Caring for the New Uninsured: Hospital Charity Care for Older People without Coverage

Derek DeLia, PhD

Despite near-universal coverage through Medicare, a number of elderly residents in the United States do not have health insurance coverage. To the author's knowledge, this study is the first to document trends in the use of hospital charity care by uninsured older people.

Data from the New Jersey Charity Care Program, which subsidizes hospitals for services provided to low-income uninsured people, were used to analyze trends in charity care utilization by older people from 1999 to 2004. Charity care charges are standardized to uniform Medicaid reimbursement rates and inflation adjusted using the Medical Care Consumer Price Index.

From 1999 to 2004, use of charity care by older people grew much faster than it did for younger patients. As a result, older people now account for a greater share of hospital charity care in New Jersey than children. Elderly users of charity care generated higher costs per patient than their younger counterparts. Cost differences were especially salient at the upper end of the distribution, where high-cost elderly patients used significantly more resources than high-cost patients in other age groups.

These results highlight an emerging source of strain on the healthcare safety net and point to a growing population of uninsured residents who have costly and complex medical needs. Similar experiences are likely to be found in other states, especially those that have growing populations of elderly immigrants who are likely to lack health insurance. **J Am Geriatr Soc 54:1933–1936, 2006.**

Key words: elderly; uninsured; charity care; distribution of medical care costs

Medicare offers nearly universal coverage to residents of the United States who are aged 65 and older. As a result, initiatives to address the uninsured have focused on nonelderly populations. Nevertheless, a recent study found that approximately 350,000 elderly residents of the United States were uninsured in 2000.[1] These individuals include immigrants who came to the United States late in life, as well as longtime residents who have spent insufficient time in officially recognized employment to qualify for the program. Because of population aging and growth in immigration, the number of uninsured elderly residents is likely to increase in the coming years.[2–4]

The uninsured of all ages depend on uncompensated care from safety net providers. In 2004, this care was valued at approximately $40 billion, with hospitals accounting for two thirds of the total.[5] It is likely that uninsured older people will also turn to hospitals for a great amount of unreimbursed medical care.

There has been no published analysis of hospital charity care delivered to uninsured older people. This is an important gap in the literature, because older people require more-extensive and -costly medical services than younger populations. In addition, the emergence of an elderly population of uninsured patients will likely add to the financial stress already faced by safety net hospitals.[6]

A unique database used to administer the Hospital Charity Care Program in New Jersey provides an opportunity to describe the use of charity care by older people. This database is used to answer the following questions.

1. How prevalent is the use of hospital charity care by older people, and how has this use changed in recent years?
2. What are the costs of charity care utilization by older people, and how have these costs changed in recent years?
3. How does charity care use by older people compare with corresponding use by younger populations?

NEW JERSEY'S CHARITY CARE PROGRAM

Before describing the research methodology, it is useful to outline key elements of the Hospital Charity Care Program. The program provides subsidies to hospitals that serve qualified uninsured and underinsured patients and receives federal support through the Medicaid Disproportionate Share Hospital subsidy. Charity care payments to hospitals are based on the state's Medicaid reimbursement rates, including add-ons for graduate medical education where appropriate. Because of chronic funding shortfalls, the total

From the Center for State Health Policy, Institute for Health, Health Care Policy, and Aging Research, Rutgers, The State University, New Brunswick, New Jersey.

Address correspondence to Derek DeLia, PhD, Assistant Professor/Senior Policy Analyst, 55 Commercial Ave., 3rd Floor, New Brunswick, NJ 08901. E-mail: ddelia@ifh.rutgers.edu

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amount of charity care payments is much less than the amount New Jersey Medicaid would have paid for the same services. For example, in the state's fiscal year 2004, hospitals statewide received $381 million in charity care payments for services that would have generated $778 million in revenue if reimbursed at the state's full Medicaid rates.[7]

Patients qualify for charity care if they meet certain conditions. First, they must have no health insurance or have coverage that pays for only part of the hospital bill. Second, they must be ineligible for public insurance coverage. Third, patients with income below 200% of the federal poverty level (FPL) receive free care, and those with income between 200% and 300% of the FPL receive income-based discounts. Patients with income above 300% of the FPL are not eligible for charity care. Fourth, individual assets (excluding primary residence and automobile) cannot exceed $7,500, and family assets cannot exceed $15,000. Individuals may spend down to these limits to qualify for charity care.

Elderly recipients of hospital charity care in New Jersey are individuals who do not have Medicare coverage or have exhausted the cap built into the standard Medicare benefit. Although underinsured patients may receive charity care, this feature does not apply to Medicare patients who do not pay their deductibles and coinsurance. The Medicare program requires hospitals to make "reasonable efforts" to collect fees from beneficiaries and, if unsuccessful, to bill Medicare for patient bad debt.[8] Medicare bad debt is not reimbursable through the Hospital Charity Care Program.[9]

METHODS

Data

Analysis is based on the entire universe of adjudicated charity care claims submitted by hospitals to the state from 1999 though 2004. These data include information about patient diagnoses, procedures received, age, and income category. The database contains 398,400 inpatient admissions and 4.47 million outpatient visits for patients of all ages in all 6 years combined. To protect patient privacy, individuals are not identified in the charity care data. As a result, some of the utilization presented in this article includes repeat users within and across study years.

The database used in this study has several advantages over other sources of charity care data. First, researchers often analyze charity care in combination with patient bad debt. Although charity care and bad debt are conceptually distinct, hospitals vary considerably in the way they define and report them, making it difficult to separate the two.[10,11] In addition, the American Hospital Association Annual Survey of Hospitals, which is a key source of national data about uncompensated care, contains limitations even in its ability to measure the combined total of charity care and bad debt. These include differences in charge systems used to calculate uncompensated care expenses and differences in the reporting period used by hospitals (e.g., fiscal vs calendar years). Also, American Hospital Association survey data (which are aggregated at the facility level) do not provide patient-level information.

To avoid the inclusion of bad debt in charity care claims, hospitals in New Jersey must satisfy a number of requirements before submitting a claim. Hospitals must interview charity care applicants and certify that those receiving charity care services meet income and asset requirements and are ineligible for public coverage. Hospitals receiving charity care subsidies must follow state guidelines for pursuing bad debts that are not eligible for charity care reimbursement. Each year, the New Jersey Department of Health and Senior Services conducts one or more sample audits of each hospital's charity care claims to determine compliance.[12]

All charity care charges are priced at rates that New Jersey Medicaid would have paid for services (excluding add-ons for graduate medical education), which is the baseline for determining each hospital's charity care subsidy. Because Medicaid typically reimburses hospitals for less than the full cost of care,[13] Medicaid reimbursement rates generally understate the true costs of hospital care. Nevertheless, amounts priced by Medicaid facilitate comparisons across hospitals and across groups of patients, because payments are based on a uniform statewide standard. All dollar amounts in this study are adjusted for inflation with the Medical Care Consumer Price Index, using 2004 as the base year.

Analysis

To answer the first study question, trends in total utilization by older people (aged $\geq$65) were tabulated for every year of the study. Utilization is measured as the total number of outpatient visits, inpatient admissions, and inpatient days. Because of confidentiality restrictions, repeat users of hospital charity care cannot be identified in the database. Therefore, utilization variables measure the total volume of care delivered and not the total number of patients receiving care. To answer the second study question, total costs (i.e., inflation-adjusted Medicaid charges) associated with utilization by older people are tabulated for each year of the study. To answer the third study question, trends in total utilization and costs for children (aged $\leq$18) and nonelderly adults (aged 19–64) were also tabulated.

RESULTS

The vast majority of charity care users have family income below 200% of the FPL and therefore do not pay anything out of pocket for hospital services. In every year of the study, more than 90% of elderly and nonelderly charity care patients had income at this level.

From 1999 to 2004, the total volume and costs of charity care for older people grew rapidly (Table 1). For all charity care utilization and cost measures, growth in older people exceeded the corresponding growth for children and nonelderly adults. For children, inpatient charity care utilization and total charity care costs declined during the study period. As a result, older people have surpassed children in their use of hospital charity care in New Jersey. A series of chi-square tests, which show significant changes in the age distribution of charity care users, confirmed the shifting distribution of charity care use from children to older people. For all four measures of charity care utilization, the *P*-value corresponding to the chi-square test was less than .001.

On average, older people generate higher costs per inpatient admission than younger charity care users. In 2004,

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Table 1. Trends in Charity Care Use by Age Group in New Jersey, 1999–2004

Use	1999	2000	2001	2002	2003	2004	Percentage Change, 1999–2004
Outpatient visits, n							
Children	34,520	31,308	41,407	47,802	57,563	46,067	33
Nonelderly adults	552,863	567,878	538,994	603,231	875,060	875,266	58
Elderly	19,050	24,261	27,882	35,705	46,348	49,139	158
Inpatient admissions, n							
Children	4,316	3,762	4,957	4,565	4,131	2,842	−34
Nonelderly adults	52,610	52,742	52,475	58,742	71,157	70,465	34
Elderly	1,815	2,025	2,520	2,766	3,154	3,356	85
Inpatient days							
Children	23,246	19,298	21,456	18,541	17,579	11,789	−49
Nonelderly adults	311,393	305,374	271,391	318,257	386,552	367,618	18
Elderly	19,021	16,243	18,740	20,925	21,933	22,813	20
Total costs, $ million*							
Children	25.5	22.2	27.5	28.8	29.2	22.8	−11
Nonelderly adults	511.8	503.6	483.0	587.1	754.2	763.3	49
Elderly	25.8	26.3	32.2	39.3	43.8	47.9	86

Source: NJ Charity Care Claim Records.

*Dollar value of charity care priced at Medicaid reimbursement rates (excluding add-ons for graduate medical education). Dollar amounts are adjusted for inflation using the 2004 Medical Care Consumer Price Index.

these costs were $7,061 per admission for older people, $3,501 for children, and $5,356 for nonelderly adults. (These differences are statistically significant according to analysis of variance and Kruskal–Wallis tests, which both produced *P*-values <.001.) A greater likelihood of older people to have costs that are extremely high influences, in part, the high average cost per admission for elderly charity care patients. For example, 4.6% of elderly charity care users had inpatient costs exceeding $20,000 in 2004. For charity care users who are children and nonelderly adults, these percentages were only 1.5% and 1.9%, respectively.

Older people also generate higher average costs per outpatient charity care visit. In 2004, these costs were $492 for older people, compared with $279 for children and $441 for nonelderly adults. (These differences are statistically significant according to analysis of variance and Kruskal–Wallis tests, which both produced *P*-values <.001.) Similar to the case for inpatient charity care costs, older people are more likely than younger charity care users to have high outpatient charity care costs. For example, 5.2% of elderly charity care users had costs per outpatient visit that exceeded $2,000 in 2004. For charity care users who are children and nonelderly adults, these percentages were only 1.6% and 3.8%, respectively.

DISCUSSION

Because they make up a small share of the uninsured population, older people have received little attention from policy makers and researchers, but evidence from New Jersey points to an emerging need to consider older people in the development of coverage and safety net options for the uninsured.

Prior research suggests that coverage expansions for the working poor decrease hospital expenses for uncompensated care.[14] Because most expansions in recent years have focused on children, any decrease in uncompensated care should be most apparent for them. This may be the case in New Jersey, because the use of charity care by older people surpassed the corresponding use by children (which fell by some measures) at a time when children were enrolled in New Jersey's State Children's Health Insurance Program.

A shift toward more elderly users of charity care, as seen in New Jersey, can have important financial and clinical implications for safety net providers. The analysis in this paper finds that older people generate much higher costs per inpatient admission than younger charity care patients. The greater likelihood of older people to have high costs (e.g., >$20,000 per admission) causes much of this difference in average costs. Elderly charity care patients also generate higher costs per outpatient charity care visit than their younger counterparts.

The shift toward an older population of charity care patients has important financial and clinical implications for safety net hospitals. Because they generate higher costs per case, a growing population of charity care users who are elderly will likely increase the financial burdens faced by safety net hospitals. In addition, elderly charity care users, like elderly patients overall, seek care for different kinds of medical conditions. For example, in New Jersey, younger charity care patients often receive treatment for mental health and substance abuse problems and receive services related to pregnancy and childbirth. In contrast, elderly charity care patients are much more likely to receive treatment for circulatory disorders, conditions involving the nervous system and sense organs, and kidney or urinary problems. As a result, safety net facilities will need to work more often with clinicians who specialize in geriatrics and other disciplines relevant to elder care and who are also willing to treat uninsured patients.

The findings in this article must be viewed in light of some limitations. First, features that are unique to its charity care subsidy program, and therefore could limit generalizability to other states, may have influenced trends in

New Jersey. Subsidies directed explicitly to hospitals may encourage more inpatient admissions or visits to the emergency department for cases that could be treated in non-hospital settings. Second, the rules governing the distribution of these subsidies suggest that elderly users of charity care are primarily immigrants who are ineligible for Medicare, but because the charity care claims data do not provide information about immigration status, this assumption remains unverified. Description of the overall demographic and immigration status of elderly charity care users is an important area for further research, because these characteristics are important determinants of medical needs and eligibility for various healthcare subsidies.

Also, the amount of charity care delivered to older people in New Jersey may be higher than the amount documented in this article. At issue is the delivery of care to uninsured older people who are undocumented immigrants. Care delivered to these patients may not appear in charity care claims data if hospitals are unable to provide the needed verification of income and residence. The costs of charity care provided to uninsured older people may also be underestimated, because all dollar values in this analysis are based on Medicaid reimbursement rates, which generally understate the true cost of services provided.[13]

Subject to these caveats, trends identified in this article are likely to occur in other states with high or growing immigrant populations. Although the most direct policy response in these states would be the provision of coverage to elderly users of charity care, budgetary and political constraints make such a policy difficult to enact. As a result, safety net providers in these states must prepare for a new class of uninsured patients with especially acute medical care needs.

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