

THE SOURCE

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Report on Useful Rate Setting Methods and Techniques from the
Maryland Hospital All-Payer Rate Setting System

Part 3B: Complementary Rate Setting Programs: Hospital Uncompensated Care (UC) Financing Systems

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Part 3B: Complementary Rate Setting Programs – Uncompensated Care Financing Systems

A. Financing Hospital Uncompensated Care

1. Introduction

Yet another important function that state-based hospital rate setting systems can provide is an ability to maintain or expand access to hospital care through the financing of reasonable levels of hospital Uncompensated Care (UC). Hospital UC consists of hospital bad debt (i.e., the cost of hospital services rendered for which payment was not received) and charity care (i.e., hospital services provided for free by a hospital or at a reduced cost to patients who were uninsured or underinsured and unable to pay their hospital bills). The funding of hospital UC through an assessment or surcharge on hospital rates, has been accomplished by both state hospital rate setting systems and also by the Medicare program, which, includes payment enhancements within the Medicare hospital payment methodology to partially address these costs.

It should be initially emphasized that a system for financing reasonable levels of hospital uncompensated care will work most effectively if applied in the context of an all-payer rate setting system, made possible by the approval of a Medicare Waiver by the Center for Medicare and Medicaid Innovation (CMMI) and the Centers for Medicare and Medicaid Services (CMS). This is because all-payer systems can spread the cost of hospital UC that a state chooses to fund through a system of rate surcharges, most equitable across all payers. Attempting to fund hospital UC when regulating only a segment of the market (e.g., rate setting applied to just private insurers) will likely require surcharges that place too much of a financial burden on the regulated payer. Thus, we recommend that states table the use of such a beneficial UC funding mechanism until they are able to develop all-payer regulatory systems under a Medicare Waiver.

We also recommend that state looking to implement a UC financing system only fund what we refer to as “Reasonable” levels of hospital UC and not attempt to fund all hospital Bad Debt and Charity Care. This means that states implementing a system UC surcharges and UC Pools should set limits on the amount of hospital UC eligible for funding through the hospital rate setting system. Setting “Reasonable” limits on the amounts of UC funded will help states avoid the problems encountered by states such as New Jersey which allowed hospitals to apply for UC funding, from the state’s UC Pools, for all uncompensated patient bills. This open-ended financing system caused hospitals in the state to greatly reduce or eliminate their patient credit

and bill collection activities, to save administrative expenses. Instead, most New Jersey hospitals elected to pass through virtually all hospital UC in the New Jersey hospital system to the states' UC funding program. This caused New Jersey hospital UC to spiral upward to extremely high levels. Maintaining financial incentives for hospitals to maintain credit and collection activities from patients with the means to pay their hospital bill (by setting upward limits on the amount of UC funded), as was the case in the Maryland all-payer hospital system, will help to avoid this phenomenon.

2. Current Programs Used by States to Assist in the Funding of Hospital UC

In the absence of a state all-payer rate setting system to fund hospital UC, states have relied on a myriad of other strategies. One mechanism that helps pay for hospital UC has been through the development of UC pools established through the authority of Section 1115 waivers now adopted in several states. The states of California, Texas, Florida, Kansas, Massachusetts, New Mexico, Tennessee and Texas have secured such waivers.

In recent years, states have also made use of elaborate and complex "Provider Tax" and "State Directed Payment" schemes to generate federal matching funds that are used either to enhance state Medicaid payments to hospitals and/or fund hospital UC. Provider taxes are general healthcare related fees or assessments applied to hospital rates (i.e., surcharges), paid by state Medicaid programs. Medicaid is jointly funded by states and the federal government, and states have been permitted by the federal government to raise funding for their share of Medicaid costs by imposing taxes on providers, including hospitals, nursing homes and managed care organizations, and then using the additional revenue generated from the tax to claim their own state-specific share of federal matching dollars.¹

States each have different proportions of federal matching funds available to them, based on a federal formula (the Federal Medical Assistance Percentage or "FMAP") and each state's per capita income relative to U.S. per capita income. States with lower income levels have a higher matching percentage, with a maximum of 83% and a statutory minimum of 50% match. In the former case, this means that for every dollar a low-income state generates through the use of a Provider Tax imposed on Medicaid rates paid to providers, it can generate 83 additional cents in federal matching funds for these higher provider payments. The strategy enables states to make higher Medicaid payments to providers in their state without drawing down funds from the state's budget. This is because the increased hospital payments are funded by a combination of revenues generated by the tax and federal Medicaid matching funds.

In addition to this Provider Tax funding scheme, states have made use of State Directed Payments (SDPs) in which a state can require Medicaid managed care organizations (MCOs), to enhance the rates they pay providers, up to the level paid by commercial insurers, in a way that is similar to the use of Provider Taxes.² Both Provider Taxes and SDPs are “leverage” tools allowing providers to pay a tax that qualifies for federal matching funds.

In recent years both Provider Tax and SDP funding schemes have grown considerably, causing them to be targets of federal budget-cutting action in 2025. These strategies are also complex and inequitable because they shift the burden of funding Medicaid programs from the state to the federal level causing many to view them as a “shell game” played by states to shift the responsibility for funding care to the poor from state to federal coffers.³ Although the One Big Beautiful Bill Act (OBBBA) of 2025 did not eliminate either program, it significantly limited the ability of states to utilize these schemes to increase Medicaid provider payments while at the same time reducing the share of state dollars devoted to Medicaid funding. According to the Congressional Budget Office (CBO), the OBBBA will reduce federal Medicaid spending by over \$1 trillion over the next 10 years, with limits on states’ funding through the use of Provider Taxes and SDPs being reduced by \$191 billion and \$149 billion respectively.⁴

As a result of these and other federal budget cuts, the CBO projects the OBBBA will increase the number of uninsured in the U.S. by 10 million by 2034 while simultaneously causing a reduction of \$1.1 trillion in federal and PPACA marketplace spending.⁵ There are currently a wide range of estimates regarding how much the projected cuts in Medicaid spending from the OBBBA and other federal actions will cause hospital UC to increase; these estimates range from \$204 billion to over \$300 billion over the period 2025-2034.^{6,7} The most recent estimate of the total amount of UC absorbed by U.S. hospitals, as of 2023, is approximately \$41.4 billion per year. In a separate analysis, Premier, Inc., a leading health care and technology firm also known for the Premier Hospital quality demonstration in the early 2000s, estimated that hospitals nationally would see an increase in hospital UC from \$32.4 billion currently to \$44.9 billion per year in each of the next several years, an increase of nearly 39%.⁸ Based on estimates from the CBO, America’s Essential Hospitals group reported that proposed cuts in the Medicaid program payments, including restrictions on Provider Tax and SDP schemes, will cause hospital UC costs to be approximately \$443.4 billion over the ten year period 2025 – 2034.⁹

These totals include bad debt and charity care but exclude so-called “governmental shortfalls” from what the American Hospital Association has characterized as excessively low hospital payments from Medicare and Medicaid (i.e., payments that are below the operating costs hospitals incur in treating these governmentally insured patients). In response to rapidly growing hospital UC, hospitals can either attempt to increase their prices to private insurers even more rapid-

ly, to offset these projected increases in UC and revenue shortfalls, or they must absorb them resulting in significant reductions in hospital profitability. Regardless, these federal changes will place more fiscal pressure on hospitals and will result in reductions in access to needed hospital care, particularly for low-income and uninsured patients.

These projected added fiscal strains on hospitals are reminiscent of the UC financing difficulties faced by U.S. hospitals in the 1960s and 1970s. State budget cutbacks and reductions in Medicaid funding then encouraged states to pursue state-based hospital rate setting systems to control hospital price and spending growth but also develop an alternative mechanism to fund hospital bad debt and charity care. The current circumstances which mirror these earlier developments (i.e., rapid increases in hospital prices and spending and growing levels of hospital UC), may well encourage states to pursue all-payer hospital rate setting systems in the future.

Although the funding of hospital UC through surcharges added to existing hospital rates can improve patients' overall access to hospital care and protect hospitals serving large proportions of uninsured patients from financial distress, it is considered a "second best" solution to the problem of insuring or expanding access to hospital care. The preferred policy approach to improving access to care is via efforts to increase the affordability of private insurance through government subsidies, as was accomplished through the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010.

However, the story of health insurance expansion in the U.S. is one of incremental progress, characterized by major or more limited and targeted expansions of private health insurance. And in recent years, the unabated growth in health care prices and spending have made these government subsidized insurance programs vulnerable to budget cuts due to economic or political reasons. And most importantly, as is discussed below, the unconstrained growth in health-care prices and spending is eroding the ability of federal and state governments to continue to subsidize the large-scale recent expansions in private health insurance.

3. Brief History of Insurance Expansion Programs in the U.S.

The development of the Medicare and Medicaid programs in 1965 was the first major federal attempt to expand access to all health care services through the provision of government established insurance programs for the elderly in the case of Medicare and for low-income residents through state Medicaid programs (which are financed by both the federal government and individual states). These programs dramatically reduced the number of uninsured people among Americans over the age of 65 and with lower incomes.¹⁰

In the 1980s, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was a federal law passed by Congress to allow employees and their families to continue group health insurance coverage for a limited time after a qualifying event (such as the loss of employment) addressing a key gap in coverage for those insured through the employer-based insurance system in the U.S. During the 1970s and 1980s the Medicaid program was also gradually expanded to cover more categories of lower-income children and pregnant women.¹¹

The Clinton health reform effort (1993–94) was the most ambitious attempt at universal coverage before the passage of President Obama’s PPACA. The proposal sought to mandate employer coverage and create regional purchasing cooperatives to expand health care coverage, but it faced intense political opposition and was never brought to a vote.¹²

The Children’s Health Insurance Program (CHIP), implemented in 1997, was a significant bipartisan legislative effort that extended coverage to millions of children in families that earned too much for Medicaid but couldn’t afford private insurance.¹³

The PPACA (passed in 2010) was the most sweeping insurance expansion reform since 1965. It originally mandated those not covered by Medicare and Medicaid to purchase insurance, expanded Medicaid eligibility to most adults up to 138% of the federal poverty level, created regulated insurance marketplaces with income-based subsidies, prohibited insurers from denying coverage based on pre-existing conditions, and allowed young adults to remain on parental plans until age 26. After the passage of the PPACA the uninsured rate in the U.S. fell from around 16% in 2010 to under 9% by 2015. Subsequent legal and political challenges — including the elimination of the individual mandate penalty in 2017 — eroded some coverage gains.¹⁴

Despite these efforts and other efforts, the U.S. still has a significant uninsured population, estimated at roughly 25–26 million people as in recent years, a gap that reflects the ongoing tension between the country’s mixed public-private healthcare financing approach with caps in coverage and the goal of universal coverage.¹⁵

While, as noted, insurance expansion is the most efficient way to expand patient access to needed health care services, both the PPACA and state-specific private insurance coverage expansion efforts (such as Commonwealth Care in Massachusetts) have been hampered by an inability to sustain insurance expansion programs because health care spending continues to escalate at a very rapid rate, reducing the overall affordability of private insurance and forcing states and the federal government to increasingly run budget deficits.

While the expansion of private health insurance through such programs as the PPACA have temporarily benefited many millions of Americans, these positive effects are proving to be temporary because we have failed to address the root causes of escalating healthcare spending by implementing effective price and spending control legislation.¹⁶ This observation indicates that large-scale health insurance expansions, such as the PPACA, may be doomed to failure as long as health care prices and spending continue to escalate without constraint, just as we appear to be witnessing with the 2025 non-renewal of enhanced Premium Tax Credits (PTCs), which were originally expended through 2025 by in the Inflation Reduction Act of 2022. The changes made by the OBBB Act, signed into law on July 4, 2025, further restricted when and how beneficiaries can access subsidized private insurance coverage.¹⁷ The recent widespread cutbacks in federal subsidies and tax credits for individuals who receive their health insurance through federal and state health insurance exchanges illustrates the vulnerability of this strategy to expand access to needed health care.

Similarly, Massachusetts' efforts to expand insurance coverage for privately insured individuals is facing an unsustainability crisis. This groundbreaking state insurance expansion initiative was originally made possible through the Commonwealth's 2006 insurance reform legislation which created a heavily subsidized program (Mass Health) to make private insurance more available and affordable for its citizens.¹⁸ Within two years of its passage, cost sustainability was a growing concern among Massachusetts' legislators and that the goal of achieving universal or near-universal coverage for Commonwealth citizens would not be achieved without success in addressing the largely unconstrained growth in healthcare prices and spending.¹⁹

Since that time, policy leaders in the state have identified the large increases in hospital prices and spending as the primary factors that have eroded the affordability of hospital care in Massachusetts. The Health Policy Commission, the primary governmental agency tasked with monitoring health spending growth and recommending policy initiatives to stem the tide in health care cost growth, noted that Massachusetts had the second highest commercial premiums in the country (average family health insurance premiums of \$26,355 per year) along with increasing proportions of privately insured residents opting for high-deductible health insurance plans.²⁰ Because of the continued growth in spending on health care in Massachusetts, the Commonwealth's uninsured rate has soared as MassHealth's insurance (Massachusetts's Medicaid program) eligibility provisions have been reduced. While the Commonwealth has not abandoned its coverage goals, like the cutbacks in subsidies provided to privately insured patients under the PPACA, the depth and breadth of health insurance coverage expansions in Massachusetts have been constrained by the inability to sustainably fund rapid growth in hospital and healthcare spending.²¹

4. Medicare Efforts to Assist in the Funding of Hospital Uncompensated Care

The national Medicare hospital reimbursement system has long provided participating hospitals with a mechanism to pay for a portion of hospital UC. Medicare pays hospitals for a portion of unpaid cost-sharing amounts (deductibles and coinsurance) owed by beneficiaries that a hospital is unable to collect after they have engaged in “reasonable” collection efforts.

Starting in 1985, with the passage of the federal COBRA legislation of 1985, the Medicare program also began to pay hospitals serving large numbers of low-income patients that experienced higher levels of non-reimbursed care and were in need of additional payments from Medicare. This legislation authorized the Medicare program to make “Disproportionate Share Hospital” (DSH) Payments to qualifying hospitals. These DSH payments were made in addition to the standardized Medicare Inpatient Prospective Payment System (IPPS) rates and were calculated based on each hospital’s “DSH percentage” – a proxy for the share of low-income patient served based on: 1) the proportion of patient days attributable to Medicaid-eligible patients, and 2) the proportion of patient days attributable to Medicare Supplemental Security Income (SSI) beneficiaries.²² The Medicare funding of DSH and UC are analogs to state-based financing of hospital UC.

The PPACA restructured the Medicare DSH program beginning in Federal Fiscal Year (FFY) 2014 by extending an element of the DSH funding mechanism but also creating a separate and new hospital UC payment pool. Under the new formula, hospital receive 25% of their pre-PPACA DSH amount, adjusted for changes in the uninsured rate nationally, with the remaining 75% being distributed through a separate UC Payment Pool. Each hospital’s share of this funding is determined by the following three factors: 1) whether a hospital qualifies under Medicare rules as DSH-eligible; 2) a reduction factor linked to the change in the uninsured rate since 2013 (which is designed to account for progress in expanding coverage); and 3) a hospital’s share of the total UC costs reported across all DSH-eligible hospitals based on data from Medicare Cost Reports.²³

5. Section 1115 Medicaid Waiver Uncompensated Care Pools

Separate from Medicare’s DSH and UC funding mechanism for hospitals, the Social Security Act (42 U.S.C. § 1315) allows states to obtain federal Medicaid matching funds for UC pools which are used to supplement payments for hospitals for bad debt and charity care not covered by Medicaid programs or other sources. These pools are state-specific and have been used in larger states such as California, Texas and Florida.²⁴

6. Rate-Setting States' Use of Surcharges on Regulated Hospital Rates to Fund Hospital UC

During the period 1970 through the early 1990s, several U.S. states established mandatory hospital rate-setting systems to address the interrelated problems of rapid increases in hospital prices and the growing burden of hospital UC. Among the states that adopted all-payer rate-setting systems, Maryland, Massachusetts, New York, and New Jersey developed the most prominent models and which also included mechanisms to fund hospital UC through each state's regulated hospital rate structure.

The rationale for using hospital rate-setting as a vehicle for hospital UC financing was as follows. If a state creates a regulated structure for setting and controlling the growth of hospital prices, it can use that structure to include an explicit add-on or surcharge on top of those rates to fund UC for individual hospitals directly or create a pool of funds dedicated to reimbursing hospitals for charity care and bad debt across the industry. In the absence of such UC funding mechanism, hospitals that experience high volumes of bad debt or provide charity care must either absorb higher levels of UC or attempt to raise their prices to private insurers and effectively "shift" the cost of UC to private payers and their beneficiaries. Regulated all-payer systems allowed states to spread this burden equitably across all payers—including Medicare, Medicaid, commercial insurers, and self-pay patients—and to redistribute funds from hospitals with low uncompensated care burdens to those with high ones.

The four states surveyed below took distinct approaches to this problem, with varying degrees of success, and eventually differing fates. Maryland's system is currently the nation's only remaining all-payer hospital rate-setting regime, although as noted the all-payer aspect of this system may change with the state's transition to the CMMI AHEAD program beginning in FY 2028. The systems in Massachusetts, New York, and New Jersey were entirely dismantled in the early 1990s as managed care grew and political and market pressures against rate regulation intensified. The following discussion describes each state's approach and traces the key mechanisms used to fund uncompensated care through regulated rates. These experiences can serve as a model to other states looking to implement similar regulated hospital payment systems in the future.

7. Funding Hospital Uncompensated Care in the Massachusetts Hospital Rate Setting System

The Commonwealth of Massachusetts adopted mandatory hospital rate setting in the late 1960s with the establishment of the Rate Setting Commission (RSC), an independent state

regulatory agency. The hospital rate setting system in Massachusetts initially applied to Blue Cross, other commercial insurers, Health Maintenance Organizations (HMOs), Medicaid and self-pay patients (i.e., uninsured individuals). The system focused initially on regulating hospital inpatient rates but later expanded to setting hospital outpatient rates as well. Health services literature shows that the RSC successfully slowed hospital price and spending growth in the late 1970s and early 1980s relative to national hospital price and spending trends.^{25,26}

The Massachusetts hospital rate setting system was expanded in 1986 to also set rates for Medicare patients, per the approval of a Medicare Waiver beginning in 1986, making it the fourth all-payer hospital rate setting system in the U.S.²⁷ In the 1970s Massachusetts implemented a UC Pool in response to growing hospital UC due to Medicaid cutbacks.²⁸ Around the time of the approval of the Medicare waiver, the Commonwealth also established a statewide hospital UC pool to “more equitably distribute the burden of financing uncompensated acute hospital services across all acute care hospitals.”²⁹ Hospitals providing proportionately more uncompensated care than the statewide average received payments from the pool, while those providing proportionately less made payments into it.³⁰ The pool was primarily funded by surcharges rates set by the RSC for each hospital’s private payers.

The RSC established a system of interim monthly payments to and from hospitals and the UC Pool, with a year-end audited settle-up. Hospital UC was defined to include both bad debts (unpaid patient bills) and charity or “free care.” The legislature also capped hospitals’ aggregate liability for funding the Pool in 1988 and after the termination of the RSC and hospital rate setting in the Massachusetts in 1991, shifted the liability for funding \$100 million of the pool to insurance carriers.³¹

As noted, Massachusetts deregulated its hospital rate setting system under Chapter 495 of the Acts of 1991.³² After deregulation, insurers (particularly Blue Cross) began negotiating discounted rates with hospitals, which greatly reduced the capacity of hospitals to continue the funding of the UC pool. Hospital UC magnitudes subsequently escalated far beyond the capacity of the pool, eventually reaching \$465 million per year in 1997. These developments were the key events that led to Massachusetts’ insurance reform efforts, eventually leading to the creation of “MassHealth,” the state’s subsidized insurance program.³³

In 2006, the legislature created the Massachusetts individual health insurance mandate, expanded Medicaid, converted the UC Pool into a Health Safety Net (HSN) fund, and established Commonwealth Care, the subsidized health care connector for privately insured individuals. Unfortunately, the continual year-over-year increases in hospital prices and spending since 2006 has resulted in a growing health insurance affordability crisis and diminishing sources of state funding to subsidize private health insurance.

8. The New York Hospital Rate Setting System and UC Financing Mechanism

In 1982, New York enacted legislation to create the New York Prospective Hospital Reimbursement Methodology (NYPRHM) to set hospital rates for all private insurers (including Blue Cross), Medicaid and uninsured or self-pay patients. Medicare was initially not subject to the state's rate setting system because New York was initially unable to receive a waiver from the federal Medicare program.

NYPRHM had two primary goals: 1) control hospital price and spending growth; and 2) finance care to the uninsured through a system of UC pools funded by surcharges on regulated hospital rates. These surcharges applied to hospital inpatient payments from private payers, Medicaid and self-pay patients. The New York Department of Health (which ran the NYPRHM system) required that hospitals collect and direct funds from the surcharges to a system of eight regional hospital UC Pools. This system of UC financing was established in an attempt to support New York hospitals in their financing of growing levels of UC spurred by the growing state fiscal crisis and reduction in Medicaid eligibility and coverage.³⁴

Hospitals reported their annual UC (both bad debt and charity care write-offs) to the New York Department of Health (DOH), which converted these charge-based revenue amounts to cost-based estimates using each hospital's cost-to-charge ratio (CCR). Hospitals whose UC costs exceeded their pool contributions received net payments from the Pool and hospitals below with UC levels below average levels made net contributions to the Pool. By 1985, the Pool had reduced an estimated deficit of \$467 million across 152 non-profit hospitals, to \$195 million for the 90 hospitals remaining in the red.^{35,36}

Over future versions of NYPRHM (in all, the state enacted five different versions of the hospital rate setting statute, which each version purportedly being more complex than the last),³⁷ the UC Pools were used not only to reimburse hospitals experiencing high levels of UC, but also to subsidize the low-income families to purchase primary and preventive care coverage for children under 13 who were not eligible for Medicaid.

Subsequent health services research on the impacts of the UC Pools in New York was mixed. A 1998 study found that the Pools were only "moderately successful" in reallocating funding for hospital UC and improving access to hospital care. These results were attributed to the measures used by the New York DOH to measure hospital "need" for these funds, rather than the overall concept of using rate surcharges to generate assistance for UC funding.³⁸ However, a subsequent study found that New York hospitals responded to the UC Pools by increasing the volume of services to uninsured patients by providing additional "non-discretionary" services,

suggesting that beneficial care to the indigent had been “rationed” prior to the use of the UC Pools. Another study found that while the use of the UC Pools was moderately successful redistributing care to the uninsured, the provision of care that was considered “highly technological,” meaning that access to high-end interventions such as open-heart surgery, were not impacted.³⁹

A New York DOH evaluation of the UC pools concluded that they covered approximately 63% of hospital bad debt and charity care losses reported by these hospitals with “coverage” ratios ranging from 46% to 100% of hospital reported UC. The study concluded that the large variation in coverage ratios was a result of the payment scale established by the DOH, hospitals’ participation in multiple pools, and the distribution of some pool dollars independent of reported need. The report also found that indigent care funding formulas made no distinction between uncompensated care provided to uninsured patients and uncompensated care for insured patients who defaulted on co-pay and deductible obligations.⁴⁰

Finally, other studies have suggested that the use of these UC funding mechanisms, which apply surcharges or add-ons to existing regulated hospital rates, had some overall success in redistributing the burden of hospital UC and improving access, the use of UC surcharges on rates can also be destabilizing.

The authors show that states’ secondary objective in implementing state-based hospital rate setting systems (secondary to the goal of constraining spending on hospital care) of funding reasonable levels of hospital uncompensated care made some rate setting regimes economically and legally unstable. This was particularly the case for states that lost their Medicare Waivers which meant that state-wide magnitudes of hospital uncompensated care had to be financed on a smaller overall revenue base (of private insurers and Medicaid), thus increasing the magnitudes of the surcharges on regulated rates required to fund eligible uncompensated care levels. When HMOs were exempted from the NYPHRM system of UC surcharges, the gap in the burden of funding hospital UC between private and other payers widened even further destabilizing the UC financing system. Some researchers have suggested a more efficient approach to funding hospital UC would be to do so directly from funds generated by state income taxes or surcharges applied to the total base revenues of hospitals across all-payers (an approach accomplished by the state of Maryland’s application of its hospital rate setting authority to all payers, including Medicare and Medicaid).⁴¹ The use of extremely high rate surcharges in New York and in New Jersey led to future ERISA challenges which ultimately led to the unraveling of both the New York and the New Jersey rate setting systems.⁴²

These results indicate that states that establish government administered and mandatory hospital rate setting systems have the ability to apply surcharges on regulated rates to fund

hospital UC, and these assessments do not necessarily violate the requirements of ERISA. However, states should be careful to spread these costs across the broadest base of payer revenueⁱ (preferably across all-payers and all hospital revenues in an all-payer system which includes the participating of Medicare and Medicaid though approval of a federal Medicare waiver).⁴³

NYPHRM was terminated by an act of the New York legislature in 1996 and was replaced by the New York Health Care Reform Act (HCRA) of 1996 under which most non-public payers continued to pay surcharges (now labeled HCRA surcharges) with the proceeds of these surcharges being distributed to a hospital Indigent Care Pool (ICP). The ICP now distributes more than \$1 billion annually to public and non-profit hospitals in the state. Funding of the ICP is now drawn mostly from Medicaid funds, rather than rate surcharges on payers. In recent years, the ICP funding mechanism has been criticized because of persistent inequalities in the distribution of funds to needy hospitals due to vestiges of the old distribution methodologies. Some non-profit hospitals receive ICP payments significantly in excess of their uninsured care need, while safety-net public hospitals appear to be chronically underfunded.⁴⁴

9. New Jersey's Prospective Hospital Rate Setting System and Uncompensated Care Financing System

New Jersey and Maryland were the first two jurisdictions to implement all-payer hospital rate setting using a prospective system of inpatient hospital reimbursement using Diagnosis-Related-Groups (DRGs).⁴⁵

The New Jersey hospital rate setting system was administered by the New Jersey Hospital Rate Setting Commission (NJHRSC) and covered all payers, including Medicare (authorized by the approval of a Medicare waiver by the national Health Care Financing Administration). An important feature of the New Jersey DRG hospital payment system was an explicit surcharge on all-payer DRG case rates to fund hospital UC (both bad debts and charity care). Under this system, each hospital's DRG rates included a hospital-specific surcharge or add-on based on the amount of the total amount of hospital UC generated by the patients being treated at a

ⁱ In New York in 1992, a labor union filed a court challenge to the imposition of large add-on assessments to regulated hospital rates related to the funding of hospital uncompensated care, under the assumption that such large surcharges violated elements of the federal Employee Retirement Income Security Act (ERISA) statute. Initially, the New York District Court determined that the New York surcharges on approved hospital rates were preempted by ERISA. This legal challenge to the New York rate setting system helped accelerate efforts to deregulate the New York hospital rate system, even though the Supreme Court ultimately held in *Blue Cross & Blue Shield v. Travelers Insurance Co.* that ERISA does not expressly preempt state laws that govern health care providers and only incidentally affect ERISA plans. See U.S. Gen. Accounting Office, GAO/HEHS-95-167, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* (1995) (discussing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)). <https://www.govinfo.gov/content/pkg/GAOREPORTS-HEHS-95-167/html/GAOREPORTS-HEHS-95-167.htm>.

particular facility. This meant that hospitals serving higher shares of uninsured and low-income patients had higher rates than hospitals with lower UC burdens. This approach did not allow the system to spread the burden of financing hospital UC equitably across the rate setting system (as was more the case with states such as Massachusetts and New York that made use of a UC Pooling methodology). When the state lost its Medicare waiver, meaning the Medicare program was no longer subject to the NHRSC's rates, the base for financing hospital UC was reduced dramatically, even while hospital UC was increasing due to state budget deficits and Medicaid cutbacks.^{46,47}

Research on the New Jersey DRG and UC financing system found that the program resulted in a more even distribution of UC and improved the financial condition of hospitals providing the largest shares of care to uninsured patients, thus improving access to needed hospital care for New Jersey residents. By 1990, this system of UC funding encountered several large problems. New Jersey, like Massachusetts, New York and Maryland, experienced increases in the number of uninsured patients due to economic downturns and reductions in Medicaid eligibility during the late 1980s and early 1990s. This circumstance, along with the elimination of New Jersey's Medicare waiver and Medicare's participation in the rate system and UC financing system, resulted in increasing hospital UC and a reduced hospital regulatory revenue base upon which the NCHRS used to impose its UC surcharges.

Another flaw in New Jersey's UC funding system was that hospitals were allowed to submit claims for any and all patient debts, whether or not the hospital made attempts to collect from patients. Allowing hospitals to completely pass-through without any restriction, any and all unpaid bills along a reduced regulatory revenue base and continued increases in numbers of uninsured patients caused hospital UC to skyrocket in the state.ⁱⁱ

In addition, managed care plans (which had been excluded from both New York's and Massachusetts's hospital rate setting systems), lobbied the state legislature for their own exemption from hospital rate setting, so that they could negotiate price discounts with what was at the time an "over bedded" hospital system, and thus escape the burden of paying their share of hospital UC. A prolonged legislative battle in the early 1990s eventually resulted in a series of temporary extensions of the hospital rate system supplemented by some direct funding from the Medicaid program. At this time the surcharges on hospital rates had ballooned to over 19%, which contributed to challenge by ERISA plans in the state. Hospital rate-setting in New

ii In contrast, Maryland imposed limits on the amount of hospital bad debt and charity care that could be financed through the state's all-payer rate setting system, specifying a formula that paid hospitals for what the regulatory agency in the state, the HSCRC determined to be "reasonable" levels of UC. This restriction still funded between 90-93% of all hospital UC but created incentives for Maryland hospitals to be more efficient in their credit and collection activities.

Jersey was eventually terminated as of January 1, 1993, per passage of the Health Care Reform Act (HCRA) in New Jersey of 1992.

The redistributive effects of state-based rate setting systems which included surcharges to fund hospital UC (including Connecticut, which operated a mandatory rate setting system that applied just to commercial payers) were considered vulnerable to legal challenge. A court ruling in New Jersey (*United Wire et al. v. Morristown Hospital et al.*) ruled that the federal ERISA statute pre-empted the use of hospital surcharges such as those used in New Jersey. This ruling, along with the other pressures faced by the New Jersey rate setting system (i.e., the push from HMOs to be exempt from the system, the exit of Medicare as a participant in the rate system and a growing anti-regulatory sentiment in the state) greatly reduced support for a rate system that permitted different reimbursement levels for different payers or required payers to contribute to a pool for the uninsured. Although the *United Wire* decision was ultimately reversed on appeal to the Third Circuit Court, the original *United Wire* decision resulted in a proliferation of similar suits in New York. These circumstances greatly accelerated these two states move toward deregulation of their rate setting systems in the early to mid-1990s.⁴⁸

The consequences of hospital rate deregulation and elimination of the mechanism to fund hospital UC in New Jersey were significant. Hospital UC and Medicare “shortfall” funds were taken out of the hospital charge structure and set up explicitly as a subsidy program funded from a surplus in the state’s unemployment insurance trust fund. The reliance on the unemployment insurance trust fund proved to be unsustainable politically. Funding of uncompensated care through this trust fund was supposed to continue only through 1995. But a 1996 stalemate over a successor funding mechanism resulted in two more years of such funding at reduced levels of \$310 million in 1996 and \$300 million in 1997.

The growth in the number of uninsured, an inequitable financing system, increases in bad debts, and the elimination of Medicare payments led to this program’s demise. An extended legislative stalemate resulted in a pair of temporary extensions — aided by an infusion of federal Medicaid dollars — but the state still had no permanent solution to this funding issue, and many New Jersey hospitals suffered financially as a result.⁴⁹

The deregulation of New Jersey’s all-payer DRG system not only led to an era of hospital consolidation and rapidly rising hospital prices,⁵⁰ it also interrupted the mandatory surcharge-based funding mechanism that had successfully spread the cost of hospital UC across all payers, including Medicare. The ERISA preemption challenge (the *United Wire* case) was the cause of the eventual collapse of both systems. This challenge was in part initiated because of the lack of constraints on the amounts that hospitals could “write-off” as bad debts, which also

contributed to the spiraling up of UC costs that were eligible to be funded through hospital rates. When these surcharges reached unacceptable levels self-funded plans challenged the entire rate-based financing structure.

The state's response, the 1992 HCRA was an attempt at replacing this surcharge system with a discretionary government subsidy funded from the state's Unemployment Insurance Trust Fund, which was not intended for this purpose and was at best a temporary source of funding. The exclusion of bad debt from hospital payments, the declining state subsidies, and subsequent legislative stalemates all reflected the difficulty of sustaining uncompensated care financing once it was removed from the all-payer rate structure and placed in annual budget politics.

10. Maryland's All-Payer Rate Setting System and the Financing of "Reasonable" Hospital UC

a) Overview of Maryland's Hospital UC Funding System

As discussed in the introduction to this paper, Maryland's all-payer hospital rate setting system is the nation's first and longest-lasting hospital rate setting system, remaining in place today. A major reason for enactment of the HSCRC statute was political support by the Maryland Hospital Association (MHA). The MHA was willing to have Maryland hospitals regulated by the state, in exchange for improved financial stability, which the MHA believed would occur with the development of a mechanism to finance hospital UC. The HSCRC defined hospital uncompensated care as hospital care for which no payment is received and includes both bad debt (unpaid patient bills) and charity care (free care offered to low-income patients that qualify per each hospital's individual free care policy).

Prior to the development of rate setting in Maryland the predominant "cost-based" hospital payment systems utilized by Medicare, Medicaid and the state's Blue Cross plan, which accounted for over 90% of hospital payments, did not recognize hospital UC as a reimbursable expense. Thus, hospitals were forced to fund patient bad debt and charity care out of their profits from operations. Eventually, increases in the number of uninsured, caused by reductions in Medicaid patient eligibility and spending, caused several inner-city Baltimore hospitals to be on the verge of financial bankruptcy. Thus, the MHA not only supported, but drafted the initial Maryland hospital rate setting statute, seeking to implement a hospital rate setting system that would apply to all payers, including Medicare and Medicaid, constrain excessive hospital price and spending growth and, most importantly to the MHA, include a new way of financing hos-

pital UC.ⁱⁱⁱ A fundamental element of the proposed hospital rate setting system, drafted by the MHA and retained in the final version of the legislation, was a mechanism to finance what were referred to as “reasonable” levels of hospital UC, to both ensure access to life-saving hospital care for Maryland residents and to financially support hospitals that served large proportions of low-income and uninsured patients.

In 1977, Maryland finalized its negotiations with the Health Care Financing Administration (HCFA) which administered the federal Medicare system, receiving a waiver from federal Medicare reimbursement methods and instead required the Medicare program to pay the hospital rates established by the HSCRC. This development was significant for the financing of hospital UC because it meant that Medicare payments, like those of Medicaid, Blue Cross, other commercial payers and self-pay patients (i.e., individuals without insurance), could include the UC add-on or surcharge to HSCRC established hospital rates. Medicare’s participation in the rate setting system created a substantial base upon which the needed UC surcharges could be spread.^{iv}

Similar to the funding of hospital UC in New York, Maryland’s initial UC funding system was hospital-specific, meaning that hospitals serving the largest numbers of low-income and uninsured patients and experiencing higher levels of UC had higher UC surcharge provisions added to their base rates. This meant that the payers and patients that utilized these high UC hospitals paid higher hospital prices. The amount of these initial provisions ranged from 2.0%, for low UC hospitals, to over 15.0% for high UC hospitals. The higher surcharges applied to high UC hospitals made them less affordable for patients and payers.⁵¹

iii The original statute of the HSCRC included this authority to fund hospital bad debt and charity care but expressly indicated that only “reasonable” levels of hospital UC should be funded through this rate setting mechanism. This provision helped Maryland to limit the amount of bad debt that hospitals could write off and induced them to continue to attempt to collect payment from patients and payers with the means to pay their hospital bills. Accordingly, Maryland avoided the problems encountered by New Jersey, which funded virtually all unpaid hospital bills and caused hospitals to inappropriately allocate larger and larger amounts of “uncollected” bills for funding through that state’s UC Pool. The absence of the imposition of a limit on UC funding led to a spiraling up of hospital UC such that surcharges on regulated hospital rates grew to over 19%, applied primarily to the rates of privately insured patients including self-funded (also known ERISA) accounts. As has been discussed previously, the application of extremely high surcharges on privately insured and ERISA account payments to hospitals, eventually caused the ERISA plans to sue the state under the argument that these excessive assessments were preempted by the federal ERISA statute.

iv As noted previously, the Medicare waiver has periodically been renegotiated with the Centers for Medicare & Medicaid Services (CMS). An overall description of the Maryland hospital rate setting system is provided in Part I of this document.

In addition to placing a higher burden for the financing hospital UC on these patients, which made the financing of hospital UC less equitable, the Commission's original hospital-specific approach to funding hospital UC created concerns about the relative price competitiveness of high UC hospitals. While inner-city hospitals received financial support for the UC they experienced during a year, their regulated rates were on average much higher than the rates of other hospitals in the state, due in large part to these higher hospital-specific UC surcharges.

In the late 1980s and early 1990s managed care companies exercised increasing dominance in hospital markets, particularly markets with excess hospital capacity. Nationally, these payers used this market dominance to either negotiate lower hospital rates, which was not allowed in Maryland's hospital rate regulated system, or shift patients to lower priced hospitals, which started to occur in Maryland in the late 1980s and early 1990s. The HSCRC's UC funding approach, which applied hospital-specific UC surcharge amounts in each hospital's final rates, caused concern that increasingly powerful Health Maintenance Organizations (HMOs) would systematically shift large proportions of patient volumes to hospitals in suburban regions of the state, reducing the patient volume and revenues of higher-priced inner-city facilities.

Over time, the concern regarding the relative price disadvantage of the highest UC hospitals led to the establishment of a UC Pooling mechanism in Maryland, similar to the UC Pools used in New York and New Jersey. In the new system, established in 2008, each Maryland hospital received the average amount of statewide hospital UC in their base rates. Hospitals that experienced actual UC less than the statewide average, were required to pay the difference between the statewide average and their actual UC, percentage, into the UC Pool. Conversely, hospitals experiencing UC levels that exceeded the statewide average UC received surplus funding (i.e., the magnitude between their actual UC and the statewide average) directly from the UC Pool. This Pooling feature made the distribution of UC funding more equitable and addressed concerns about the relative lack of price competitiveness of high UC hospitals (i.e., after the implementation of the UC Pool in Maryland, all hospitals had the statewide average amount of hospital UC built into their rates).⁵² This new UC Pooling mechanism was also supported by the state Medicaid program, because under this approach the hospitals that were predominantly used by the Medicaid program, located in economically distressed areas and serving high proportions of uninsured residents, had their overall hospital rates reduced.

b) UC Funding Limited to “Reasonable” Levels of Hospital UC

In both its original UC funding methodology and the subsequent Pooling approach, the HSCRC recognized only “reasonable” levels of hospital UC in its UC funding approach. This limitation was important because it allowed the Maryland system to avoid the negative ex-

perience of the New Jersey rate setting UC funding methodology which allowed New Jersey hospitals to effectively eliminate their patient credit and collection efforts, leading, along with other environmental factors, to a spiraling up of hospital UC that needed to be funded through hospital surcharges. The UC provision in hospital rates in Maryland is applied prospectively (UC surcharges are set at the beginning of each year and persist throughout the year), is calculated to be predictive of actual UC costs each year and sets limits on UC funding and not a 100% pass-through of uncollected accounts to payers.

The Maryland approach to funding hospital UC also incentivizes Maryland hospitals to continue their patient credit and collection activities directed at patients who can afford to pay their bills or purchase healthcare insurance. This is a difficult balance for a rate setting agency to navigate. On the one hand, some hospitals pursue very aggressive credit and collection efforts from patients who have not paid their hospital bills. On the other hand, the elimination of all incentives for hospitals to collect can lead, as in the case of New Jersey, to the tendency of hospitals to classify all unpaid bills as hospital UC and being eligible for funding from a state's UC pool. Maryland's approach seems to have maintained an appropriate balance in this regard.

c) The Mechanics of the HSCRC UC Funding Mechanism

As noted, the HSCRC builds UC funding prospectively into the regulated rates, and now under Maryland's HSCRC approved Hospital Global Budget (HGB) hospital payment structure, each hospital's largely fixed hospital global budgets. This mechanism uses a multi-step process. First, the HSCRC determines the statewide actual hospital UC level from the prior completed fiscal year (or a blend of several years' experience^v), expressed as a percentage of gross patient revenue or gross charge levels.^{vi} For rate year 2026, this figure was set at 3.99 percent. Second, each hospital's specific UC provision is calculated as a 50/50 blend of: (a) the hospital's most recent actual UC experience; and (b) a regression model prediction of expected UC based on hospital and community characteristics. Third, the redistributive UC Pool is used to equalize the burden across hospitals; hospitals whose 50/50 blend falls below the statewide average must pay into the Pool, while hospitals whose blend exceeds the statewide average draw from the Pool.

^v Currently the HSCRC uses a three-year moving average of each hospital's actual (or "observed") UC.

^{vi} It should be noted that unlike other states where hospital markup their charges by extremely large amounts (often in excess of 300%), the HSCRC rate regulation prohibits such massive markups of charges over cost. In Maryland, the average markup is closer to 10% and it includes the Surcharge for funding hospital UC. Thus hospital charges in Maryland are close to net payment levels and net payments and charges are nearly identical.

This mechanism means that the cost of hospital UC is shared across all payers at all hospitals. As noted, hospitals with disproportionately high UC burdens (typically inner-city and safety-net hospitals) are not financially disadvantaged relative to suburban hospitals with lower UC levels. This approach means that Maryland hospitals have no financial incentive to discourage or transfer patients who lack insurance, because their rates are set to fund a majority of actual UC costs.^{vii} As noted by the HSCRC staff, as a result of this funding system, Maryland is the only state that assures its citizens they can receive hospital care at any facility regardless of ability to pay. There are no charity hospitals in the state because every acute care hospital has an outside means of funding the vast majority of unpaid hospital care.

Table 8: Example of the HSCRC’s UC Pooling Mechanism ⁵³

Assumptions: Annual Patient Revenue: \$20 billion; Annual Hospital UC: \$800 million; State-wide Average UC Percentage: 4.0%

	A	B	C = A-B
High UC Hospitals	Policy Determined hospital-specific UC Provisions (50% actual & 50% regression determined)	UC Provision (placed in rates)	Payment from the UC Pool to Hospital
Hospital 1	12.0%	4.0%	8.0%
Hospital 2	11.0%	4.0%	7.0%
Hospital 3	10.0%	4.0%	6.0%
Hospital 4	9.0%	4.0%	5.0%
Hospital 5	8.0%	4.0%	4.0%
Low UC Hospitals	Policy Determined hospital-specific UC Provisions	UC Provision (placed in each hospital’s rates)	Remittance from Hospital to the Pool
Hospital 6	4.0%	4.0%	0.0%
Hospital 7	3.0%	4.0%	-1.0%
Hospital 8	2.0%	4.0%	-2.0%
Hospital 9	1.0%	4.0%	-3.0%
Hospital 10	0.5%	4.0%	-3.5%

^{vii} This system, which is designed to fund only what the HSCRC considers to be “reasonable” UC amounts, has traditionally funded between 90-93% of actual annual hospital UC each year.

As noted, the HSCRC uses a statistical regression methodology to predict actual hospital UC in a given year. The UC regression estimates the relationship between a set of variables that the HSCRC determined were highly predictive of hospital UC at each facility, as well as the actual UC observed for each hospital.

d) Statistical Variables Used in the HSCRC UC Regression

The HSCRC's UC policy previously used the following statistical variables are used in the regression:

- The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room;
- The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases;
- The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room; and
- The proportion of a hospital's total charges from outpatient charges.

These factors were used by the HSCRC in the 2000s because they were found to be highly predictive of Maryland hospital UC. However, in more recent years the HSCRC has added other statistics to this regression analysis that factors in the economic status of each hospital's patients by including an "Area Deprivation" Index (ADI).⁵⁴ The ADI is a composite metric of 17 socio-economic indicators derived from census data, including such things as patient income, education, employment, and housing), to identify and attempt to assess healthcare disparities.⁵⁵

The UC funding methodology consists of the following five steps:⁵⁶

- **Statewide UC Calculation:** The HSCRC determines the statewide UC percentage amount (i.e., the statewide percent of UC as a proportion of gross hospital revenue) in a year based on previous years' experience. This calculation determines the statewide UC percentage that will be included in every Maryland hospital's approved rates. In the example in Table 8 above shows this amount to be 4.0% (i.e., every hospital's rates are "marked up" by a 4.0% surcharge).
- **Hospital-specific UC:** The HSCRC then determines each hospital's hospital-specific actual UC based on that hospital's prior year's UC as a percentage of gross patient revenues as reported via each hospital's annual revenue and expense reports.
- **Predicted Future UC:** This step uses a logistic regression to predict hospital UC for the

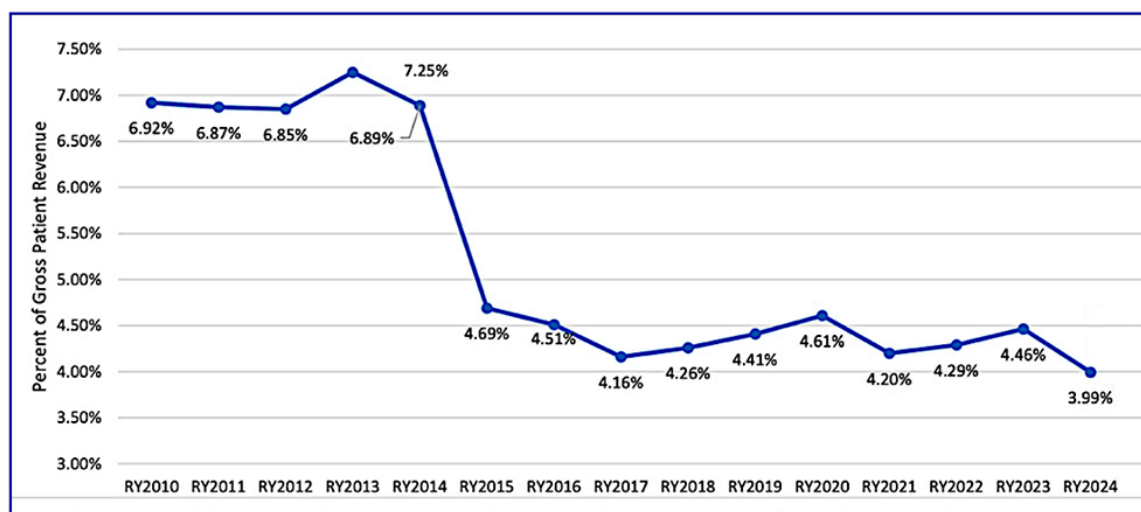
next year. The regression involves the use of a statistical analysis which determines a predicted value of estimated hospital-specific UC based on changes in the multiple inputs listed above as “The Statistical Variables used in the UC Regression” with the eventual addition of the ADI as component used in this regression analysis. The regression produces a predicted or expected UC dollar amount per hospital patient encounter. These UC dollar estimates are totaled for each Maryland hospital and divided by hospital gross revenues to calculate a hospital’s projected level of hospital UC.

- **Blended Actual and Predicted UC:** The Commission uses a 50/50 blend of each hospital’s specific UC as a predicted level of UC for the hospital given the characteristics of the patients it serves. The HSCRC believes this approach balances the Commission’s policy goals of paying hospitals for a majority of UC experienced in a year, while also retaining some incentive for hospitals to continue to attempt to collect unpaid bills from patients with the financial means to pay their bills.
- **Mechanics of Hospital Payments into and from the UC Pool:** The 50/50 blend calculation, for each hospital, calculated in step 4, is subtracted from the amount of UCC funding provided in each hospital’s HSCRC-approved budget (calculated in step 1) and multiplied by each hospital’s allowed gross revenue (per its approved HGB). This calculation determines the amount of money a hospital will either pay into or withdraw from the UC Pool. As illustrated in Table 8, if a hospital has a UC percentage from this methodology that is less than the percentage of UC statewide, the hospital will pay an amount equal to the difference between these two levels, while if the hospital’s calculated UC percentage (using the 50/50 blending methodology) is greater than the statewide level of hospital UC, it will receive funding from the UC Pool equal to the difference between its calculated or predicted level of UC (from the methodology outlined above) and the statewide average percentage of UC.

Figure 1, below, shows the actual total hospital UC percentage realized by all regulated Maryland hospitals between the years HSCRC Rate Year 2010 and 2024. Uncompensated care levels dropped between Rate Year 2010 and FY 2024. This graph shows the actual changes in the Maryland hospital statewide UC percentage over this period. The large drop in hospital UC in Rate Year 2015 and future years, reflects the expansion of Medicaid eligibility and implementation of private insurance subsidies per the PPACA. The COVID-19 pandemic in Rate Years 2020 and 2021 also caused a slight decline in hospital actual UC percentages.^{viii}

^{viii} The HSCRC staff maintains that the use of a predicted and prospectively guaranteed UC funding amount (or percent of gross revenue) that each hospital is guaranteed to earn, gives hospitals an incentive to engage in patient credit and collection activities (something not required of hospitals in the New Jersey UC funding methodology), and help cap levels of hospital UC funded through the rate setting system through surcharges.

Figure 1: Maryland Hospital Actual Statewide UC Rate Years 2010 -2024 ⁵⁷



e) Accounting for Changes in the Health Insurance Landscape

The HSCRC has also made periodic adjustments to the amount of statewide UC expected, accounting for predicted changes in the number of insured individuals in the state, taking into account estimates of the potential increase or decrease in the availability of governmental or private insurance.

For instance, in fiscal 2015, the HSCRC adjusted this methodology to incorporate a prospective yet “conservative” adjustment for the expected impact of the Affordable Care Act’s (ACA) Medicaid expansion on uncompensated care. The results of the 2016 UC policy blend of historical UC amounts and regression-determined UC amounts was adjusted down from 7.23% to 6.14% to capture the HSCRC’s estimate of Maryland Medicaid expansion in coverage in 2016 and the estimated impacts on the number of privately insured patients covered by the PPACA.⁵⁸

Overall, the HSCRC’s experience in assisting Maryland hospitals to fund the vast majority of UC it experiences seems to have created a balanced and effective mechanism to support acute care hospitals in the state to provide access for all patients in the state.

Table 9 below summarizes key features of each of the four all-payer rate setting state’s approach to funding hospital UC along with other summary information.

Table 9: Summary of All-Payer Hospital Regulatory States and UC Funding

Rate Setting Feature	Maryland	Massachusetts	New York	New Jersey
Regulatory Body	Maryland Health Services Cost Review Commission (HSCRC) - an independent Agency separate from the Department of Health "DOH"	Massachusetts Rate Setting Commission (RSC) – an independent Agency operating separately from the state DOH	New York State DOH which ran the New York Prospective Hospital Reimbursement Methodology (NYPHRM)	New Jersey Hospital Rate Setting Commission (NJHRSC) - an independent Agency operating separately from the state DOH
Medicare Participation	As authorized by Maryland's Medicare Waiver originally negotiated in 1977 and updated in recent years	Medicare was included in the rate setting system via a Medicare waiver but only for the period 1982-1985 ⁵⁹	Medicare was included in the rate setting system but only for 3 years: 1983-1985. ⁶⁰	Medicare was included in the rate setting system for the period 1980-1989) ⁶¹
UC Funding Mechanism	Hospital-specific UC surcharges (1977-2007) and under a UC Pooling Method 2008-present	Hospital State-side UC Pooling Mechanism	Hospital State-side UC Pooling Mechanism	Hospital State-side UC Pooling Mechanism
UC Distribution	Via hospital Surcharges (average statewide amounts built into each hospital's rates) with surplus or deficit funding from or to the UC Pool	Via hospital Surcharges (average statewide amounts built into each hospital's rates) with surplus or deficit funding from/to the UC Pool	Via hospital Surcharges (average statewide amounts built into each hospital's rates) with surplus or deficit funding from/to the UC Pool	Via hospital Surcharges (average statewide amounts built into each hospital's rates) with surplus or deficit funding from/to the UC Pool
Status of State System	Currently Operating	Deregulated as of 1991 (Pooling Mechanism restructured post rate setting)	Deregulated as of 1996 with Health Care Reform Act retaining the State's Surcharge Mechanism to partially fund hospital UC	Deregulated in 1993 Health Care Reform Act retaining the State's Surcharge Mechanism to partially fund hospital UC
Current UC Funding Program(s)	HSCRC CC pool (global budget era)	Health Safety Net (post-2006)	Hospital Indigent Care Pool (HCRA)	Charity Care / Healthcare Subsidy Fund

f) Financing Hospital Uncompensated Care: Lessons Learned

Across all four states, the fundamental mechanism for financing uncompensated care through rate setting was the same - an add-on or surcharge incorporated into regulated hospital rates that all participating payers were required to pay. The key distinction was whether the surcharge on regulated hospital rates was hospital-specific (as in the early Maryland and New Jersey systems) or pooled and redistributed (as in Maryland's eventual UC pooling approach as of 2008, Massachusetts's statewide pool, and New York's regional UC pools). Pooled systems are considered more equitable because they spread the funding of the UC burden most equitably across payers. As demonstrated in Maryland, the pooling approach resulted in reductions in the amounts that the state Medicaid program paid Maryland hospitals overall – because of the redistribution of the UC funding burden across the state reduced the UC Surcharge magnitudes at hospitals that served large proportions of uninsured patients and Medicaid patients.

In each state, the scope of the mechanism was limited by which payers were included in the regulated rate system. Maryland's Medicare waiver, which was and remains unique among all states, allowed it to include Medicare in the UC financing obligation, substantially broadening the funding base. New York included Medicare in NYPHRM only for a transitional period. Massachusetts and New Jersey either never included Medicare or included it only briefly. The exclusion of Medicare from the UC surcharge significantly constrained the revenue available for these state pools and created inequities between payers.

The experiences of states like New Jersey and New York are instructive regarding factors that can cause instability in this type of surcharge-based hospital UC funding approach. The UC funding systems in these two states were less stable and sustainable because both states experienced the following circumstances: 1) a rapid increase in the number of insured patients in the 1980s, due to an economic recession, which increased the number of uninsured individuals as unemployment increased; 2) Medicaid eligibility cut backs due to growing state budget deficits which caused governments in all four All-payer rate setting states to reduce their Medicaid rolls; and 3) the diminishment of the base of hospital revenue subject to rate setting (and application of the UC surcharges) due to the exit of the Medicare program from state-based rate setting in New York and New Jersey. Additionally, New Jersey's policy with regard to the magnitude of hospital UC that could be funded under the state's Surcharge system was a fourth factor contributing to the destabilization of the state's UC financing system because the state placed few limits on how many patient bills hospitals could "write off" (i.e., classify as an uncollectable account) which also led to a spiraling up of UC eligible for funding via these states' UC pools. All four factors conspired to make a Surcharge-based system less feasible because it

required increasingly large increases in the UC Surcharges applied to the payers that remained subject to each of these states' hospital rate setting system.

This experience demonstrates the importance of certain features and characteristics of future state-based hospital rate setting systems to make this type of broad-based funding of hospital UC feasible:

- Maintaining the broadest base of hospital revenue possible under rate regulation, encompassing all-payers including Medicare and Medicaid (via the approval of a Medicare Waiver from CMMI and CMS) – this will create a manageable ratio of hospital UC amounts to be funded through surcharges as a percentage of total hospital revenue.
- Limits on the magnitudes of hospital bills that can be written off and thus counted as hospital bad debt along with maintaining financial incentives (as Maryland has been able to do) for hospitals to have some financial incentives to continue reasonable bad debt credit and collection activities in order to avoid a spiraling up of hospital UC over time.
- The use of a Pooling mechanism to more equitably spread the financing of hospital UC across payers and reduce the disproportionate funding of UC by state Medicaid programs, which have a disproportionate number of patients treated at facilities with high levels of hospital UC.
- The state of Maryland was able to accomplish these three important undertakings and as a result this state's system of UC hospital financing has remained stable and viable for over 50 years.

g) Rate Setting States' Divergent Fates

By the mid-1990s, Maryland was the only one of these four states still operating a comprehensive all-payer hospital rate-setting system and funding uncompensated care through regulated rates. Massachusetts, New York, and New Jersey all moved to deregulated or partially deregulated hospital markets for reasons including: pressure from managed care organizations seeking the right to negotiate discounts; the collapse of the uncompensated care funding mechanism when some payers (particularly Medicare) reduced or eliminated their contributions; growing complexity and perceived inequities in rate-setting methodologies; and a national policy environment increasingly favoring market-based health care financing.

The consequences of deregulation for uncompensated care funding were significant. In New Jersey, UCC subsidies were cut roughly in half within three years of HCRA 1992 enactment. In Massachusetts, the post-deregulation pool was chronically underfunded. Only New York maintained a substantial pool post-NYPHRM through the HCRA surcharge mechanism, though research has documented persistent inequities in its distribution. Maryland's continued success in financing UCC through regulated rates is often cited as evidence that the key challenge for such systems is maintaining the breadth of payer coverage (especially Medicare) and the political sustainability of the regulatory framework.

The experience of these four state-based hospital rate-setting systems illustrates the key challenges associated with the use of surcharges or add-ons to hospital rates as a means of funding hospital UC and meeting the goal of these rate systems to maintain or expand access to crucial life-saving care for all citizens and particularly the uninsured.

D. Conclusions

An important and highly beneficial program designed to fund a majority of UC experienced by hospitals was used by virtually all past state-based hospital rate setting systems. Indeed, this authority was a key reason why many hospitals in these states supported the initial rate setting legislation. These rate setting systems were implemented at a time when hospital uncompensated care was increasing rapidly, largely due to cutbacks in funding for state Medicaid programs. UC increases in the rate setting states were also exacerbated by periods of slowdowns in economic growth experienced by many states in the early 1960s and 1970s.

A UC funding program not only greatly stabilized hospital financial performance in these states, particularly for hospitals in low-income and underserved areas, it also greatly improved the access to needed hospital services for citizens residing in these states. Thus, the UC funding systems helped these initial rate setting states achieve two policy goal, in addition to their primary goal of constraining overall hospital price and spending growth: 1) creating a more stable and predictable financial environment for hospitals; and 2) expanding the access to hospital care for low-income patients without the financial means to pay for health insurance.

The key lessons from these past state-based rate setting system are as follows:

1. States can create an equitable funding mechanism by establishing state-wide UC pools, where pre-established UC surcharges are added on to established hospital rates. These surcharges will reflect the state-wide (or regional) average level of hospital UC. Hospitals with UC levels below the state-wide average will pay into these UC Pools and those with

UC levels in excess of the Statewide average will be allowed to withdraw money from the Pools to fund their higher-than-average UC levels. Applying State-wide average levels of UC surcharges across all hospital and the use of UC Pools will result in a more equitable UC funding system (compared to systems that based hospital UC surcharge levels based on each individual hospital's level of UC).

2. States that have received approval of a Medicare Waiver, which extends the state rate setting authority to all payers, including Medicare and Medicaid, have the advantage of creating the largest hospital revenue base upon which to implement its system of UC surcharges and UC Pools. This means that the magnitude of the surcharges for any payer will be lower than if a state did not have an all-payer system and attempted to apply UC surcharges to just private insurers, say. In the past, states that lost their Medicare Waivers (and the participation of both Medicare and Medicaid as regulated payers) were forced to impose extremely large UC surcharge amounts on private insurer rates. These excessive surcharges caused self-funded plans in the state to mount an ERISA challenge which, in the case of New York and New Jersey were successful at the state level.^{ix}
3. A third key conclusion is that states looking to implement UC funding systems should set limits on the amounts of hospital bad debt and charity care that can be funded from these systems. Hospital should still have a financial incentive to maintain their bad debt credit and collection activities from patients with the means to pay their hospital bills. Setting limits on the amounts of hospital UC that can be financed collectively, will help keep the UC amounts needed to be funded at reasonable levels and not lead to a spiraling up of hospital UC (as occurred in New Jersey when hospitals classified virtually all uncollected accounts as eligible for funding from the states UC Pools and effectively eliminated all credit and collection activity).

Overall, however, a UC funding system, as described in this report, can be an extremely valuable complementary program for states, that can add to patient access to care and help to financially support hospitals that serve large numbers of indigent patients or reside in underserved parts of the state.

ix Note: these ERISA challenges were, however, overturned at the Supreme Court Level.

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