURED: AN ONGOING UNRESOLVED PROBLEM- FUNDING CHARITY CARE IN NEW JERSEY

A CLASSICAL SUNSET STORY

In the Homeric Greek epic poem The Odyssey, Odysseus, the story's hero, is renowned throughout the pre-Classical world as a man of many skills, who can solve any puzzle or problem confronting him by figuring out all of the angles. When we meet him at the beginning of his ten-year Odyssey, however, he's a King in trouble: he can't find his way home. At one point in his journey, he tries to ask a character named Proteus — a very ancient divinity of the sea who knows most everything— for the answer. But the trick is that you have to get a handle on Proteus; you've got to pin him down in order to ask your question. And then, even when you've got him in a strong grip, he keeps changing shapes, becoming mysterious beings, some larger, some smaller, to scare you into letting him go. Finally, after holding on tightly, Odysseus gets to ask his question of Proteus in his true form; he gets an answer and proceeds on his way, but everything he encounters — his environment, the people and players in it and his own perceptions of solving the problem — keeps changing or throwing up obstacles in his path. It's a very long ten years' home.

Background information
for

THE POLICY FORUM
on Wednesday, October 15, 1997
9:00 am - 1:00 pm
Masonic Temple Library
Trenton, New Jersey

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THE UNINSURED: AN ONGOING UNRESOLVED PROBLEM- FUNDING CHARITY CARE IN NEW JERSEY

ISSUE: Given the current forces that are driving the uncompensated hospital care system in New Jersey, and in the absence of a stable funding source for charity care, what are the questions that our policy makers should ask with respect to legislative, fiscal and delivery system issues?

INTRODUCTION

New Jersey is one amongst a small handful of states (including Massachusetts and New York) that maintains a long-standing position to provide charity care to its uninsured/under-insured population. Our current charity care system in New Jersey has been formed in a patchwork way through strict regulation and "deregulation," responses to statutory mandates, litigation[1], and delivery system requirements, played out against the backdrop of an ambiguous value system.

Historically, the American collective populace has maintained an ambivalence regarding the deserving poor — such as children — and those we view as "bringing it upon themselves." At the same time, we also collectively hold to the tradition to provide care for those in need as part of a deep social contract. And hospitals in this country were first built primarily for the poor, organized as charities and supported by religious organizations and wealthy patrons (Fishman and Bentley, 1997). A brief review of the past 20 years of charity care in New Jersey reveals how in many ways it has evolved in reaction to expanding and contracting sources of funding, challenged by the issues of ensuring access and delivering health care to the state's medically indigent population (N.J.S.A. 26:2H-18.24).

CHARITY CARE - A SHORT HISTORY OF A COMPLEX SOCIAL PROBLEM

1971 The identification of appropriate financing mechanisms to fund charity care — through which health care services are provided to New Jersey's indigent at its acute care hospitals — continues to challenge state policymakers and lawmakers. Under New Jersey law (N.J.S.A. 26:2H et seq.), hospitals are prohibited from denying persons medically necessary treatment if the hospital has the medical capacity to provide such care. Under provisions set forth in several Federal laws, hospitals are required to provide certain levels of charity care; e.g., Medicare reimbursement requirements (for hospitals to provide medical emergency care, regardless of a patient's ability to pay); the Hill-Burton Act that financed hospital construction; and under the terms of a hospital's maintaining a non-profit tax status.

1978 Historically, hospitals provided medical care to indigent patients[2], and the costs either were absorbed by the hospitals themselves (usually through some form of cost shifting), or were supported by philanthropic means. With the promulgation of P.L. 1978, c.83; N.J.S.A. 26:2H-4.1, such cost-shifting was prohibited by the strict regulating mechanisms of the hospital rate-setting and reimbursement system. The system controlled hospital rates charged to all payers, except Medicare, and allowed hospitals to increase their charges to cover the costs of care for those who did not pay.

1992 From 1978 to 1992[3], under the state's acute care hospital rate-setting regulations, hospitals received reimbursement for all uncompensated care, including both charity care and bad debt. New Jersey's uncompensated care program differed from other "uncompensated care" states, e.g., New York, Massachusetts and Maryland[4], in that it provided full reimbursement for all approved uncompensated care (Berliner and Delgado, 1993). Under the provisions of the Health Care Reform Act of 1992, chapter 83 was repealed, and New Jersey's rate-setting system was eliminated, along with the state's reimbursement to hospitals for bad debt. Our once highly regulated hospital rate-setting system was "deregulated" to operate in a competitive, free-market environment, with some allowances made for charity care (Ibid.).

[1] In May 1992, Federal District Court Judge Alfred Wolin struck down the hospital reimbursement system, known as "Chapter 83" and ruled that the method by which New Jersey paid for uncompensated hospital care violated ERISA, the Federal employee benefit law and cited all of Chapter 83 as "unenforceable."

[2] Under a general definition, the uninsured are those individuals who do not qualify for Medicaid and who, for the most part, cannot afford to purchase private health insurance.

[3] In 1980, New Jersey was the first state to implement an all-payer system for hospital rate regulation that utilized Diagnosis-Related Groups (DRG's).

[4] Maryland is the only state which has a single rate-setting system.

1995 The Health Care Reform Act (1992) established a new mechanism to fund hospital charity care by creating a Health Care Subsidy Fund. The terms of financing the Fund by diverting monies from the state's surplus unemployment revenues expired on December 31, 1995. After a five-month stalemate concerning the mechanism to be used for hospital charity care funding, P.L. 1996, c.28 (signed into law May 16, 1996) re-authorized the state's charity care system for two years. The provisions of this law will expire on December 31, 1997.

1996 For the years 1996 and 1997, P.L. 1996, c.28 has funded charity care for hospitals by continuing to use funds from the Unemployment Trust Fund, in addition to general revenue funds. The law has set spending
1997 levels of $310 million for hospital charity care in 1996 and $300 million in 1997. Support for the charity care program will come from $660 million diverted from the Unemployment Trust Fund. In addition, the state's general revenue fund will provide $15 million in 1996 and $41 million in 1997. Also in 1997, the Hospital Relief Fund will provide $71 million (through state funds, with a match of Medicaid monies) to the 30 urban hospitals which it supports. By comparison, in 1995, New Jersey hospitals received approximately $542 million — comprised of $400 million for charity care and $142 million for the Hospital Relief Fund. [Reference is made the *Issue Brief Review*, April 1997, for detailed background information on the issue of charity care delivery system and funding.]

1998 Regarding the delivery system changes for charity care, P.L. 1996, c.28 directed that a new model to provide charity care be developed beginning January 1, 1998: the state must "implement a health care program to provide low income residents . . .with eligible charity care on a managed care basis" (Sec. 8); (NJSA 26:2H-18 et seq.). The Department of Health and Senior Services (DHSS) is authorized under the statute to direct the charity care managed care system. Based on guidelines developed by the Charity Care Managed Care Advisory Committee, DHSS has focused on a hospital-centered managed care network as the best approach to follow.

CHARITY CARE MANAGED CARE

At present, New Jersey's approach to addressing the delivery system problems of providing charity care and ensuring access to care for its uninsured population appears to be a two-pronged strategy: (1) to develop and fund a charity care managed care system to be operated from a hospital base; and (2) to use old and new funding sources (federal/state/private) for children's health insurance expansions through insurance subsidy programs. A recent New York Times article reported that the Whitman administration has announced a new children's health care initiative (pending approval by the State legislature) targeted at uninsured and low-income children in New Jersey. The initial phase of New Jersey KidCare will be funded through $88 million from the federal side (with monies from the newly enacted Children's Health Insurance Program[1] (Title XXI)) and $47.6 million in state matching funds, for a total of $136 million. Governor Whitman also reported that "with the help of the Robert Wood Johnson Foundation and federal waivers," the second phase of the program would be implemented "early next year." In a Governor's Office press release, it was reported that a combined approach will be used to provide health insurance through managed care programs for 102,000 children whose families have incomes up to 200 percent of the federal poverty level ($26,600 for a family of three). The initiative will be accomplished through Medicaid program expansion to cover all children up to 133 percent of the poverty level and by providing comprehensive, managed care coverage for uninsured children with family incomes between 133 percent and 200 percent of the poverty level (Office of the Governor, News Release, September 23, 1997).

These strategies tie in with other initiatives to increase access to health care, including restructuring Medicaid under section 1115 waivers; specifically, Medicaid managed care systems and Medicaid expansion programs to extend Medicaid coverage to populations that do not meet Medicaid's income or categorical eligibility criteria. Several states are also engaged in "re-directing" Federal disproportionate share hospital (DSH) payments by reducing their payment adjustments to DSH hospitals and using the Federal matching funds to cover previously ineligible individuals (*Policy Brief*. The Kaiser Commission on the Future of Medicaid, May 1997).

The provision of charity care in the current "de-regulated" time of devolution of authority to the states is soon to be directly affected by Federal changes in the distribution of disproportionate hospital share (DSH) payments, Federal reductions in Medicaid spending and the newly promulgated federal initiative — the State Children's Health Insurance Program. How these multiple external variables will affect charity care funding and its delivery system framework are

[1] In the September Federal Register, the State CHIP is now refered to as CHIP)

yet to be seen. Safety net providers — who provide the majority of charity care and our graduate medical education (GME) — are most vulnerable to financing changes in particular. As Baxter and Mechanic point out in their overview of safety net providers across the country, "The pace of change affecting the safety net is faster than our ability to monitor the stability of safety-net institutions and the welfare of populations that depend on them" (1997). What is known is the emerging trend that each state is implementing reforms in response to its own health care system's strengths and weaknesses.

DRIVEN BACK TO WELFARE FOR HEALTH INSURANCE?

Susan W. and her two children, ages 3 and 5, have been living on "welfare" for the past three years. She has been raising them on her own since her husband left with no return address. Her younger child developed asthma and severe respiratory allergies. Last year, Susan worked with her social worker and was linked to a job training program as part of the state's "welfare-to-work" initiative. She trained as a data entry assistant.

Six months ago, she literally walked into a job when a local business was advertising for a data entry position; she knew the owner of the business, which handles packaging and shipping orders. The business had been doing well; the owner knew and liked Susan and her children and he promised her flex time and payment of her health insurance premiums once her Medicaid "ran out." For Susan, health insurance coverage was the most important part of the package; she had been pleased with the care provided to her asthmatic daughter since her enrollment in Medicaid managed care, as she had access to good primary care through a wonderful pediatrician and her daughter's expensive asthma medications are being covered.

Just last week, Mr. D, Susan's boss, informed her that sales were slowing down as a large, chain packaging company had opened just one mile from his store; he could no longer promise health benefits coverage. Susan has no financial resources to purchase health insurance for herself and her two children and yet she makes just $50.00 above the highest limits for Medicaid expansion eligibility. Where does this family turn to in our current health care system? Can Susan and her children be assured that they will have access to needed health care services? How does she get information about the many new insurance programs specifically designed for children?

THAT WAS THEN; THIS IS NOW

While the charity care delivery system is being re-structured in a managed care environment, the legislative clock is ticking down to the December 31, 1997 deadline for financing New Jersey's charity care system. Many of the same factors as were at play two years ago continue at present: estimates of New Jersey's uninsured population still stand at over 1 million, (approximately 248,000 of whom are children); New Jersey's business and industry advocates continue to be critical of diverting the state's unemployment revenues to fund charity care; and the New Jersey Hospital Alliance's urban hospitals assert their struggle to operate without the fiscal support they say they need to provide needed medical services in their communities.

One difference that bears noting lies in the Legislature's decision not to renew funding for its Health Access program, established under the 1992 Health Care Reform Act. The program, which represented one of New Jersey's insurance reform efforts, aimed to provide subsidies to facilitate payment of health insurance premiums for low-income New Jerseyans.[6] This year, the Department of Health and Senior Services has shifted the focus of the program and its subsidy monies to the purchase of health insurance for children, rather than for both children and adults as was originally intended under Health Access. Two programs are re-cast from the original Health Access program: Children First and the Access Program. In the FY 1997-1998 budget, $5 million is dedicated to the Children First initiative, which would subsidize children up to 250 percent of poverty (Sparer, 1997). According to the DHSS, it is estimated that 5,000 children could be covered by the Children First program; latest estimates for the number of uninsured children in New Jersey stand at 248,000. Reforms of the individual and small group insurance markets are proceeding with mixed results.

CHARITY CARE MANAGED CARE 1997: WIDENING THE PROVIDER NETWORK

Proposed new rules have been drafted for the charity care managed care system but they have not yet been formally introduced in the *New Jersey Register*. The Department's March 1997 section 1115 Medicaid waiver application to the Health Care Financing Administration (HCFA) is currently under review. The waiver seeks approval for the restructuring of the charity care managed care system. Specifically, the waiver relates to federal statutory and regulatory mandates involving Medicaid disproportionate share hospital (DSH) reimbursement. Under current law, it is required that all charity care be delivered by the DSH hospital. New Jersey's proposed charity care managed care program would

[6] The Health Access program accepted applications between April 10, 1995 and December 31, 1995, with enrollment reaching 22,000. Since funding was not renewed, enrollment has gone steadily downward; by the end of March 1997, enrollment stood at 15,678.

permit hospitals to use less-intensive settings in the provision of charity care, for example, network mental health providers in the community.

Target Populations

Of the over 1 million uninsured living in New Jersey, approximately 141,000 unique individuals had their medical care subsidized through charity care in 1996, or approximately one in ten. How can we improve broader access to health care for the general uninsured population of all age groups within our charity care system? What do we know about the health service utilization behaviors of the uninsured to inform decision-making about the continued evolution of our charity care system?

The Department of Health and Senior Services analysis of the types of patients who are seen in the charity care system has found that most charity care patients are seen only once in a given time period (reference is made to *The Issue Brief Review*, April 1997). Further research on service utilization by New Jersey's charity care population indicated that behavioral health services — substance abuse, dual diagnosis of substance abuse and mental illness — were significantly used by the population. DHSS has determined that individuals requiring treatment for substance abuse and mental illness, and those with chronic conditions would be targeted populations for charity care managed care. In draft proposed new rules for the charity care managed care system, DHSS sets forth that hospitals are not required to provide managed care for all of their charity care patients, but are expected to provide managed care for the categories of patients identified in their submitted plans.

TOMORROW'S SEASIDE BOARDING HOME RESIDENT?

James G. just turned 17. He's entered vo-tech school after graduating from his local high school. When he was three years old, he lost his father in a boating accident. He lived with his mother as a single parent for two years — until his fifth birthday —, when she became too ill to care for him. That same year, she died from breast cancer. James' maternal grandparents legally adopted him soon after his mother had died.

During his early years, James was doing well even after the loss of his parents. But by adolescence, he starting exhibiting inappropriate behaviors and actions. Between the ages of 13 and 15, he tried to commit suicide on three different occasions; his grandfather had died soon after James' last suicide attempt. After his grandmother took him for help to a psychiatrist, he was diagnosed as schizophrenic, hospitalized for two short periods and placed on multiple medications.

Because both of his grandparents were on Medicare during the time, they paid for James care out-of-pocket, from a small trust that had been left by his father's family many years before. This trust was gone within two years of paying for James' psychiatric bills and medication. There has been great difficulty establishing Medicaid eligibility for James since neither he nor his grandmother are very good at paperwork. His grandmother's health is failing and the roles have been shifting by which she needs more care for herself than she is able to give to James. This past year, when he entered vo-tech school and was stable on his medications, his therapist encouraged him to move into an independent setting in a group home. She has helped with Medicaid for James but knows that this is only a short-term solution. James has "slips" and is at high-risk for re-hospitalization when he goes off his meds, which are not affordable for him without any health insurance.

What are James' options? At present, the age group from 11 to 18 years has one of the the highest rates of uninsurance; provision of mental health services to this group is even more challenging. How will a charity care managed care system benefit someone like James, who suffers from chronic mental illness and in his age group, is also at risk for substance abuse?

Data Requirements

Under the hospital-centered system of managed charity care, hospitals would be required to develop a managed care plan; plan requirements include the creation of a network of providers, utilization management a quality assurance program and a data system. Regarding data system requirements, DHSS would develop a data system to evaluate the effectiveness of the charity care managed care systems in improving quality of care, reducing costs and providing adequate access to care. Hospitals would be required to submit data to DHSS to be used for evaluating system performance. System evaluation will have an impact on charity care funding: the meeting of established benchmarks will determine whether or not full charity care funding will be continued to the hospital.

Delivery System Changes

New Jersey's charity care system has a long history as being hospital-based. And hospitals have had an equally long history of being the most expensive component of the health care system (on average approximately 60 percent of New

Jersey's categorical health care expenditures). Under the proposed charity care managed care system, the hospital-based program will use managed care operations such as utilization management, prior authorization and case management. As the center of operations, the hospital would be allowed to establish affiliations with other hospitals and community-based physicians and providers to offer appropriate services to targeted charity care patients. Designated system providers may be located in settings outside of the hospital itself. Such broadening of access points should allow greater efficiency in the provision of charity care, as well as offering more appropriate care for patients. What are the implications of the delivery system "shifting" of reimbursed services under a broader managed care network outside of the hospital facility to different settings? What level of financial savings are expected to be derived from this shift?

BUT WHERE IS THE MONEY COMING FROM?

The following table breaks out charity care pool funds in New Jersey from 1992 (the last year of the Uncompensated Care Trust Fund) through 1997. The Health Care Subsidy Fund includes Charity Care and the Hospital Relief Fund. New Jersey's disproportionate share hospitals (DSH) also receive combined state and federal payments to support the care which they provide to uninsured patients. These Medicaid DSH payments averaged approximately $1.094 billion each year during the past two years. These payments supported both acute care hospitals in New Jersey and the state and county psychiatric hospitals; psychiatric hospitals received on average 30 percent of DSH payments each year.

The Health Care Subsidy Fund is supported by $660 million diverted from unemployment taxes in 1996 and 1997, and $15 million from the state's general revenue fund in 1996; $41 million is to be drawn from that fund in 1997. How much or how little more reliance will be placed on the state's general revenue fund in the near future remains unclear.

New Jersey Charity Care Pool Funds 1992-1997 *(millions)*

		Charity Care	Hospital Relief Fund (started 7/1/93)		
	1992	$754	Hospital Relief Fund	Mental Health	Other Uncompensated Care
Health Care Subsidy Fund	1993	$500	$125	$17.5	$100
	1994	$383	$125	$17.5	$67
	1995	$400	$125	$17.5	$33
	1996	$310	$125	$17.5	0
	1997	$300	$125	$17.5	0

Note: Figures for Charity Care and Other Uncompensated Care provided by New Jersey Department of Health & Senior Services.

States throughout the country continue to tap various sources of revenue to support hospitals in their provision of charity care: common sources include taxes, surcharges or fees; these may be collected on provider charges, revenues or insurance premiums (Ladenheim, 1997). Sin taxes — particularly tobacco taxes — have also been used, but in many cases are usually used to expand insurance-like programs or Medicaid (Ibid.). Can New Jersey realistically consider any of the sin tax alternatives — such as tobacco, beer or wine — at this time of sensitivity regarding new taxes?

New Jersey was not alone in eliminating its rate-setting system when it did; by the mid-1990s, most states had repealed these systems and established alternative mechanisms to fund charity care through their hospital system (Atkinson, Helms and Needleman, 1997). These researchers looked at seven states — Connecticut, Maryland, New Jersey, New York, California, Florida and Washington — to examine overall levels of uncompensated care provided and changes in the levels over time. One interesting finding indicated that the level of uncompensated care being provided by hospitals is declining at a time when the rate of uninsured individuals is increasing. (See Appendix, Table 1, "Uncompensated Care as a Percentage of Total Hospital Charges, By State, 1983-1996.") Policy implications drawn from this finding in particular focus on the need for better data to assess "the extent to which persons without adequate health insurance actually obtain the care that they need" (Ibid.).[7]

Of the seven states under study, responses to the provision of uncompensated care and strategies to preserve or expand access have taken various forms, including insurance coverage expansions, uncompensated care pools, and

[7] Reference is made to Whitmore, H. "Access to Health Care: Bridging the Gap Between Policy and Research." Center for Studying Health System Change, Issue Brief, no 8, April 1997. In discussing how there is no "gold standard" to measure access, the author identifies the limitations in using the level of charity or uncompensated care given by hospitals and other health care providers as a measure of services provided to the uninsured. For example, changes of the amount of uncompensated care "may not be a valid indicator of changes in access because it may reflect the quantity of care supplied, rather than the quantity of care demanded by those without insurance."

ıcturing the delivery system and the way care is provided. New York is a state which regulated its hospitals' rate-
ıg from the 1970s through January 1997. Throughout those years, its uncompensated care pool funded by hospital
sments funded hospitals for uncompensated care and also provided (from a separate pool) support to "distressed"
tals (Id.) Although rate-setting ended in January of this year, New York has modified and kept its pool approach
a "covered lives assessment mechanism" to support uncompensated care and medical education costs.

\s another example, the Commonwealth of Massachusetts takes a multi-pronged approach to financing its
mpensated Care Pool, which was established in 1985 and which continues to be a crucial piece of the state's safety
National Academy for State Health Policy, 1997). There are varying levels of patient eligibility for free care paid
/ the pool; there are 86 acute care hospitals and 31 community health centers that participate in the pool. At pre-
the Commonwealth of Massachusetts contributes $15 million to the pool. Through an assessment on acute care
tals, an additional $315 million (capped) is collected and contributed to the pool. New funding established under a
Act sets new contribution levels on the Commonwealth and private sector: the Commonwealth will contribute $30
)n; the hospital assessment will be reduced to $215 million; and payers will contribute $100 million surcharge on
ents to hospitals and ambulatory surgical centers (Ibid.).

: BIG PICTURE OF THE UNINSURED:

d States: 40 million and counting. . .; New Jersey: 1 million and counting...

\ny policy analysis of charity care must be done in the context of the larger public policy issue of the uninsured. In
:ent national research study, "Patching the Safety Net: Shifting Health Care Costs and State Policies," Kala
ıheim points out that:

'or the last ten years, state and national policy has focused on expanding health insurance coverage for the unin-
ured. At the same time, the uninsured population continues to grow. People without coverage tend to receive care
rom hospitals and other publicly oriented providers, and the cost of their care is borne by payers. Changes in the
ealth care system, particularly the growth of managed care and for-profit hospital chains, make it increasingly dif-
icult to provide for the uninsured in this way....Absent major reforms, states have relied on approaches developed
ı a hospital-centered era. Lawmakers now face the challenge of adapting old strategies to a managed care environ-
ıent. Like *the small group insurance market reforms that most states have enacted, these are limited strategies*
esigned to shore up an eroding status quo. Their aims and effects are modest, while they may be useful elements
ı a broader strategy, they cannot stand alone ([emphasis added], 1997).

\s we move towards creating our charity care system in New Jersey in a managed care framework, how do these
ectural changes fit into a broader strategy?

adenheim's study found that states address the problem of health care for the poor by improving access to cover-
r by improving access to services. She notes that states have sought to expand health care coverage for the poor by
ıding eligibility (such as in the Medicaid program); creating state-funded insurance programs, and/or by encourag-
e development of low-cost private sector insurance products. The reality remains that such efforts are incremental:
:mands for insurance coverage are high, while the funding of such programs is limited. (Reference is made to New
/'s Health Access program.)

NEXT YEAR'S UNEMPLOYED CHARITY CARE APPLICANT?

Max L., age 55, makes his living by teaching drums out of his apartment to students of all ages and by playing gigs throughout New Jersey, with occasional jaunts into Philadelphia and New York City. He's been doing so since he was out of music school, over 30 years ago. Every time he tried to get a job teaching music in the schools, he was either turned down, or on the rare occasions he did make the cut, he was "down-sized" as part of staff reduction in school music programs.

He remains self-employed, makes $20.00 an hour from his students (when they show up) and on a good night walks out of a club with about $200. In any given month, Max plays out about twice a month, even with the upsurge in the number of coffee houses in the area. With his limited income, he often has difficulty making his estimated state and federal tax payments. Payment of health insurance premiums is out of the question on his annual income of approximately $15,000.

Last month, he was diagnosed with loss of hearing in his left ear, which had been inflamed for months from a middle ear infection that he could not afford to treat. The emergency room doctor found an atypical growth in the same ear. If Max loses his hearing, he loses his livelihood of performing and teaching music. Whose responsibility is it to finance the exploratory surgery to pinpoint the cause of the hearing loss? Is Max one of the worthy or unworthy uninsured in New Jersey?

THE UNINSURED - NOT JUST A LOCAL PROBLEM

In 1988, there were approximately 697,000 uninsured individuals in new Jersey, representing 10.5 percent of the under-65 population (Employee Benefit Research Institute, 1997). Within five years, in 1993, the number grew to 1,126,000, or 16.2 percent of the non-elderly population. The March 1996 Population Survey (most current) indicated that New Jersey's uninsured rate is statistically equal to the national average: still holding at 16.2 percent (approximately 1.2 million) of the total state population; over 700,000 of the state's uninsured population represent full-time workers and their families. Nationally, the uninsured rate has been steady throughout the 1990s at between 15 to 17 percent of the total population, despite growth in the national economy (*State Initiatives in Health Care Reform*, July 1997).

The geographic distribution of the uninsured indicates that Midwestern states have the lowest rates of uninsurance (between 8.6 percent in Wisconsin to 14 percent in Indiana); while Southern and Southwestern states (including Florida and Texas) had uninsured rates that are statistically higher than the national average. For example, Florida, California, Arizona, Louisiana, Texas and New Mexico each had uninsured rates over 22 percent, with New Mexico's the highest in the country at 28.8 percent (Ibid.). [Please refer to Appendix, Chart 1, "States Ranked by Uninsured Rate and Percent of Workers Employed in Small Firms, 1995."]

THE FEDERAL GOVERNMENT'S PROTEAN ROLE

Provision of charity care in New Jersey is bound to be affected by two recent variables introduced by the Federal government: (1) the reduction of federal Disproportionate Share Hospital (DSH) payments to the states, and (2) new funding support for children's health care through its State Children's Health Insurance Program.

DSH Payments: The Rules Keep Changing

As part of this year's efforts to balance the Federal budget, the issue of Medicaid reform is prominent. One component of the balanced budget agreement aims to reduce the Medicaid budget by approximately $16 billion over five years. One prong of the Medicaid budget reduction strategy is to reduce disproportionate share hospital (DSH) payments to the states; these are payments that states make to hospitals that serve a large percentage of Medicaid and uninsured patients.

Although the legislative intent of DSH payments was to provide financial relief and funding support to such hospitals, over the years many states have used the program "to generate federal funds for the state rather than to help solve the problems of these hospitals" (Holahan et al, 1997). Nationally, DSH expenditures increased from about $400 million in 1988 to $17 billion by 1992; by 1995, DSH levels were estimated at $19 billion, with the Federal share comprising approximately $10.8 billion of that amount (Ibid.). States commonly used provider taxes or transfers from local governments to finance the state share of DSH. In New Jersey, the federal share for 1995 was $600 million.

Changes in Federal Medicaid law enacted in 1991 and 1993 affected DSH payments to states; current changes under the Balanced Budget Act will further affect Federal DSH allocations to states. The 1991 legislation capped DSH payments at 12 percent of Medicaid program expenditures; any state whose DSH payment exceeded that level was frozen at 1993 levels until such time as DSH payments accounted for 12 percent of overall Medicaid expenditures.

Current plans involve a set of DSH reductions to be applied over the next five years. However, as Holohan points out in his 1997 report on Medicaid reform, there is currently "no rational basis for the distribution of DSH dollars to states. . .[A]s a result, 13 states accounted for over 75 percent of all federal DSH expenditures in 1994" (Ibid.). New Jersey is one of those 13 states, along with New York, California, Texas, Louisiana, Michigan, Massachusetts, South Carolina, Alabama, Missouri, Pennsylvania, and Ohio.

In the Appendix, Chart 2, :"Federal Medicaid DSH payments under Balanced Budget Act of 1997" specifically indicates that the impact of federal DSH reductions will be significantly felt by the four states which comprise over half of the $1.738 billion in reductions from fiscal year 1995 levels to 2002: California, Louisiana, New York and Texas. Each of these states had been classified as a "high-DSH" state in 1997. However, from fiscal year 1997 to 1998, five states (also classified as high-DSH) will qualify for an increase in federal DSH funds: — New Jersey, Alabama, Louisiana, South Carolina and Texas (Ibid). The opposite is true for the states of Illinois, Michigan and New York, which will experience a reduction of approximately $100 million during the same time period (See Appendix, Chart 3. "Federal Medicaid DSH payments by State, FY 1995 through 2002").

The amount of federal DSH funds that states may pay to institutions for mental diseases (IMDs), such as state or county psychiatric hospitals, is also limited under the Act. Table 2 offers a state-by-state breakdown of federal and state Medicaid DSH payments for psychiatric institutions, for both Fiscal Year 1995 and the five-year period from 1998 through 2002 (See Appendix). In fiscal year 1995, the federal DSH payments to New Jersey's psychiatric hospitals represented 30 percent of total Federal DSH payments to the state.

Children's Health Insurance Program

The predominant trend across the country since last year has been the launching of initiatives to provide health insurance coverage for many of the nation's 10 million uninsured children (General Accounting Office, *Report*, June 1996). Reasons for this trend are driven by values — children (especially young children) are considered a deserving group; by fiscal realities — child health care is relatively inexpensive; by political realties — it represent an incremental approach; and by the ongoing erosion of the private insurance market which has led to a growing number of uninsured children (Sparer, 1997). In the face of these reasons, a number of states have enacted child insurance expansions, including New York, Massachusetts, Pennsylvania, Minnesota, Florida and New Jersey.

On the national level, no where more evident was the country's move to commit to children's health care than in the enactment of the Children's Health Insurance Program, signed into law on August 5, 1997, as part of the Balanced Budget Act of 1997 (Public Law 105-33). The Act created the program under a new title — Title XXI — of the Social Security Act to enable states to "initiate and expand the provision of child health assistance to targeted, low-income children." Congressional Budget Office estimates for the child health block grant are at $24 billion in federal funds over five years (Mann and Guyer, 1997). [Table 3 indicates the General Accounting Office initial estimates (August 1997) of state allocations for children's health insurance.][1] Funds, which become available October 1, 1997, may be used by the states to implement these programs for children's health care either through expansion of already existing Medicaid programs, by creating new programs, or through a combination of both.

At present, there is a blended formula which attempts to balance the concerns of states that have high numbers of uninsured children under 200 percent of the Federal Poverty Level ($32,00 for a family of four), and those states which have been using aggressive strategies to cover this population (*State Health Watch*, 1997). During the first three years, those states with the highest numbers of uninsured children will receive greater funding amounts; over the following two years, more money will be shifted to states that have already implemented programs to insure these children.

The Children's Health Insurance Program is partially funded by a 10-cent-per -pack increase in tobacco taxes, effective in 2000, and an additional 5-cent tax, effective in 2002. Congress also expects to save at least $10.4 billion over five years by capping DSH funds distributed to the states (Ibid.).

Each state must submit specific plans to the Department of Health and Human Services, outlining its child health insurance strategies. Although the states will have great flexibility in using the monies, there are also many rules and guidelines regarding states' use of the funds, including benefits plans, family coverage, outreach requirements and income limits (e.g., generally only children with household incomes at or below 200 percent of poverty may be assisted), and how they will address the potential "crowding-out" problem.

Crowding-Out — A Balancing Act for Policymakers

Policymakers are faced with a significant balancing-act when it comes to the potential "crowding-out" issue of finding a way to expand coverage to more uninsured children without eroding employment-based coverage (*EBRI Issue Brief*, July 1997). At present, precise policy implications cannot be drawn regarding the issue of crowding out because current research on the subject has drawn no definitive conclusions as to whether or not there is a "cause-and-effect" relationship between, for example, increased enrollment in Medicaid expansion programs and decreased private insurance coverage for the same population (Cutler and Gruber, 1997; Dubay and Kenney, 1996 & 1997).

Several of the current legislative proposals for children's health insurance plans at national and state levels carry a provision that excludes children who have access to employment-based coverage. The Children's Health Insurance Program requires that insured children may not be excluded from coverage under a private program because they are eligible for assistance under this new program. Congress set the limit of 200 percent of the Federal Poverty Level for this program in order to address the concerns that the program could lead to a further erosion of employment-based insurance.

[1] *The state allotments and formulas for calculating them appear in the Federal Register, September 10, 1997.*

END NOTES AND POLICY IMPLICATIONS

The efforts of New Jersey and other states to address the issue of providing charity care to their uninsured and indigent population must be considered a "work in progress." At present, no single state has composed a magnum opus that can serve as a model; as with state's efforts to address the broader issue of the uninsured population in general, various initiatives are being "tested" to assess their viability. These efforts carry with them policy implications that cut across many aspects of health care financing, delivery and accessibility:

NEW JERSEY'S SAFETY NET PROVIDERS

Urban hospitals in New Jersey serve a disproportionate share of indigent clients. In a recent report released by the New Jersey Hospital Alliance, which represents the 26 urban hospitals in the state, findings demonstrate that although urban hospitals represent only one-third of the state's hospitals, they provide the majority of vital health services to New Jersey's indigent as a result of their historical mission of serving the most vulnerable in their communities (Hospital Alliance of New Jersey, May 1997). The report points out that Alliance hospitals are responsible for 58 percent of all documented charity care services provided in New Jersey hospitals. How can we collectively assess and address problems such as these which are providing medical services to our indigent populations? Why isn't the level of charity care funding "enough" for their operation?

A recent issue (July/August 1997) of the journal *Health Affairs* was dedicated to issues that surround the safety net, including uncompensated care for the medically indigent, the funding of safety net providers in a health care environment driven by market forces, the future of graduate medical education, reductions in Medicaid spending, DSH payments and the implications of welfare reform. In "The Status of Local Health Safety Nets," the authors provide an overview of the pressures facing safety net providers in 23 communities across the country (Baxter and Mechanic). Common challenges included: the loss of publicly insured patients to private hospitals and clinics, the competition from private-sector health plans and providers for Medicaid managed care clients, and the instability of financing sources, such as Medicaid DSH payments. What is our commitment, as a state, to these providers in addressing these issues cooperatively, as both a purchaser and funder of health care?

The separation of Medicaid from the welfare program (under the Personal Responsibility and Work Opportunity Act) may create an increase in indigent care for those losing Medicaid eligibility. What are New Jersey's plans for protecting these vulnerable, at-risk individuals?

PAYING ATTENTION TO RESEARCH

In an opinion piece entitled "Health Care Unreform" written at the end of 1993, health policy analyst Joel Cantor expressed concerns that New Jersey's responses to Judge Wolin's decision on Chapter 83 may have "gone too far" in dismantling the uncompensated care pool system and the system of hospital rate-setting (Cantor, 1993). Are there benchmarks that can be used to evaluate whether or not his analysis holds true in the current challenges facing the charity care system?

MIT researchers Sanford Weiner and Harvey Sapolsky found in their analysis of rate setting in New Jersey that two major lessons could be learned from the experience: (1) program management is at least as important as which program concept and strategy was chosen initially; and (2) the significance of state bureaucracy's implementation obstacles and difficulties. Both issues have critical implications as states, in the era of devolution, take on current health care reform proposals and operations. How can we ensure that policy makers and program administrators truly learn from the downside of "what didn't work" in other programs?

DATA COLLECTION AND ANALYSIS

Data remains a critical component to facilitate decision-making about charity care in particular and health care for the uninsured in general. The Department of Health and Senior Services uses a system of data collection and analysis in order to form a "picture" of charity care in New Jersey and the individuals who are being served under the system. How does this data collection tie in with monitoring the broader issue of the uninsured in New Jersey, which cuts across departmental lines? What entity should be in charge of collecting and analyzing this data in an ongoing and consistent way?

Tracking the provision of charity care is a protean exercise: providers historically would absorb the costs of care to the poor and in many private medical practices, some physicians may make the decision to still do so. How is charity care provided in physician's practices tracked? And when it is provided, who is monitoring and recording it? And, if some of these physicians will now come under the compensated managed care provider umbrella, will this represent a new cost to the charity care system?

APPENDIX

Chart 1

States Ranked by Percent of Workers Employed in Small Firms and Uninsured Rate, 1995

STATE	Percent of Population Under Age 65 That is Uninsured	Percent of Total Employment in Firms with 1 to 24 Employees	Percent of Total Employment in Firms with 1 to 99 Employees
*Uninsured rate is significantly below the national average:**			
Wisconsin	8.6%	27.6%	42.5%
Connecticut	9.4%	29.4%	41.9%
Minnesota	9.8%	29.1%	41.7%
Hawaii	10.5%	36.7%	49.0%
Nebraska	10.7%	30.8%	45.2%
Michigan	10.8%	25.8%	39.4%
Pennsylvania	11.4%	27.7%	40.9%
Illinois	12.0%	25.6%	39.3%
South Dakota	12.3%	34.7%	49.3%
Massachusetts	12.7%	25.7%	39.1%
Iowa	12.8%	31.4%	44.3%
Utah	13.0%	28.0%	37.0%
New Hampshire	13.6%	28.5%	41.2%
Indiana	14.0%	27.6%	40.0%
Ohio	14.5%	24.1%	37.3%
Alaska	15.0%	34.1%	47.3%
Oregon	15.0%	35.9%	49.4%
Kansas	15.5%	30.9%	45.0%
Washington	16.4%	32.5%	44.5%
Rhode Island	16.7%	31.6%	46.8%
*Uninsured rate is statistically equal to the national average:**			
South Carolina	13.3%	27.6%	40.6%
Colorado	15.5%	33.2%	47.2%
Maine	15.6%	31.0%	47.8%
Kentucky	16.0%	28.6%	38.5%
New Jersey	16.2%	26.6%	40.9%
Virginia	16.4%	28.6%	40.2%
Missouri	16.5%	28.3%	40.0%
Vermont	16.6%	37.9%	53.0%
Tennessee	16.7%	26.2%	39.0%
Alabama	16.8%	30.1%	42.8%
North Carolina	17.1%	26.6%	38.5%
Delaware	17.2%	24.2%	37.3%
New York	17.3%	27.4%	41.0%
Maryland	17.4%	22.2%	35.4%
Idaho	17.4%	34.4%	45.3%
D.C.	17.4%	22.4%	33.4%
West Virginia	20.7%	30.8%	41.9%
*Uninsured rate is significantly above the national average:**			
Wyoming	17.7%	39.4%	51.2%
Arkansas	20.6%	28.1%	41.0%
Nevada	20.7%	26.9%	36.8%
Georgia	20.8%	29.5%	40.4%
Oklahoma	22.3%	38.3%	52.6%
Mississippi	22.3%	25.4%	36.1%
Florida	23.1%	32.1%	45.1%
California	23.7%	32.7%	46.0%
Arizona	24.2%	30.8%	44.1%
Louisiana	25.6%	33.4%	44.4%
Texas	26.9%	32.5%	44.3%
New Mexico	28.8%	37.0%	49.2%

Source: Alpha Center tabulations of the March 1996 Population Survey.
**Catagories refer to uninsured rates among the entire population. State rankings refer to unisured among the under-65 population may differ.*
Source: *State Initiatives in Health Care Reform. "Rates of Uninsured Change Little Despite Economic Growth." No.23. July 1997.*

Table 1

Uncompensated Care As A Percentage Of Total Hospital Charges, By State, 1983-1996

Year	CA (nonpublic hospitals only)	CA	FL	WA	CT	NJ	NY	MD
1983	5.12%	3.01%	7.37%	4.06%	4.19%	-a	-a	5.67%
1984	5.95	3.26	9.45	4.34	4.80	-a	-a	6.30
1985	6.65	3.28	9.73	4.12	4.90	-a	-a	7.27
1986	6.44	3.36	10.65	4.15	4.86	-a	-a	7.22
1987	6.52	3.33	11.17	4.33	5.62	-a	-a	7.14
1988	6.77	3.75	9.89	4.18	5.77	11.64%	6.86%	7.42
1989	7.02	4.14	9.40	4.19	5.59	11.85	6.68	7.79
1990	6.58	4.12	8.87	3.83	4.87	10.74	5.97	7.70
1991	6.23	4.02	8.23	3.48	5.00	11.02	5.49	8.06
1992	5.86	3.61	7.44	3.59	4.61	9.63	5.06	9.25
1993	3.32	2.98	7.17	3.72	4.50	8.97	4.95	9.37
1994	3.17	2.96	7.35	3.47	3.45	8.47	5.24	8.22
1995	-a	-a	-a	-a	4.06	8.01	-a	8.00
1996	-a	-a	-a	-a	-a	-a	-a	7.22

Source: Author's calculations from state financial reports.
Note: The states are arrayed from left to right according to the extent to which they regulated hospital rates, with California being the least regulated and Maryland the most regulated. The uncompensated care ratio represents the sum of bad debt and charity care divided by total charges.
a = not available.
Source: Atkinson, Graham, W. David Helms and J. Needleman. "State Trends in Hospital Uncompensated Care." Health Affairs. July/August 1997.

Chart 2

Federal Medicaid DSH payments under Balanced Buget Act of 1997 (Federal outlays in millions)

	FY95 Federal DSH allotment	FY95 DSH as % of total Federal Medicaid payments	Federal DSH allotment under legislation FY98	FY99	FY00	FY01	FY02	Dollar reduction in 2002 from 1995 level	Percent reduction in 2002 from 1995 level
Alabama	$294	21.5%	293	269	248	246	246	-$48	-16%
Alaska	$10	6.2%	10	10	10	9	9	-$1	-15%
Arizona	$81	7.7%	81	81	81	81	81	-$0	-0%
Arkansas	$2	0.3%	2	2	2	2	2	-$0	(a)
California	$1,096	13.8%	1086	1068	986	931	877	-$219	-20%
Colorado	$93	11.4%	93	85	79	74	74	-$19	-20%
Connecticut	$204	16.2%	200	194	164	160	160	-$44	-22%
Delaware	$4	2.1%	4	4	4	4	4	$0	13%
District of Col.	$23	2.9%	23	23	23	23	23	-$0	-0%
Florida	$188	5.5%	207	203	197	188	160	-$28	-15%
Georgia	$253	11.7%	253	248	241	228	215	-$38	-15%
Hawaii	$0	0.0%	0	0	0	0	0	$0	0%
Idaho	$1	0.6%	1	1	1	1	1	-$0	(a)
Illinois	$203	6.9%	203	199	193	182	172	-$31	-15%
Indiana	$201	15.7%	201	197	191	181	171	-$30	-15%
Iowa	$8	1.1%	8	8	8	8	8	$0	6%
Kansas	$52	9.5%	51	49	42	36	33	-$19	-37%
Kentucky	$137	9.3%	137	134	130	123	116	-$21	-15%
Louisiana	$880	29.4%	880	796	713	658	631	-$249	-28%
Maine	$105	18.0%	103	99	84	84	84	-$21	-20%
Maryland	$72	5.9%	72	70	68	64	61	-$11	-15%
Massachusetts	$288	11.6%	288	282	273	259	244	-$44	-15%
Michigan	$249	8.6%	249	244	237	224	212	-$37	-15%
Minnesota	$16	1.1%	16	16	16	16	16	-$0	-0%
Mississippi	$143	11.8%	143	141	136	129	122	-$21	-15%
Missouri	$436	26.5%	436	423	379	379	379	-$57	-13%
Montana	$0	0.1%	0.2	0.2	0.2	0.2	0.2	$0	(a)
Nebraska	$5	1.3%	5	5	5	5	5	$0	0%
Nevada	$37	16.2%	37	37	37	37	37	$0	1%
New Hampshire	$143	38.4%	140	136	130	130	130	-$13	-9%
New Jersey	$600	24.6%	600	582	515	515	515	-$85	-14%
New Mexico	$5	0.9%	5	5	5	5	5	$0	1%
New York	$1,512	12.7%	1512	1482	1436	1361	1285	-$227	-15%
North Carolina	$278	11.7%	278	272	264	250	236	-$42	-15%
North Dakota	$1	0.4%	1	1	1	1	1	$0	(a)
Ohio	$382	10.1%	382	374	363	344	325	-$57	-15%
Oklahoma	$16	2.1%	16	16	16	16	16	-$0	-2%
Oregon	$20	2.2%	20	20	20	20	20	$0	2%
Pennsylvania	$529	13.1%	529	518	502	476	449	-$80	-15%
Rhode Island	$62	11.3%	62	60	58	55	52	-$10	-15%
South Carolina	$311	22.2%	313	303	262	262	262	-$49	-16%
South Dakota	$1	0.3%	1	1	1	1	1	$0	(a)
Tennessee	$0	0.0%	0	0	0	0	0	$0	0%
Texas	$958	17.4%	979	950	806	765	765	-$193	-20%
Utah	$3	0.8%	3	3	3	3	3	-$0	-10%
Vermont	$18	8.6%	18	18	18	18	18	$0	-15%
Virginia	$70	6.8%	70	68	66	63	59	-$11	-15%
Washington	$174	11.8%	174	171	166	157	148	-$26	-15%
West Virginia	$64	6.7%	64	63	61	58	54	-$10	-15%
Wisconsin	$7	0.4%	7	7	7	7	7	$0	5%
Wyoming	$0	0.0%	0	0	0	0	0	$0	0%
United States	$10,232	11.9%	$10,256	$9,938	$9,248	$8,839	$8,494	-$1,738	-17%

NA=not available

(a) Percentage reductions from FY95 level not shown because federal DSH allotment is greater than 0 but less than $2 million.

Source: Section 4721 of the Balanced Budget Act of 1997. FY95 data from HCFA.

Source: Schneider, Andy, S. Cha and S. Elkin. "Overview of Medicaid DSH Provisions in the Balanced Budget Act of 1997, P.L. 105-33." Center on Budget and Policy Priorities.

Chart 3

Federal Medicaid DSH payments by state, Fiscal Year 1995 through 2002 (Federal outlays in millions)

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02
Alabama	$294	$292	$290	$293	$269	$248	$246	$246
Alaska	$10	$11	$12	$10	$10	$10	$9	$9
Arizona	$81	NA	NA	$81	$81	$81	$81	$81
Arkansas	$2	$3	$5	$2	$2	$2	$2	$2
California	$1,096	$1,096	$1,106	$1,086	$1,068	$986	$931	$877
Colorado	$93	$158	$158	$93	$85	$79	$74	$74
Connecticut	$204	$204	$204	$200	$194	$164	$160	$160
Delaware	$4	$4	$5	$4	$4	$4	$4	$4
District of Col.	$23	$31	$32	$23	$23	$23	$23	$23
Florida	$188	$190	$212	$207	$203	$197	$188	$160
Georgia	$253	$264	$281	$253	$248	$241	$228	$215
Hawaii	$0	$0	$0	$0	$0	$0	$0	$0
Idaho	$1	$2	$2	$1	$1	$1	$1	$1
Illinois	$203	$271	$300	$203	$199	$193	$182	$172
Indiana	$201	$214	$214	$201	$197	$191	$181	$171
Iowa	$8	$10	$12	$8	$8	$8	$8	$8
Kansas	$52	$112	$111	$51	$49	$42	$36	$33
Kentucky	$137	$200	$207	$137	$134	$130	$123	$116
Louisiana	$880	$875	$869	$880	$796	$713	$658	$631
Maine	$105	$105	$105	$103	$99	$84	$84	$84
Maryland	$72	$75	$87	$72	$70	$68	$64	$61
Massachusetts	$288	$288	$293	$288	$282	$273	$259	$244
Michigan	$249	$390	$399	$249	$244	$237	$224	$212
Minnesota	$16	$34	$40	$16	$16	$16	$16	$16
Mississippi	$143	$157	$170	$143	$141	$136	$129	$122
Missouri	$436	$440	$439	$436	$423	$379	$379	$379
Montana	$0	$1	$2	$0	$0	$0	$0	$0
Nebraska	$5	$7	$9	$5	$5	$5	$5	$5
Nevada	$37	$37	$37	$37	$37	$37	$37	$37
New Hampshire	$143	$196	$196	$140	$136	$130	$130	$130
New Jersey	$600	$547	$547	$600	$582	$515	$515	$515
New Mexico	$5	$11	$13	$5	$5	$5	$5	$5
New York	$1,512	$1,524	$1,797	$1,512	$1,482	$1,436	$1,361	$1,285
North Carolina	$278	$296	$347	$278	$272	$264	$250	$236
North Dakota	$1	$1	$1	$1	$1	$1	$1	$1
Ohio	$382	$392	$432	$382	$374	$363	$344	$325
Oklahoma	$16	$17	$20	$16	$16	$16	$16	$16
Oregon	$20	$20	$22	$20	$20	$20	$20	$20
Pennsylvania	$529	$512	$537	$529	$518	$502	$476	$449
Rhode Island	$62	$60	$62	$62	$60	$58	$55	$52
South Carolina	$311	$311	$310	$313	$303	$262	$262	$262
South Dakota	$1	$1	$2	$1	$1	$1	$1	$1
Tennessee	$0	$0	$0	$0	$0	$0	$0	$0
Texas	$958	$943	$947	$979	$950	$806	$765	$765
Utah	$3	$5	$6	$3	$3	$3	$3	$3
Vermont	$18	$19	$22	$18	$18	$18	$18	$18
Virginia	$70	$114	$125	$70	$68	$66	$63	$59
Washington	$174	$177	$192	$174	$171	$166	$157	$148
West Virginia	$64	$97	$98	$64	$63	$61	$58	$54
Wisconsin	$7	$7	$10	$7	$7	$7	$7	$7
Wyoming	$0	$1	$1	$0	$0	$0	$0	$0

Source: FY95 data from HCFA. FY96 and FY97 data from 1/31/97 Federal Register. FY98 through FY02 data from section 4721 of P.L. 105-33.

Source: Schneider, Andy, S. Cha and S. Elkin. "Overview of Medicaid DSH Provisions in the Balanced Budget Act of 1997, P.L. 105-33." Center on Budget and Policy Priorities.

Table 2

Total (federal and state) Medicaid DSH payments for IMDs (outlays in millions)

	FY95 total (federal and state) DSH payments to IMDs	FY95 federal DSH payments to IMDs	FY95 federal IMD payments as a % of total federal DSH payments	Total (federal and state) DSH payments to IMDs allowed under legislation				
				FY98	FY99	FY00	FY01	FY02
Alabama	$4	$3	1%	$0	$0	$0	$0	$0
Alaska	$18	$9	88%	$8	$8	$8	$4	$4
Arizona	$0	$0	0%	$0	$0	$0	$0	$0
Arkansas	$0	$0	0%	$0	$0	$0	$0	$0
California	$0	$0	0%	$0	$0	$0	$0	$0
Colorado	$1	$0.3	0%	$0	$0	$0	$0	$0
Connecticut	$106	$53	26%	$14	$14	$14	$14	$14
Delaware	$0	$0	0%	$0	$0	$0	$0	$0
District of Col.	$7	$3	14%	$0	$0	$0	$0	$0
Florida	$150	$84	45%	$38	$38	$38	$38	$34
Georgia	$0	$0	0%	$0	$0	$0	$0	$0
Hawaii	$0	$0	(a)	$0	$0	$0	$0	$0
Idaho	$0	$0	0%	$0	$0	$0	$0	$0
Illinois	$89	$45	22%	$10	$10	$10	$10	$10
Indiana	$237	$149	74%	$111	$111	$111	$75	$60
Iowa	$0	$0	0%	$0	$0	$0	$0	$0
Kansas	$77	$45	87%	$39	$39	$39	$23	$18
Kentucky	$35	$24	18%	$4	$4	$4	$4	$4
Louisiana	$126	$92	10%	$10	$10	$10	$10	$10
Maine	$44	$28	27%	$7	$7	$7	$7	$7
Maryland	$121	$60	84%	$51	$51	$51	$30	$24
Massachusetts	$106	$53	18%	$10	$10	$10	$10	$10
Michigan	$305	$173	70%	$121	$121	$121	$87	$69
Minnesota	$5	$3	18%	$1	$1	$1	$1	$1
Mississippi	$0	$0	0%	$0	$0	$0	$0	$0
Missouri	$207	$124	28%	$35	$35	$35	$35	$35
Montana	$0	$0	0%	$0	$0	$0	$0	$0
Nebraska	$2	$1	22%	$0	$0	$0	$0	$0
Nevada	$0	$0	0%	$0	$0	$0	$0	$0
New Hampshire	$195	$98	68%	$66	$66	$66	$49	$39
New Jersey	$357	$179	30%	$53	$53	$53	$53	$53
New Mexico	$0	$0	0%	$0	$0	$0	$0	$0
New York	$605	$303	20%	$61	$61	$61	$61	$61
North Carolina	$236	$153	55%	$84	$84	$84	$76	$61
North Dakota	$1	$0.7	82%	$1	$1	$1	$0	$0
Ohio	$93	$57	15%	$8	$8	$8	$8	$8
Oklahoma	$3	$2	14%	$0	$0	$0	$0	$0
Oregon	$20	$12	64%	$8	$8	$8	$6	$5
Pennsylvania	$556	$302	57%	$172	$172	$172	$151	$121
Rhode Island	$2	$1	2%	$0	$0	$0	$0	$0
South Carolina	$72	$52	17%	$9	$9	$9	$9	$9
South Dakota	$1	$0.5	70%	$0	$0	$0	$0	$0
Tennessee	$0	$0	(a)	$0	$0	$0	$0	$0
Texas	$284	$180	19%	$34	$34	$34	$34	$34
Utah	$1	$0.7	20%	$0	$0	$0	$0	$0
Vermont	$9	$5	31%	$2	$2	$2	$2	$2
Virginia	$8	$4	6%	$0	$0	$0	$0	$0
Washington	$164	$85	49%	$42	$42	$42	$42	$34
West Virginia	$19	$14	22%	$3	$3	$3	$3	$3
Wisconsin	$4	$3	40%	$1	$1	$1	$1	$1
Wyoming	$0	$0	(a)	$0	$0	$0	$0	$0
United States	$4,270	$2,400	23%	$1,002	$1,002	$1,002	$843	$731

(a) These states received no federal DSH payments in FY95.

Source: FY95 data from HCFA. Other numbers are CBPP calculations based on section 4721 of the Balanced Budget Act of 1997.

Source: Schneider, Andy, S. Cha and S. Elkin. "Overview of Medicaid DSH Provisions in the Balanced Budget Act of 1997, P.L. 105-33." Center on Budget and Policy Priorities.

Table 3

Estimated State Allocation for Children's Health Insurance

STATE	YEARLY GRANT (1998-2000)	5-YEAR TOTAL (1998-2002)
Alabama	$85,634,397	$398,860,045
Alaska	$5,152,005	$26,335,898
Arizona	$112,965,830	$518,369,446
Arkansas	$46,860,505	$218,689,584
California	$855,208,654	$3,969,181,386
Colorado	$43,219,361	$206,077,579
Connecticut	$36,017,176	$174,685,412
Delaware	$8,436,772	$40,792,844
District of Columbia	$14,372,424	$69,107,613
Florida	$279,202,492	$1,304,075,073
Georgia	$126,783,707	$593,692,703
Hawaii	$10,992,634	$56,705,333
Idaho	$15,694,892	$76,610,121
Illinois	$128,782,081	$640,384,030
Indiana	$73,093,951	$354,904,721
Iowa	$32,987,149	$156,573,446
Kansas	$31,433,507	$152,505,401
Kentucky	$50,701,096	$246,807,956
Louisiana	$101,768,262	$472,855,637
Maine	$12,724,728	$61,534,777
Maryland	$61,706,349	$296,556,514
Massachusetts	$45,229,971	$227,638,908
Michigan	$92,045,047	$467,287,706
Minnesota	$27,022,565	$142,314,026
Mississippi	$55,654,715	$260,977,536
Missouri	$59,268,396	$288,234,289
Montana	$9,739,680	$47,019,685
Nebraska	$15,448,224	$76,181,442
Nevada	$32,550,586	$149,726,677
New Hampshire	$10,910,006	$51,976,292
New Jersey	$91,592,766	$434,504,171
New Mexico	$56,753,577	$256,539,339
New York	$265,835,633	$1,291,959,275
North Carolina	$79,741,341	$385,769,381
North Dakota	$5,202,463	$26,118,262
Ohio	$114,442,019	$571,215,061
Oklahoma	$79,467,777	$360,183,605
Oregon	$41,881,622	$202,638,993
Pennsylvania	$123,329,744	$607,039,872
Rhode Island	$10,673,243	$51,037,602
South Carolina	$65,234,386	$314,707,881
South Dakota	$7,522,023	$37,932,903
Tennessee	$66,618,662	$330,731,571
Texas	$558,774,867	$2,523,604,663
Utah	$25,053,748	$124,222,997
Vermont	$3,959,814	$20,744,831
Virginia	$71,424,313	$345,875,137
Washington	$47,351,081	$230,930,528
West Virginia	$23,053,013	$111,158,963
Wisconsin	$37,300,536	$190,993,635
Wyoming	$7,492,707	$34,804,248

Source: General Accounting Office initial estimates, Aug. 4, 1997. (Subject to revision.)

Source: State Health Watch. The Newsletter on State Health Care Reform. Vol.4, No. 7. July 1997 and Vol.4, No. 8, August 1997.

REFERENCES

Atkinson, Graham, W. David Helms and J. Needleman. "State Trends in Hospital Uncompensated Care." *Health Affairs.* July/August 1997.

Baxter, Raymond J. and R.E. Mechanic. "The Status of Local Health Care Safety Nets." *Health Affairs.* July/August 1997.

Berliner, H.S. and S. Delgado. "The Rise and Fall of New Jersey's Uncompensated Care Trust Fund." *Journal of American Health Policy.* 1(2): 47-50. 1991.

"From DRGs to Deregulation: New Jersey Takes the Road Less Traveled." *Journal of American Health Policy.* 3(4):44-8. 19993.

Cantor, Joel C. "Health Care Unreform: The New Jersey Approach." *Journal of the American Medical Association.* vol. 270, no. 24. December22/29, 1993.

Current Population Survey. Reports at www.bls.census.gov/cps/

Cutler, David M. and J. Gruber. "Medicaid and Private Insurance: Evidence and Implications." *Health Affairs.* January/February 1997.

Dubay, Lisa C. and G.M. Kenney. "The Effects of Medicaid Expansions on Insurance Coverage for Children." *The Future of Children.* Spring 1996.

Employee Benefit Research Institute. *"Expanding Health Insurance for Children: Examining the Alternatives."* Issue Brief No. 187. July 1997.

Fishman, Linda E. and J.D. Bentley. "The Evolution of Support for Safety-Net Hospitals." *Health Affairs.* July/August 1997.

Guyer, Jocelyn and C. Mann. "Overview of the New Child Health Block Grant." Center on Budget and Policy Priorities. August 1997.

Holahan, John and D. Liska. "Where is Medicaid Spending Headed?" The Kaiser Commission on the Future of Medicaid. December 1996.

Hospital Alliance of New Jersey. "Report on the Financial Status of Urban Hospitals." April 1997.

The Kaiser Commission on the Future of Medicaid. "Restructuring Medicaid: Key Elements and Issues in Section 1115 Waivers." *Policy Brief.* May. 1997.

"Medicaid's Role for Children." *Medicaid Facts.* May 1997.

Ladenheim, Kala. "Patching the Safety Net: Shifting Health Care Costs and State Policies." National Council of State Legislatures. Forum on State Health Policy Leadership. April 1997.

Mann, Joyce M., G.A. Melnick, A. Bamezai and J. Zwanziger. "A Profile of Uncompensated Hospital Care, 1983-1995." *Health Affairs.* July/August 1997.

National Academy for State Health Policy. "Access for the Uninsured: Where Have We Been? Where Are We Going?" Presentation. Annual Conference. Portland, Maine. August 1997.

New Jersey Department of Human Services. New Jersey Medicaid Program. *Silver Anniversary Report.* 1995.