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An Overview of Charity Care in New Jersey – Past, Present and Future

Background Information for . . .

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The Issue: On August 6, 2004, New Jersey's Governor James McGreevey signed into law an act revising the formula for distribution of charity care subsidies to New Jersey's hospitals in an effort to provide for a more equitable distribution of charity care subsidy payments. The passage of this law marked another in a series of statutory and administrative actions regarding New Jersey's charity care program. The 2004 law created the largest single increase to the state's charity care program in over 10 years. The 53 percent increase in charity care funds – or $202 million – brings total charity care funding to $583.4 million for the current fiscal year.

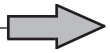
- **How will economic forces and changes in health services administration and provision affect New Jersey's state charity care program in the future?**
- **With possibly increased burdens on the state's hospitals located in areas with high numbers of uninsured, will current financing mechanisms suffice?**
- **What is the sustainability of the program if the numbers of uninsured in New Jersey continues to grow overall?**

INTRODUCTION

The ability of hospitals to provide charity care to the uninsured – currently 1.4 million in New Jersey – continues to be the main public safety net for those in need of health care services.[1] According to state Health Commissioner Dr. Clifton Lacy, approximately 1 million visits to New Jersey hospitals were paid by charity care funds in 2003.[2] The state's Charity Care assistance is available to New Jersey residents who:

- Have no health coverage or have coverage that pays only for part of the bill; and
- Are ineligible for any private or governmental sponsored coverage (e.g., Medicaid); and
- Meet both the income and assets eligibility criteria of the program[3].

New Jersey's unique set of challenges related to hospital charity care include the fact that the state has no public hospitals to be the uninsured, and a state legal mandate (N.J.S.A. 26:2h et seq., 1971) which requires that hospitals treat all patients, regardless of ability to pay. During the past 20 years, a series of internal and external factors have affected New Jersey's Charity Care program, including the state's system of hospital rate-setting and reimbursement (P.L. 1978, c.83; N.J.S.A. 26:2h-4.1); the Health Care Reform Act of 1992 (which repealed Chapter 83 and eliminated hospital rate-setting); the Health Care Subsidy Fund and amendments under P. L. 1992, c.160 and P.L. 1996, c.28; and most recently the passage of A-2406/S-1214, the law which revised the charity care distribution formula to "provide for a more equitable distribution of charity care subsidy payments . . .and [to] weight payments to hospitals in a



manner that protects and preserves those hospitals that provide the greatest relative amount of charity care in relation to their total revenue" (P. L. 2004, c.113; approved August 6, 2004).

The law was developed through a consensus process involving the 84 acute care member hospitals of the New Jersey Hospital Association and forged upon a set of agreed-upon core principles regarding hospital charity care. The New Jersey Charity Care timeline (inset) summarizes the primary statutory, judicial and administrative actions related to the program and offers a short history of the program in New Jersey.[4]

The New Charity Care Formula – A Move Toward Equity

P.L. 2004, c.113 revises the formula for distribution of charity care subsidies (effective July 1, 2004), to provide for a more equitable distribution of charity care subsidy payments. Historically, the charity care distribution from the state to the hospitals is based on a statutory formula, and the total amount of payments by the state is capped.[5] The calculation of cost reimbursement for charity care is made at Medicaid fee-for-service rate, with add-ons for Graduate Medical Education. As a means to improve distribution of funds, the new law provides that "in order to ensure that these payments remain viable and appropriate, the state will fund the subsidies in an amount not less than 75 percent of the Medicaid-priced amounts of charity care provided by hospitals in the state, plus such amounts, as are applicable, to reflect Medicaid payments to hospitals for Graduate Medical Education and Indirect Medical Education."[6]

History of Charity Care in NJ

1971 Hospitals are prohibited from denying persons medically necessary treatment if the hospital has the medical capacity to provide such care (N.J.S.A. 26:2h et seq).

1978 The practice of cost shifting by hospitals to absorb charity care expenses is prohibited through strict regulating mechanisms of the hospital rate-setting and reimbursement system. The new system controls hospital rates charged to all payers, except Medicare, and allows hospitals to increase their charges to cover the costs of care for those who did not pay (P.L. 1978, c.83; N.J.S.A. 26:2h-4.1).

1978-1992 Under NJ's acute care hospital rate-setting regulations, hospitals are reimbursed for all uncompensated care, including both charity care and bad debt.

1992 The Health Care Reform Act of 1992 repeals chapter 83 and New Jersey's rate-setting system is eliminated, along with the state's reimbursement to hospitals for bad debt.

1995 The funding mechanism for charity care, the Health Care Subsidy Fund, was due to expire December 31, 1995. After much deliberation, P.L. 1996, c.28 was signed into law authorizing the state's charity care system for two more years. Provisions of this law will expire on December 31, 1997.

1998 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. Despite the guidelines developed by the Charity Care Managed Care Advisory Committee, the move to a managed care model was never implemented, as a result of P.L. 1998, c. 37, s.2, which made participation in the model voluntary.

2004 Legislation is passed (A2406, S1214) to amend the formula by which charity care is reimbursed by the state. The new formula ranks hospitals on the "relative charity care percentage" and the level of compensation is based on that percentage. Statewide, hospitals will be reimbursed for 75% of the cost of charity care, with no hospital receiving less than 43 cents on the dollar, and the top hospitals receiving 96 cents on the dollar (P.L. 2004, c.113).

The revised formula weights payments to hospitals in order to protect those hospitals that provide the greatest relative amount of charity care in relation to their total revenue. In order to do so, the formula calculates hospitals' "relative charity care percentage (RCCP)" and then ranks the hospitals from high to low based on their RCCP. For example, under the terms of the new formula, payments to hospitals with the eleven highest RCCPs will be equal to 96 percent of their hospital-specific charity care amounts (set at Medicaid rates).

The increase to a total of $583.4 million in the FY 2005 budget is 53 percent over the FY 2004 total for charity care funding. Included in the Appendix is Table 4, representing the 2004 Hospital Charity Care Distribution Amounts prior to the revised formula changes effective July 1, 2004. According to the New Jersey Hospital Association, in 2003, New Jersey hospitals provided $781 million in charity care, yet they received $381 million in state reimbursements; seventy (70) percent of the hospitals received as little as 12 cents for every dollar of charity care they provided.[7] The new formula will adjust funding levels so that no hospital would receive less than 43 cents on the dollar for charity care payments, and those with the highest RCCPs would receive 96 cents for every dollar of charity care.

Funding

Fiscal support for New Jersey charity care program comes through a mix of funding sources. In 1993, the state ended a system of hospital surcharges and instituted the charity care program to reimburse hospitals for the care they are legally required to provide to poor and uninsured patients. The Health Care Subsidy Fund – which funds hospital charity care – is supported by funds diverted from unemployment taxes and the state's general revenue fund. Funding for the FY 2005 budget total of $583.4 million to the state's hospitals will come – in part – through a $50 million transfer from the unemployment insurance fund, a new tax on Health Maintenance Organizations (HMOs) to generate $55 million and $31 million from a new tax on certain non-hospital ambulatory medical facilities (Stainton, 2004).

Issues of High Hospital Rates for Private Payers and the Uninsured

The new formula leaves open for analysis whether or not the state's renewed commitment to charity care for the uninsured will have an impact on rates for private payers. New Jersey hospital leadership has contended that the state's inadequate funding for charity care is one of the primary factors contributing to New Jersey's having hospital rates which are higher than the rest of the country. A recently released report which focused on hospital rates and mark-ups found that New Jersey and Pennsylvania hospitals charge some of the highest rates for care in the country (Institute for Health and Socio-Economic Policy [IHSP], 2004[8]). The study group analyzed the most recent federal cost reports for close to 4,200 hospitals and 30.4 million discharges and compared charges to the cost of care. Prominent study findings pertinent to New Jersey and its neighbor Pennsylvania:

- New Jersey hospitals ranked first in the country, charging an average of nearly 415 percent above the cost of care
- Pennsylvania hospitals ranked fourth, behind California and Florida, with average charges of 308 percent of costs
- Nationally, hospitals charged an average of 232 percent over costs

Hospital representatives in both New Jersey and Pennsylvania commented that "the industry is struggling financially and few patients ever pay the actual charges," adding that the increase in numbers of uninsured patients is the critical policy issue that must be addressed by the states (Goldstein, September 6, 2004). The IHSP report also carries implications for the overall health care market: another key finding from the report was that high hospital charges are, in part, "a result of the hospitals' battle with other segments of the healthcare industry, especially pharmaceuticals and HMOs" (IHSP, 2004).[9]

The revised charity care funding formula in New Jersey carries another "unknown," relating to what kind of impact, if any, the new charity care funding may have on several lawsuits pending against New Jersey hospitals. The lawsuits focus on rates charged to uninsured patients, specifically the disparity between rates charged to uninsured patients and the actual cost of care.[10] (Goldstein, September 6, 2004; *Symptoms & Cures*, August 8, 2004). The U. S. House of Representatives' Committee on Energy and Commerce is actively engaged in focusing on problems in the hospital industry related to billing practices for the uninsured. Financial experts have testified before the committee – chaired by Representative Jim Greenwood (R-Pa.) – that hospitals routinely charge uninsured patients from two to four times higher than patients who are covered by insurance.

Re-visiting Proposed Managed Care Charity Care Reforms (P. L. 1996, C.28)

P.L. 1996, c. 28 authorized the state's charity system to continue for two more years and required delivery system changes for the state's charity care program (see *Timeline*). Specifically, it directed that a new model to provide charity care be developed beginning January 1, 1998 – a model designed on managed care principles. Although the Charity Care Managed Care Advisory Committee developed guidelines, the move to a managed care model was never implemented. During the course of developing a managed care model among stakeholders – including the hospitals, other community providers, the Department of Health and Senior Services and the Legislature – there was a decision to drop the statewide mandate and to allow participation in the managed care model to be voluntary. Participation in the charity care managed care model was made voluntary through P.L. 1998, c. 37, s.2, which amended N. J. S.A. 26:2H-18.59f. As a result of these statutory changes, interest in the charity care managed care model waned as capacity and administrative costs became prohibitive with only voluntary participation. A planned voluntary demonstration was never implemented as concerns grew regarding the projected high start-up costs of managed care networks.

New Jersey, New York And Massachusetts – Three States Committed To Support For Uncompensated Care

The cost of providing health care for uninsured Americans will total $125 billion in 2004, with federal, state and local governments paying as much as 85 percent of the care, according to a Kaiser Commission on Medicaid and the Uninsured (KCMU) study (Hadley and Holahan, 2004).[11] The cost estimate was based on out-of-pocket expenses incurred by uninsured patients, hospitals' costs for uncompensated care, and insurance payments for any coverage the individuals had during the year.

New Jersey and its neighbors New York and Massachusetts represent three state governments that have made a commitment to addressing the issue of hospital care for uninsured. All three states have had decades-long experience in developing, reforming and redesigning their charity care and uncompensated care pools.[12] (See Table 1—"The Evolution of Charity Pools in Three States," and Tables 2 and 3 – "New Jersey Charity Care and Non-Pool Subsidies, Before and After Reform," for a history of the programs in the three states prior to 2000.) As Bovbjerg and his colleagues pointed in their analysis of uncompensated care pools in a time of increased market competition: "Indeed, hospitals are the only medical provider legally required to see patients in extreme need. Most hospitals' charitable capabilities have been eroded by increased price competition, and the few hospitals in each area that provide large amounts of safety net care are especially burdened in the competition for paying patients"[13] (Bovbjerg et al, 2000).

The development and implementation of each state's hospital uncompensated care pool occurred during the 1980s under the regulatory environment of hospital rate-setting. Massachusetts created its pool in 1985[14] and New Jersey's was initiated in 1987. New York's all-payer system incorporated an uncompensated care pool from its beginnings in 1983 (Bovbjerg et al, 2000; Thorpe, 1987). By the early 1990s, all three states deregulated hospital rates: in 1992 both in Massachusetts and New Jersey and in 1996 in New York. Following deregulation, each state continued to maintain its uncompensated care program. New Jersey and Massachusetts[15] shifted their focus from uncompensated care to charity care; New Jersey eliminated the state's reimbursement to hospitals for bad debt (under the Health Care Reform Act of 1992), while Massachusetts continued to cover emergency bad debt (Ibid. at 7). As part of New Jersey's FY 2005 budget recommendations, hospitals are encouraged to use the state's existing bad debt collection program, which had been authorized in the FY 2004 budget. P.L. 2003, c.112 (N.J.S.A. 17B:30-41 et seq.) allows hospitals to voluntarily assign unpaid accounts to a new state entity – the Hospital Care Payment Commission – for set-off against gross income tax refunds, NJ SAVER checks and Homestead rebates to

pay the hospital debts. It is as yet unknown as to how actively the program will be utilized by individual hospitals, which already have their internal bad debt collection mechanisms in place. The program was authorized as a means of assisting New Jersey's hospitals in recouping a portion of the approximately $1 billion in patient charges that hospitals bill but do not collect each year.

The state of Massachusetts' Uncompensated Care Pool (Pool) has experienced recent scrutiny by state lawmakers and advocates as in New Jersey. In 2002, a Special Commission on Uncompensated Care was convened to "devise a fair and equitable allocation of the burden of uncompensated care and free care among affected participants in the health care delivery system" in the Commonwealth. New regulations have recently been proposed (2004) by the state's Division of Health Care Finance and Policy (DHCPP). A significant change in the 2004 regulations was made to the program's "critical access" services: "the Pool will no longer cover hospital outpatient primary care if the hospital is within 15 miles of a community health center, unless the patient's acuity requires a hospital setting." (Reference is made to www.hcfama.org, Health Care for All, for details about the proposed regulatory changes.) Other modifications to Pool regulations include:

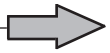
- Processing of applications for Pool eligibility will be handled by the state and not the institution
- The Pool will not longer cover emergency and urgent services for non-residents of Massachusetts
- The Grace Period and Retroactivity for Pool eligibility are reduced to 60 days before the date of application, rather than the current one-year time frame
- Changes to billing, collection and notice requirements.

The state of New York made fundamental changes to its pools following the dismantling of its all-payer rate-setting system under the New York Health Care Reform Act of 1996 (HCRA). The Act transformed the state's original Bad Debt and Charity Care Pool (BDCC) into two discrete pools: the Indigent Care Pool and the Health Care Initiatives Pool – which support both hospitals and community health centers. The pool for funding indigent care subsidies is largely supported by assessments on patient service revenues and payor surcharges on payments made for hospital and certain freestanding clinic services (www.health.state.ny.us/nysdoh/hcra). New York's HCRA was amended in 1999 and again during the 2003 legislative session. The pool funds are currently designated as the Indigent Care and High Need Indigent Care Adjustment Pools. The HCRA allocation for indigent care totaled $847 million dollars per year from 2000 to 2003: $765 million for the Indigent Care Pool and $82 million for the High Need Pool. Unlike the states of New Jersey and Massachusetts, New York law does not require that hospitals have an explicit charity care policy.

New York is one of 13 states with a program to provide health insurance coverage to its working uninsured. The state's Healthy New York program – which makes health coverage available to small employers, sole proprietors and other working individuals seeking to purchase health insurance – reached a milestone enrollment of 100,000 in August 2004. The program begin in 2001 and targets workers who earn too much to qualify for Medicaid or other public programs.

Concluding Remarks

New Jersey, Massachusetts and New York remain among a handful of states that provide specific funding to support the provision of hospital care to uninsured and medically indigent citizens. In a few states – such as Maryland and Colorado – state-funded programs make direct payments to providers of uncompensated care, including primary care clinics.



The State Coverage Initiatives program, a national initiative of The Robert Wood Johnson Foundation, works with states to plan, execute, and maintain health insurance expansions, as well as to improve the availability and affordability of health care coverage. In its 2004 state coverage matrix, it reports that in addition to Medicaid, Medicaid waiver and State Children's Health Insurance Program (CHIP) initiatives, states are also engaged in a variety of state-funded programs to provide health care access to their uninsured residents:

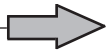
- 13 states provide direct, major-medical health insurance coverage, or premium assistance for private insurance coverage, through programs that are state-designed and state-funded (without federal financial support). They fund or subsidize insurance coverage for those who do not quality for Medicaid or CHIP.
- 32 states operate a high-risk pool to cover otherwise "uninsurable" residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.
- 15 states offer tax incentives and provide tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees.

Critics of charity care and uncompensated care pools argue that they are part of a hospital-centered era in health care that is becoming increasingly less viable in a competitive managed care marketplace. Supporters counter that the types of alternatives outlined above are evolving and carry their own inherent weaknesses and "unknowns." As New Jersey enters its next phase of charity care funding – with a new formula based on equity and core principles developed by the hospitals that are providing the care – state and national experts will be monitoring its progress with great interest.

Policy Implications

Policy analysts who are engaged in the study and evaluation of charity care and uncompensated care programs at the state-level agree that the primary "challenge" areas confronting policymakers include:

- Chronic under-funding of charity care and uncompensated care pools – the state of New Jersey is committed to providing some level of health care access to its uninsured; is the financing of its charity care program adequate and equitable to all funders?
- Shifting and/or unsustainable funding sources for the charity care program – is long-term reliance on the Unemployment Insurance Fund possible?
- Unreliable accounting data from hospitals regarding charges posted vs. actual costs of care – what is the level of transparency regarding the system of hospital billing practice? How can accountability and reporting systems be improved in order to accurately assess the charity care burden on hospitals?
- Growing numbers of uninsured, especially in the state's inner cities and rural areas – the highest uninsured rates are found in the densely populated regions of northern New Jersey (24 percent uninsured in Passaic, Bergen, Union, Essex and Hudson counties, compared to 11 percent uninsured in Gloucester, Camden and Burlington counties). How will the distribution formula remain equitable in an ever-changing environment?
- Will the new formula have an impact on rates for private payers given that hospital leadership has stated that inadequate funding for charity care is one of the primary factors contributing to New Jersey's having hospital rates that are the highest in the nation?
- The policy issues related to hospital charity care are by definition connected to the selected mechanism by which a state is addressing the problem of providing health care and access to its uninsured residents. Is the current hospital-centered infrastruc-



ture a viable model for the future in New Jersey? Or should hospital charity care be balanced with other program initiatives for the uninsured? For example, as a result of recent budget shortfalls, enrollment in the FamilyCare program – which provides health care access to the state's working poor – was halted. Currently, approximately 128,000 adults receive benefits under FamilyCare. What is New Jersey's commitment to support again expanding such programs as part of the infrastructure of providing access and coverage to its uninsured? What ways can program stability be maintained?

- Are there lessons to be learned from the Charity Care Managed Care Advisory Committee guidelines that remain unimplemented? Are there innovative strategies to explore developing charity care managed care networks for outpatient charity care visits?

ENDNOTES

[1] Reference is made to THE MEDICALLY UNINSURED IN NEW JERSEY: A CHARTBOOK, released by the State of New Jersey, Department of Human Services, in collaboration with Rutgers Center for State Health Policy. August 2004. The project was funded under HRSA's State Planning Grant to New Jersey.

[2] According to the New Jersey Department of Health and Senior Services, outpatient charity care accounts for half of the total documented charity care.

[3] Individuals with incomes less than or equal to 200 percent of the Federal Poverty Level (FPL) receive full coverage of their charges ($31,340 for a family of three). The percentage of charges paid by the patient increases incrementally as their income increases between 200 percent to 300 percent of the FPL. Individual assets cannot exceed $7,500 and family assets cannot exceed $15,000. (See www.state.nj.us/health/hcsa/ccfactsh.htm.)

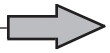
[4] Reference is made to New Jersey Policy Forums' *Issue Briefs* published in 1995 and 1997, for a detailed analysis of the program from its beginnings, and the 1997 *Issue Brief Review*, for updates on the New Jersey Charity Care program. The purpose of this *Issue Brief* is to summarize recent system changes in the context of the current health systems environment and of providers' mechanisms to care for uninsured and under-insured citizens.

[5] Because of the formula-driven basis of the charity care program, there is no room for discretionary changes to the formula.

[6] New Jersey's major teaching hospitals, many of which are located in urban areas, provide a disproportionate share of services to charity care patients, while constituting less than 20 percent of the state's hospitals. In affiliation with the University of Medicine and Dentistry's seven schools, New Jersey's teaching hospitals train more than 1,300 resident physicians, physician assistants, and nurse practitioners each year.

[7] Since 1994 (following the implementation of the Health Care Reform Act of 1992), the state has provided between $300 million to $400 million to hospitals for charity care – about half of the amount that facilities reported to spend on care to uninsured patients (Stainton, 2004).

[8] The Institute for Health & Socio-Economic Policy is a non-profit policy and research group. Its focus is on current political/economic policy analysis in health care and other industries and the constructive engagement of alternative policies with international, national, state and local bodies to enhance, promote and defend the quality of life for all. Its Health Care Advisory Board is comprised of scholars from the Albert Einstein College of Medicine, Boston University, Harvard University, the Canadian National Federation of Nurses' Unions, the New School University and the University of California.



[9] The report also focused on the role of regulation and the assumption that public sector oversight contributes to the reduction of profit and has a negative impact on the public interest. The study found, however, that the most regulated state – Maryland – has the lowest average hospital charges, while the number of Maryland hospitals that are making profits is at the national average, not significantly below it.

[10] In June 2004, class-action lawyer Richard Scruggs filed federal lawsuits in Jackson, Mississippi, against 13 not-for-profit hospitals in eight states alleging they inflated the amount of charity care they provide and employed aggressive "bullying" tactics to collect debts from the uninsured.

[11] The study also found that if the country provided coverage to all the uninsured, the cost of additional medical care provided to this population would be $48 billion, an increase of 0.4 percent in health spending's share of the gross domestic product.

[12] By the mid-1990s, most states had repealed their hospital rate-setting systems and established alternative mechanisms to fund charity care through their hospital systems. Atkinson, Helms and Needleman 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. A significant finding: the level of uncompensated care being provided by hospitals was declining at a time when the rate of uninsured individuals was increasing (*Health Affairs*, July/August 1997).

[13] The state of Maryland has pursued various strategies to expand health insurance coverage for its residents. Maryland's reform initiatives have been centered around the state's unique hospital payment system and its reimbursement of uncompensated care, an evolving Medicaid and children's health program, and regulation of its small group health insurance market. Reference is made to T. R. Oliver's analysis – "Holding Back the Tide: Policies to Preserve and Reconstruct Health Insurance Coverage in Maryland" – published in the *Journal of Health Politics, Policy and Law*, April 2004. The author suggests that the state's incremental approaches to expanding coverage may be generalizable to most state-level activities regarding health reform and "each step toward greater health security, no matter how small, is a major technical and political challenge and that it will be difficult if not impossible to rely on states to secure coverage for all Americans in the foreseeable future." The state of Maine's initiative for universal coverage continues to be closely watched by state and federal policymakers.

[14] The program is administered by the Division of Health Care Finance and Policy; the $345 million Pool is funded through a $215 million assessment on hospitals' private sector charges, a $100 million surcharge on payments from private sector payers to hospitals and ambulatory surgical centers, and a $30 million contribution from the Commonwealth. According to Seifert (2002), the private sector liability to the Pool is $315 million according to state statute; in FY 2002 and FY 2003, the legislature reduced it to $270 million.

[15] Massachusetts' Pool was also modified significantly in 1997 and is at the core of its health safety net. The fund, however, has experienced chronic under-funding and since 1990, allowable uncompensated care costs have exceeded the available funds in all but two years (Massachusetts Health Policy Forum, *Issue Brief*, October 23, 2002).

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APPENDIX

Table I
The Evolution of Charity Pools in Three States

Early Provisions		*Pools under Rate Setting*[a]	*Pools under Compensation*
Chronology	**Early 1970s to early 1980s**	**Mid-1980s to 1990**[b]	**1990s**
Provisions for uncompensated care	Hospital-specific markup allowed.	Broad pools created to redistribute cost of uncompensated care across hospitals (New York in 1983, New Jersey in 1985, Massachusetts in 1987), modified over time.	Pools continued under competitive pricing, but with new funding mechanisms and distribution rules.
Policy concerns, comments	• Uncompensated care high, given recession, health cost inflation. • Distribution of uncompensated care burdens very unequal across hospitals, mismatch with payer base to collect funds. • Payer contributions unequal.	• High rate of growth in pool spending. • Growing political resistance to redistribution across hospitals. • Growing disenchantment with regulation as against market mechanisms. • Focus on hospital needs in order to fund uncompensated care, uniformity of hospital regulation.	• Finding stable funding without rate setting to ensure revenues. • Pool management: extent of redistribution toward high uncompensated care, utilization management. • Relative emphasis on hospitals compared to other providers and insurance for uninsured people. • Emphasis on uninsured need for charity, not hospital need to fund bad debts.

Source: Bovbjerg, R. R., Cuellar, A.E. and Holahan, J. "Market Competition and Uncompensated Care Pools." Occasional Paper No. 35. Assessing the New Federalism. Urban Institute (www.urban.org). March 2000. Authors' compilation.

[a] High-water mark was "all-payer" regulation of all payers, including Medicare, by federal waivers granted in 1983; waivers were dropped or withdrawn in 1985 (Massachusetts and New York) and 1987 (New Jersey).

[b] Hospital rates were deregulated in 1992 (Massachusetts), 1993 (New Jersey), and 1997 (New York).

Table 2
New Jersey Uncompensated Care and Non-Pool Subsidies before and after 1992 Reform (First of Two Reforms)

Before Reform, 1992			*After Reform, 1998*		
Pools/Subsidies (1991)	**Financing**	**Distribution**	**Pools/Subsidies (1993)**	**Financing**	**Distribution**
Uncompensated Care Pool	$912 million statewide surcharge on hospital rates (Medicare withdrew 1989), Medicaid share used for DSH matching.	Distributed to all hospitals with uncompensated care greater than surcharge collection.	Charity Care Pool	$500 million from Unemployment Insurance Trust Fund,* federal Medicaid DSH contribution on full amount.	1993: top 80% of state hospitals in charity care as percentage of 1992 cost base; paid at Medicaid rate.
Other Health Initiatives (from Health Care Cost Reduction Act of 1991)	Up to $40 million from 0.53% tax on hospital revenue, $10 adjusted admission fee.	Grants for innovative health delivery programs or primary care; $8 million for federally qualified CHCs to expand hours; some Medicaid expansion.	Other Uncompensated Care,* A.K.A. "Medicare Shortfall" Fund	$100 million from Unemployment Insurance Trust Fund.**	Top 45% of hospitals in OUC percentage.
			Hospital Relief Subsidy Fund	$110.4 million.	Hospitals with high caseloads of specified high-risk diagnoses; AIDS, high-risk pregnancy, TB, substance abuse, and mental illness
			Hospital Relief Subsidy Fund-Mentally Ill, Developmentally Disabled	$15.4 million.	Hospitals with high loads of mentally ill and developmentally disabled.
			Other	No Change	

Source: Bovbjerg, R. R., Cuellar, A.E. and Holahan, J. "Market Competition and Uncompensated Care Pools." Occasional Paper No. 35. Assessing the New Federalism. Urban Institute (www.urban.org). March 2000.
Evans (1997)

Notes: *To decline over 3 years (1995 level was $400 million), to be replaced with general funds.
**To decline over 3 years (1995 level was $33 million), to be phased out thereafter.

Table 3
New Jersey Charity Care and Non-Pool Subsidies, Before And After Reform

Before Reform, 1997			*After Reform, 1998*	
Pools/Subsidies	**Financing**	**Distribution**	**Financing**	**Distribution**
Charity Care Pool	Unemployment Insurance Trust Fund ($300 million).	Covers documented charity cap (not bad debt); distributed to hospitals based mainly on payer mix (shiftability), also on profitability; about 90% of hospitals receive funds.	$320 million Unemployment Insurance Trust Fund, tobacco tax, general revenues.	No change.
Hospital Relief Subsidy Fund	$124.5 million from state appropriations, Unemployment Insurance Trust Fund.	About 30 hospitals with high patient loads of AIDS, high-risk pregnancy, TB, substance abuse and mental illness.	$183 million.	Two more categories 32 hospitals.
Hospital Relief Subsidy Fund for Mentally ill and Developmentally Disabled	$17.5 million from state appropriations, Unemployment Insurance Trust Fund.	Distributed to hospitals for maintaining mental illness, developmental disability beds; about 30 recipients.	$20 million.	No change.
Other	Assessments on hospital revenue ($40 million).	$8 million to federally qualified community health centers; grants for innovative programs, etc.	No change.	No change.

Source: Bovbjerg, R. R., Cuellar, A.E. and Holahan, J. "Market Competition and Uncompensated Care Pools." Occasional Paper No. 35. Assessing the New Federalism. Urban Institute (www.urban.org). March 2000.
Assessing the New Federalism (Evans 1997; Bovbjerg et. al. 1998; Wiggins 1997).

Notes: State spending also claimed for federal DSH funding. Dollars are nominal.

Table 4

State of New Jersey, Department of Health and Senior Services, Health Care Systems Analysis: 2004 Hospital Charity Care Distribution Amounts

Hospital Name	Final 2004 Charity Care Subsidies
Atlantic City Medical Center-City	6,431,365
Atlantic City Medical Center-Mainland	987,992
Barnert Hospital	2,266,942
Bayonne Hospital	804,125
Bayshore Community Hospital	245,342
Bergen Regional Medical Center	21,797,200
Beth Israel Hospital (Passaic)	3,632,264
Bon Secours - St. Mary Hospital (Hoboken)	9,468,893
Burdette Tomlin Memorial Hospital	221,562
Capital Health System at Fuld	12,277,231
Capital Health System at Mercer	714,863
Cathedral Healthcare System	23,182,877
CentraState Medical Center	651,066
Chilton Memorial Hospital	123,322
Christ Hospital	5,326,251
Clara Maass Medical Center	721,298
Columbus Hospital	545,307
Community Medical Center	892,870
Cooper Hospital/University Medical Center	16,883,182
Deborah Heart & Lung Center	6,833,474
East Orange General Hospital	10,232,629
Englewood Hospital and Medical Center	967,391
General Hospital Center at Passaic	347,626
Greenville Hospital	1,298,750
Hackensack University Medical Center	3,544,851
Hackettstown Community Hospital	134,623
Holy Name Hospital	331,610
Hospital Center at Orange	474,694
Hunterdon Medical Center	493,369
Irvington General Hospital	473,937
Jersey City Medical Center	50,125,756
Jersey Shore Medical Center	1,376,381
JFK Medical Center at Edison	281,359
Kennedy Memorial Hospitals-UMC	1,785,212
Kimball Medical Center	946,233
Meadowlands Hospital Medical Center	145,458
Memorial Hospital of Salem County	36,232
Monmouth Medical Center	1,826,742
Morristown Memorial Hospital	2,025,773
Mountainside Hospital	580,245
Muhlenberg Regional Medical Center	2,382,720
Newark Beth Israel Medical Center	15,847,535
Newton Memorial Hospital	758,952
Ocean Medical Center	299,506
OLOL MC Camden/Burlington	1,582,972
Overlook Hospital	660,132
Palisades Medical Center of New York	2,132,286
Pascack Valley Hospital	179,819
Rahway Hospital	256,978
Raritan Bay Medical Center	14,973,734
Riverview Medical Center	461,255
Robert Wood Johnson University Hospital	2,489,022
RWJ University Hospital at Hamilton	387,592
Shore Memorial Hospital	135,186
Somerset Medical Center	325,074
South Jersey Hospital	621,450
South Jersey Hospital, Elmer	50,952
Southern Ocean County Hospital	114,777
St. Barnabas Medical Center	1,240,557
St. Clare's Hospital, Denville	2,161,062
St. Clare's Hospital, Sussex	73,718
St. Francis Medical Center (Trenton)	2,281,221
St. Joseph's Hospital & Medical Center	25,766,854
St. Joseph's Wayne Hospital	333,739
St. Mary's Hospital (Passaic)	5,555,213
St. Peter's University Hospital	777,594
Trinitas Hospital	26,346,074
Underwood Memorial Hospital	529,138
Union Hospital	392,192
University Hospital/UMDNJ	78,982,267
University Medical Center at Princeton	241,340
Valley Hospital	328,960
Virtua Health System, Burlington	207,582
Virtua Health System, West Jersey Hospitals	292,488
Warren Hospital	435,861
West Hudson Hospital	155,802
William B. Kessler Memorial Hospital	34,101
TOTALS	**381,232,000**