THE CAPITOL FORUMS
On Health & Medical Care

HOW WILL NEW JERSEY FUND CHARITY CARE & SUBSIDIZED HEALTH INSURANCE AFTER DECEMBER 31?

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HOW WILL NEW JERSEY FUND CHARITY CARE & SUBSIDIZED HEALTH INSURANCE AFTER DECEMBER 31?

The Issue:

Close to 1.1 million individuals in New Jersey are uninsured. Since 1980, the state has defined charity and subsidized care for the uninsured (charity care and bad debt) through its hospital system. Currently, the means for financing charity care (excluding bad debt) is by diverting monies from the Unemployment Trust Fund. The legislation authorizing this method of financing expires in December 1995.

As the state moves forward to restructure its Medicaid program in an effort to expand care to uninsured individuals, and as it embarks on implementing its subsidized health insurance program, Health Access New Jersey, how will the state finance these efforts to provide health care to the uninsured and continue financing charity care in its hospital system?

PROFILE OF UNCOMPENSATED CARE

History

New Jersey has long been a state in the forefront of health policy, in particular regarding hospital payment systems. Under New Jersey law (N.J.S.A. 26:2H et seq.; N.J.A.C. 8:31B-4.37), hospitals are prohibited from denying persons medically necessary treatment if the hospital has the medical capacity to provide such care. Full reimbursement for uncompensated care provided to uninsured individuals had been a cornerstone of New Jersey's all payer hospital reimbursement system since its inception in 1980. The uninsured are those individuals who do not qualify for Medicaid and who, for the most part, cannot afford private health coverage. (Reference is made to Capitol Forum Issue Brief, April 5, 1995: ***The Uninsured - An Unresolved Problem***, for a profile of the uninsured population in New Jersey.)

The hospital reimbursement system, which was authorized under P.L. 1978, c. 83 (N.J.S.A. 26:2H-4.1; N.J.A.C. 8:31B), 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 do not pay. New Jersey's uncompensated care program differed from other states, including Massachusetts, New York and Maryland, in that it provided full reimbursement for all approved uncompensated care (Berliner and Delgado, 1993).

Since 1980, New Jersey's hospital system has developed from a completely all-payer system (with all hospital reimbursement rates comparable) to a partial all-payer system, in which the Federal Medicare program (the largest payer for hospital services) paid a separate rate based on diagnosis-related groups (DRGs) and currently to an unregulated system, with some allowances made for charity care. The deregulation of the hospital rate setting system now allows hospitals to establish their own pricing structures and payers can seek discounts from those rates in a competitive market environment (Ibid).

Against this background, the provision of charity care by hospitals has been a consistent presence. Historically, hospitals provided medical care to indigent patients and costs either were absorbed by the hospitals themselves, usually through some of cost shifting, or supported by philanthropic means. The regulating of hospital rate setting and reimbursement systems prohibited such cost-shifting. And as the costs of medical care increased exponentially and the number of uninsured residents grew, hospitals could no longer depend on cost-shifting and philanthropic sources to subsidize indigent care. In particular, urban hospitals in the state, which serve a disproportionate share of indigent clients, have increasingly come to depend upon a system of charity care for their survival. Public hospitals and clinics, which have traditionally been responsible for treating the indigent and uninsured, have undergone severe cutbacks in Federal and state support during the last decade. A recent report predicts that up to 40 percent of the country's 450 public hospitals could close within the next ten years (The New York Times, September 17, 1995.) Barring direction from the Federal government, the states have been left with the challenge to develop responsible financing mechanisms to pay for and provide access to health care for their uninsured residents.

Charity Care, Bad Debt and Uncompensated Care

Within the hospital payment system, uncompensated care has historically be divided into two significantly different sub-groups: charity care and bad debt. Charity care is care provided to patients who can document that they are financially unable to pay for the services they receive. Charity care reimbursement recognizes that there are some New Jersey citizens who are "medically indigent," i.e., they do not have the means to pay for health care and yet are ineligible for Medicaid or other health care entitlement programs. New Jersey uses a scale based on the Federal poverty level to establish eligibility for charity care.

Bad debt accrues when care provided to patients who, after repeated collection efforts by the hospital, do not pay the bill. According to the New Jersey Department of Health, in the experience of its Uncompensated Care Trust Fund, bad debt, that is bills designated as uncollectible, comes from two sources: uninsured self-pay patients who cannot pay for their care, and the balance left after 3rd party payment when the insurer did not pay the full amount of the bill. The complexities of holding patients responsible for payment of co-payments, payments of deductibles and payment for non-covered services under their insurance plans adds to the problem of bad debt for the hospitals.

From the early 1980s, New Jersey had designed and utilized a system of hospital regulation to control health costs and to provide access to care. This system involved the state's authority to set rates through DRGs and its administration of the Uncompensated Care Trust Fund, which was financed by a surcharge imposed on every hospital bill. While the surcharge initially ranged from 7-to-9 percent added to each hospital bill in 1986, the surcharge had increased to 19 percent by 1992. The Fund guaranteed payment to hospitals not only for documented charity care, but for all bad debts not covered after specific collection efforts had been exhausted. One of the primary complaints from the hospitals about the Trust Fund was that the patients were not compliant about returning documentation regarding indigence or about disclosing the required personal financial information.

However, multiple factors led to the Fund's problems, including the withdrawal of Medicare payments for uncompensated care (in 1988), the growth of the state's uninsured population, the inequities involved with financing, questionable administrative practices by providers, and the increases in bad debt, since the program had little incentive for hospitals to pursue collection from delinquent patients (Berliner and Delgado, 1993). All of these factors led to the increased costs of uncompensated care.

Health Care Reform Act of 1992 and Its Effect on Uncompensated Care

The passage of the Health Care Reform Act of 1992 signaled a significant change in the state's approach to assure its citizens access to health care. It repealed Chapter 83, eliminating the rate-setting system New Jersey adopted in 1980. It established a new mechanism to fund charity care without violating the 1974 Employee Retirement Income Security Act (ERISA) and it contained the element of insurance reform, which was aimed at developing insurance programs for individuals and small groups. New Jersey joined many other states with its insurance reform initiative facilitating access to insurance: if health insurance could be made more affordable and accessible to residents, then the number of charity care and bad debt patients would decrease and the amount of uncompensated care in the hospitals would be reduced.

The chain of events leading to Health Care Reform Act 1992 were significant in that it involved both legislative and judicial system actions regarding health care in New Jersey. In May 1992, Judge Alfred Wolin ruled that many components of the state's hospital reimbursement system (Chapter 83) were in violation of the ERISA law; this Federal act limits states' rights to tax or regulate health benefits provided by self-insured firms or union plans. Specifically, the Court ruled that the uncompensated care surcharge, discounts to Blue Cross and the program to reimburse hospitals for Medicare shortfalls forced self-insured funds to pay for the care of others.

With the implementation of the Health Care Reform Act of 1992, the Uncompensated Care Trust Fund was eliminated and hospitals entered into a deregulated, competitive market for health care, in which they are free to negotiate agreements with insurers and managed care providers and to set prices for their services. Consequently, New Jersey, which was the first state that adopted DRGs as a method for reimbursing hospitals and reimbursed hospitals fully for their uncompensated care, moved to a system under which the state no longer set hospital rates and was no longer participating in assisting hospitals for their own bad debt (Berliner and Delgado, 1993). Recovery of "bad debt" accounts became the sole responsibility of the individual hospital, and charity care was reimbursed by the state's Health Care Subsidy Fund.

Health Care Subsidy Fund

The New Jersey Essential Health Services Commission, which was established under Health Care Reform Act of 1992, oversaw payments to hospitals for charity care through the Health Care Subsidy Fund. The program of hospital charity care subsidies paid out an estimated $450 million in 1994. This charity care program differs from the Uncompensated Care Trust Fund in that it does not pay for any hospital bad debt, but only for care provided to patients whose eligibility for charity care can be documented. The Fund is currently being financed by surplus state unemployment revenues, a significant shift from the state's historical position of relying on a surcharge to subsidize charity care. Under the Health Care Reform Act, this method of financing through revenue diversion from state unemployment revenues expires on December 31, 1995.

COSTS OF PROVIDING CHARITY CARE IN NEW JERSEY

During the period from 1986 to 1990, under the rate setting system, charity care payments to hospitals increased from $148,875,000 to $153,426,000. For the same period, hospital bad debt payments increased from $276,272,000 to $626,502,000. Total uncompensated care payments to hospitals were close to $780 million. By 1992, the Uncompensated Care Trust Fund's last year of operation, over $754 million had been paid to hospitals for uncompensated care in New Jersey. Under the funding provisions of the Health Care Reform Act of 1992, the Health Care Subsidy Fund may provide the following amounts for charity care: $500 million in 1993; $450 million in 1994; $400 million in 1995; $350 million in 1996 and $300 million in 1997. Bad debt must be absorbed by the individual hospital provider.

The Fund also includes a smaller program of uncompensated care subsidies which was designed to recognize Medicare shortfalls. The program, which supports fewer hospitals each year at declining levels, is intended to ease the transition for high Medicare hospitals to a deregulated environment. In 1994, the allotment under the Fund for Medicare shortfalls was $67 million, decreasing to $33 million for 1995. Under the Health Care Reform Act, the program is not authorized after 1995.

During the past two years, the Fund has come under criticism from different fronts, including business and industry leaders who are concerned about tapping the state's unemployment revenues and view it as a "tax" of sorts on employees and employers. The New Jersey Hospital Alliance, which represents 22 urban hospitals, have also raised criticism about the Fund. The urban hospitals, which provide care to high numbers of indigent patients, contend that the Fund's distribution method is "flawed and unfair." (Modern Healthcare. August 8, 1994.) Citing overly stringent documentation procedures for charity care reimbursement, the hospitals pointed out that while $315 million in charity care funds were distributed in 1994, the Health Care Subsidy Fund provides as much as $450 million in funds under the Health Care Reform Act funding provisions.

ALTERNATIVE FINANCING MECHANISMS FOR CHARITY CARE: The Experience of Other States

In 1990, when then Governor James Florio convened the Commission on Health Care Costs, there was agreement among all members that the method of financing uncompensated care through a surcharge on patient bills was not a fair way to collect the funds. They acknowledged that the surcharge was also making health insurance more unaffordable to greater numbers of New Jersey citizens because of the increase in premiums being imposed as a result of the surcharge on hospital bills. Included among the suggestions for alternative funding mechanisms were: a flat tax per each employed person in the state; a value-added medical services tax and mandating insurance.

Many states are also investigating similar alternative funding mechanisms for subsidizing charity care. Most states are in agreement that the goal continues to be to develop a broad-based financing mechanism that would fairly distribute the societal burden and at the same time make health insurance more accessible and affordable for all individuals and employers in the state. There is variation, however, in the ways by which states identify and address the problem of financing uncompensated care for their medically indigent residents. Three general approaches utilized by the states to address the problem of uncompensated care are: (1) supporting and subsidizing local governments, i.e., cities and counties that provide care to uninsured residents; (2) directly subsidizing the hospital providers; and (3) identifying uninsured individuals and providing expanded coverage or subsidies to them for their health care costs. A recent trend which has emerged is based on the demographic reality that the majority of the uninsured are employed by small businesses: 43 states have enacted legislation to assist employers with fewer than 50 workers with purchasing health insurance for their uninsured workers. (Health Care Financing and Organization, July 1995).

Reviews of state health reform efforts in general during 1995 continue to indicate that while many states launched bold and ambitious health care reform programs in the early 1990s, most are currently taking a much slower path to reform. In the aftermath of the Clinton Administration's unsuccessful bid to reform health care on a national level, and with most states experiencing significant budget deficits and greater numbers of uninsured residents, many of the more comprehensive health reform plans are currently "stalled" (The New York Times, July 2, 1995). Florida, which has withdrawn a health reform plan

requiring that employers provide health insurance, is one of six states, along with Hawaii, Massachusetts, Minnesota, Oregon and Washington, that had enacted formal commitments to universal health coverage. None of these states, including others that had considered similar provisions for health care reform, has moved forward with them. A national review of state health reform plans indicated that in 1994 and 1995, comprehensive health reforms, such as universal coverage and cost containment, were rejected in favor of incremental steps that reform insurance laws and allow Medicaid waiver programs, especially enrollment in managed care plans and eligibility expansion to other low-income residents (The New York Times, July 2, 1995).

Currently, states are constrained to reduce Medicaid spending while, at the same time, the number of people without insurance continues to grow. As several states, including New Jersey, are attempting to expand their basic Medicaid programs for low-income individuals, the number of uninsured people is rising in the United States by 1.1 million annually, up to 40.9 million in early 1994, over 16 percent of the total population of the U.S. (Ibid.) New Jersey's uninsured population was 1,089,000 in 1993, or 13.7 percent of the state's population (Capitol Forum Issue Brief, April 2, 1995).

States continue to utilize a range of methods to finance the care of medically indigent residents, including direct appropriation of state funds, general sales tax or special purpose excise taxes, taxes on hospitals or other health care providers, license fees, rate-setting "add-on" mechanisms, and taxes on employers. However, given the current climate of tax cuts, financing any part of health care through tax increases or new taxes is not a politically viable alternative for most states.

The states of Minnesota, Vermont and Washington help to pay health care costs with tobacco and alcohol taxes and hospital surcharges. The states of Connecticut, Maryland, Massachusetts and New York use various mechanisms to provide for uncompensated care costs, creating charity and bad debt pools. The state of New Mexico allows specific counties to assess an additional sales tax to fund indigent care. Minnesota has put off its decision on a tax package that would pay for health insurance for its uninsured population of approximately 300,000 until the end of this year. The state is awaiting court action as its two percent tax on providers is being challenged by self-insured plans (Health Care Financing and Organization, July 1995).

Historically, Federal ERISA laws have prohibited states from certain types of broad insurance reform affecting self-insured health plans. A recent Supreme Court decision involving a challenge to New York State's hospital surcharge system (New York State Conference on Blue Cross and Blue Shield Plans v. Travelers Insurance Co.) found that the suit was invalid and that the surcharges were not pre-empted by Federal ERISA laws. While the court decision has a direct impact on New York, the decision may have wide implications for other states interested in pursing hospital or provider taxes to fund charity care or subsidize insurance premiums for low-income residents currently without insurance (State Initiatives in Health Care Reform, July-August, 1995). While ERISA has clear prohibitions against states enacting employer mandates, against the regulation of terms and conditions of self-insured employer health plans, and against the imposition of insurance market reforms on self-insured plans, it has not been clear if state surcharges or taxes that may have an indirect effect on employer benefit plans are prohibited by ERISA (Ibid.)

In light of this Supreme Court decision, Connecticut Governor John Rowland recently requested that the State Legislature reinstate its hospital tax, which had been declared illegal by the lower courts. The state had initiated a six percent sales tax on hospital bills and an eleven percent assessment on hospital gross receipts. It is also anticipated that this Supreme Court decision may have an impact on the state of Minnesota's pending case regarding provider taxes. (State Initiatives in Health Care, July-August, 1995). There is agreement among health policy experts that other states may look at this decision as a means to assume greater flexibility in devising tax-like programs to fund charity care for uninsured residents (Ibid).

NEW JERSEY'S RESTRUCTURING OF HEALTH CARE DELIVERY

New Jersey continues to move forward with its health reform efforts to expand coverage for its uninsured population, working towards a revised structure for the delivery of health care to its citizens. As managed care enrollment for the state's Medicaid recipients continues, New Jersey is also moving ahead with its Section 1115 waiver program to restructure Medicaid eligibility to cover more individuals who are currently uninsured. As with the waiver programs in Massachusetts, Oregon, Kentucky and Tennessee, the program allows for mandatory managed care for Medicaid recipients and the monies saved are used for coverage expansion.

The Health Access New Jersey (Access) program, which developed from the 1992 Health Care Reform Act, is aimed at lower income residents who do not qualify for Medicaid. Subsidies are provided to help program participants purchase private insurance from the state's individual insurance market. While funds for the Access program are currently available from the Unemployment Insurance Trust Funds, with a $50 million subsidy designated for the program, there are

no funds allocated for 1996 (Capitol Forum Issue Brief, April 26, 1995).

Both of these initiatives focus on improving access, lower costs and expanding services to Medicaid recipients and to uninsured and underinsured residents. As emerging programs such as Medicaid managed care, which has the primary goal to reduce inappropriate hospital emergency room utilization by Medicaid patients, continue to expand in New Jersey, what is the anticipated impact on hospital utilization by these groups?

Public funding of uncompensated care has historically focused primarily on hospitals based on a variety of inter-related factors. Hospitals are the largest component of the health care industry, and hospital care is more expensive than primary care on a per patient basis. Also, most state and local government programs that pay for health care for uninsured low-income persons focus on hospital care since many uninsured low-income persons use the hospital emergency room as their primary source of care. As New Jersey continues with its re-structuring of its health care delivery systems, how do these efforts dovetail with the state's funding of uncompensated care in the hospital system?

Four of the new section 1115 waiver states — Florida, Hawaii, Kentucky and Tennessee — are reducing or discontinuing Medicaid Disproportionate Share Hospital payments to hospitals and re-channeling these revenues to the uninsured (National Health Policy Forum Issue Brief, No. 662, February 1995). What are New Jersey's plans regarding this method and how will the diversion of Disproportionate Share Hospital payments, if planned, affect New Jersey's hospital system?

CONCLUSION

In the absence of direction from the Federal government regarding health care reform and with looming cutbacks expected in the Medicare and Medicaid programs, the individual states continue to experiment with various methods to provide health care to their uninsured residents. An emerging trend appears to be the putting forth of more incremental measures and model experiments on a smaller scale as a means to test the waters, before full-scale reforms are implemented.

Regarding the responsibility of subsidizing charity care, what are current public attitudes in New Jersey? This question is significant as New Jersey's laws and policies must have as a "backbone" the collective values of its residents and leaders, most especially in this time of a rapidly changing health care environment. A recent poll conducted by Eagleton Institute, for the New Jersey Hospital Association reported an interesting finding: when asked about the question of subsidizing charity care, 93 percent of those polled in New Jersey believe residents who cannot pay for hospital care should still receive it (The Trenton Times, September 8, 1995). In responses to more specific questions about funding charity care in the state, 79 percent of those New Jersey residents polled reported that they would support increasing taxes on alcohol or cigarettes to pay for indigent care. Regarding other alternative charity care subsidy methods, 55 percent responded that they would support a 1-cent increase in the state's 6 percent sales tax to pay for charity care, while 44 percent would support a 1 percent increase in state income taxes for charity care (Ibid). The results of the poll are interesting as they reflect the view that New Jersey citizens feel strongly that charity care be a part of the state's health care system and that they are willing to consider increased taxes in order to subsidize this care.

New Jersey proceeded with a major reform of its health care system with the implementation of the Health Care Reform Act of 1992. Our state continues to explore innovative models as it rises to the challenge of funding charity care, while ensuring access to health care and keeping down health and medical costs through responsible insurance reform. What is the state's most fiscally responsible position regarding the continuation of charity care subsidies and insurance reform initiatives? At this juncture in health care reform, will New Jersey join other states in a more incremental approach to reform, or will we take a more broad-sweeping action, as we have in the past?

QUESTIONS FOR DISCUSSION

Charity Care

- Given the implications of the Supreme Court decision and interpretation on ERISA's impact on states and health insurance reform, is New Jersey in a position to consider hospital or provider taxes as a resource to fund charity care?
- How do we maintain the viability of urban hospitals, which have long been responsible for treating the indigent and uninsured, within out state? Is it a realistic expectation that private hospitals, whose occupancy rates are down as a result of managed care, will move to accept and treat these clients?
- Hospital admissions continue to decrease, leading to declining occupancy rates. As mergers, consolidation and closures become more evident, how will New Jersey's economy be affected? What will be the impact on health workers and facilities?
- What is the future of Medicaid disproportionate share payments to hospitals? How will proposed cutbacks affect this component of the Medicaid program and New Jersey's share of it?

Bad Debt and Undocumented Residents

- When an undocumented resident receives hospital services, these individuals cannot provide the necessary documentation to receive charity care. Consequently, hospitals that provide care to New Jersey's undocumented residents will generate bad debt, for which they will not be reimbursed (Capitol Forums Issue Brief, April, 1995). What is the state's role in ensuring that the undocumented receive adequate care and the hospitals and providers receive adequate funds to provide these services?

General Questions

- A recent study of some 40 state-sponsored measures to assist small employers to purchase health insurance for their uninsured workers indicated that such efforts will have a "modest" effect on widening health coverage to uninsured residents (Health Care Financing and Organization, July 1995). While efforts put forth to make coverage affordable varied — from allowing insurers to offer "bare bones" policies to offering minimal tax subsidies or tax credits to firms to help them buy insurance — the researchers did not anticipate any significant inroads regarding the problems of the uninsured. How will New Jersey identify new "access points" in the health care system in which to test new reform efforts in order to widen health coverage for its growing uninsured population?
- In a recent New York Times interview, Bruce Vladeck, who heads the Federal Medicare and Medicaid programs, cautioned that the future of Medicaid waivers is "clouded," noting that under proposed budget cuts and debate about "restructuring" Medicaid, none of the Medicaid waivers were likely to be sustained. Even with savings from managed care, under Section 1115 waivers, there would not be enough money to pay for additional people without insurance. How will the state handle its coverage of acute and non-acute care for its uninsured and Medicaid populations?
- The state of Oregon, in its efforts to define the state's responsibility for providing health care to its citizens, has within its reform plan a public policy definition of the socially acceptable minimum level of care to which everyone should have access. As legislators and policy makers accept the challenge of providing accessible, affordable and quality health care to all New Jersey citizens, where do we stand on the question of identifying an acceptable level of care?

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