



**Institutional Ambivalence and Permanently Failing Health Care: Access by
Immigrants and the Categorically Unequal in the Nation and New Jersey**

by

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**Institutional Ambivalence and Permanently Failing Health Care:
Access by Immigrants and the Categorically Unequal in the Nation
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Abstract:

Immigrants seeking health care, especially those without some kind of public or private insurance, highlight the barriers to access that arose as intended or unintended barriers of how dominant stakeholders shaped American medicine. This paper draws on a new study of those consequences for immigrants and focuses on efforts by one state to increase access. Such efforts are framed and constrained by past institutional developments and the layered actions of federal, state, and sometimes county or city actions. We develop a conceptual framework based on Merton & Barber, Meyer & Zucker, Tilly, and Massey that is useful for analyzing health care and other human service programs. Categorical inequalities underlie institutional ambivalence in many programs and policies, and in efforts to reduce or increase them. These inequalities and ambivalence contribute to American health care and health insurance being permanently failing systems driven by provider and insurer moral hazard that never collapse but run inefficiently, ineffectively, and inequitably.

Two major challenges in social policy today are large-scale immigration and increasingly unaffordable health care. The institutional responses of providers to the needs of immigrants have been the subject of the Health and Immigration Study (HIS) at the Center for Migration and Development at Princeton University, funded by an Investigator Award by the Robert Wood Johnson Foundation. Through semi-structured interviews and institutional analyses in Miami-Dade, San Diego County, and Mercer-Middlesex Counties in New Jersey, comparative insights have been gleaned and a new conceptual framework developed that can be applied to policy research on human services. This paper will analyze the layers of institutional change in different programs that constitute the terms of access or denial when immigrants seek health services. It concentrates on access for immigrants to a range of medical services in one state, New Jersey. What any one state can do, and decides to do, about sick or injured immigrants, barriers to access, and rising costs depends deeply on the institutional structure of health care and insurance, and on federal action. Thus an institutional history of financing and service organizations must set the context for state actions.

There are several barriers to access not addressed in this paper and shared by immigrants everywhere, even in universal health care systems in the UK, The Netherlands or France. Immigrants are impeded by a lack of fluency in the native tongue and familiarity with the procedures and strategies for getting services. Low-skill immigrants are likely to face further barriers from being poorer and lacking much education, from holding traditional “folk” concepts of pathology and treatment, and from a fear of being caught by authorities at their most vulnerable when going to a hospital or clinic (Smith 2005).

The uninsured are also 3-4 times more likely than the insured to postpone medical attention or not fill a prescription because of cost, and 3 times more likely to be contacted by a collection agency about bills for hospital care they could not avoid (Kaiser Commission on Medicaid and the Uninsured 2004 (Nov)). These differences partly reflect barriers of income, language, and prejudice (Smith 2005). The fear of getting a large bill, or being scrutinized by the authorities helps explain the much lower enrollment of US-born children

of non-citizens versus citizens in SCHIP, the expanded part of Medicaid for children (NCLR 2004).

Further, many immigrants view health care as a repair shop, somewhere you go after you become not only injured or ill but after enduring the pain or disabilities while self-treating them, until you can take in no longer. This cultural outlook contrasts with widespread efforts to create a “medical home” where check-ups and preventive services keep people from becoming ill. Thus the principal reason immigrants give for not having seen a doctor in the last 12 months is that they had no health problem (Nandi et al. 2008). Even then, the demands of work with no job security, the complexities of low-income life, and the scheduling practices of clinics result in a high rate of not showing up or following through with a treatment plan. For these reasons and others, uninsured immigrants receive services worth less than half those received by US-born patients (Mohanty et al. 2005). Even when controlling for poor health, age, income, and education, the costs of medical service for immigrants are lower.

When senior physicians and administrators were asked, “What are the principal medical problems of immigrant patients?”, some answered diabetes, or hypertension, or pregnancies. But others answered,

Language...and transportation...and compliance. Follow up is very hard. 10/9/07:4

Or,

Language, culture. Patients don't understand what their problem is. Diet. No insurance, and they can't get it. 12/11/07:3.

Or, from a nurse who dedicates her life to inner-city patients:

Many have no care so they come in with old problems that haven't been treated.

She told of a Guatemalan patient who came to the emergency room (ER) with stomach pain, and her team found he had stage-4 pancreatic cancer. Only 33 years old, he had left his wife and three children back home to come and support them from working in New Jersey. His

only wish was to die at home, and the staff of this Catholic hospital raised the funds to fly him back.

These life circumstances, outlooks, barriers, and acts of compassion happen everywhere, including advance universal health care systems. What does not happen anywhere else are the financial, legal, and institutional barriers to needed health care in the United States. An in-depth study found a new, stigmatized caste of “Americans who have seen loved ones die because they did not have medical coverage, Americans who have declared bankruptcy or were forced to sell their homes to pay for medical care, and Americans stuck in dead-end jobs because their health is too poor to allow them the career mobility available to Americans of earlier generations (Sered and Fernandopulle 2005:27). No other system has 46 million people uninsured, increasing about 4,000 people a day, net of uninsured covered through expanding the eligibility criteria and funding for public programs. No other system has another 50 million deemed underinsured because their policies have limitations in coverage sufficiently large that a serious illness would leave them paying more than 10 percent of their income for uncovered parts of the bills. Most of the practices of for-profit insurance companies in a voluntary “free market” are illegal in other advanced countries and unthinkable, such as denying coverage altogether for higher risk applicants, writing in exclusion clauses to deny coverage for one’s diabetes, cancer, or heart condition (Light 1992a).

Imagine, then, our surprise to find in New Jersey near-universal access to all hospital-based care, the most costly and inaccessible to the uninsured, free to anyone with income up to 200 percent of the poverty level (\$20,000 in 2009) and available on a sliding scale up to 300 percent. Proof of eligibility? Some form of identification (N. J. Department of Human Services 2009). Proof of residency? Said a long-time CEO who came up from patient care,

Let’s put it this way. We do not put them through practices that would jeopardize their immigration status. As Judy said, if you live in a car, we’ll take care of you anyway.

10/9/07:6

This contrasts with the national debate about illegal immigrants and “what – if any – benefits they deserve while they’re here. ...The phrase ‘illegal immigrant’ is just radioactive at the moment” (Wolf 2008 (Jan 21)).

Proof of income? If not pay stubs, a letter from one’s boss. If not that, a description of where one works and how much one makes that is filled out by bilingual staff and signed by the patient. Immigrant status? Not relevant. Don’t ask. Don’t know. Don’t care. We kept asking how many of a facility’s patients were immigrants and got bewildered looks:

We really don’t know. 10/9/07:6

We don’t collect data on foreign-born or migration status. 11/16/07:4

The administrator for New Jersey’s Charity Care program, which will be explained later, had no data or interest in questions about immigrants. The program treats a new immigrant the same as a 4th generation American with low income and not qualified for Medicaid. All facilities, in fact, try on intake to determine if patients are eligible for Medicaid, which means asking if they have papers; but if they do not, the interview moves on to evidence of their income and residency in the state.

What this all means to immigrants in New Jersey is illustrated by the case of Christina Munoz (not her name), a recent immigrant from Mexico. She came in to the “Charity Care Clinic” at a suburban New Jersey hospital for a pre-natal check. The intake staff determined that she was not eligible for Medicaid or other programs, but she qualified for New Jersey’s Charity Care (explained later). The physician found that she had lupus and sent her to the high-risk unit at a university hospital, where she received costly tests and close monitoring at no charge. Her baby was born at 35 weeks, weighing 4 pounds and needing neonatal care, also at no charge. Her vulnerability (serious illness, baby at risk, no money, no insurance, little English) mobilized a pre-established network of health care providers and organizations that have a tradition of helping the least advantaged. One is a hospital pharmacist who is skilled at getting drugs at little or no cost through manufacturers’ charity programs and other means. Several months later, Ms. Munoz was diagnosed with lymphoma. Serial CAT scans

and radiotherapy followed, at no charge. This level of sophisticated, complex care is comparable to what a CEO would receive, with no deductible or co-payments.

Categorical Inequalities and Institutional Ambivalence

To understand the origins and dynamics that shape immigrant access to health care or other human services, and state programs like New Jersey's Charity Care, one must first take account of the delivery and financing institutions that frame and channel their policy options. An insightful way to understand them from an immigration perspective highlights the role of *categorical inequalities* set by providers, legislators and insurers over the past century. Sometimes they are direct, such refugees being granted access to Medicaid, while green-card legal immigrants are usually not. Sometimes they are indirect, like the key role of racism built into Medicaid by Southern democrats insisting that states be given extensive jurisdiction over eligibility and coverage decisions (Gordon 2003; Quadagno 1996). Categorical inequalities, Tilly (1998) wrote in his prize-winning book, are durable and come in bounded pairs. Their roots lie in exploitation or opportunity hoarding, and they "depend on extensive social organization, belief, and enforcement" (pg 7). They tend spread by emulation or adaptation so as to produce multiplier effects throughout an institution, as we will see in the development of both health insurance and medical services as two large institutions. Through adaptation, categorical inequalities can vary in their application, such as the extensive variations between states in how the boundaries of Medicaid are set and applied in use. Scripting plays an important role in facilitating both the powerful and powerless as categorical pairs to buy into the inequality and reinforce it through mutual labeling and accepted use. Local knowledge is used to modify scripts to allow greater improvisation, such as seen when intake staff determine for what kind of coverage, if any, an immigrant patient is eligible.

The institutionalization of categories is critical to making them durable, and then organizations depend on enforcing, if not exploiting the categorical inequalities built into it. (Tilly 1998:Ch 2, 85). The categories of exclusion-inclusion, disadvantage-advantage, or liabilities-benefits affect the culture, customs, attitudes, and prejudices of actors as indirect

effects that become especially apparent when individuals (either staff or recipients) try to ignore, override, object, or break out of the categories. “Once in place, . . . beliefs justify, fortify, and constrain social interaction” (pg 102). Massey (2007), in an important extension of Tilly’s concept, analyzes the dynamics of categorical inequalities in American society. He adds to the concept the underlying dimensions of warmth-coolness and competence-incompetence that result in four categories of dispositions and boundaries.

For providers, the categories of eligibility, coverage, and payment are external and imported (Tilly 1998:Ch 3). When we asked hospitals or clinics if they screened immigrants for their legal status or residence or income, they said it’s not them but the requirements of different insurance programs. Clinicians exhibited limited knowledge and misinformation about these critical categorical inequalities and operate in what we call a Hippocratic Bubble (Portes, Light and Fernandez-Kelly 2009). Internal categories interact with the external ones, such as clinicians determining whether a patient in emergency requires stabilization, admission to a bed, or just regular ambulatory care. These are organizational categories of triage and not only determine the speed and institutional location of treatment but trigger categorical differences in payment levels and coverage rules. For example, Medicaid pays a much lower percent of costs for ambulatory care than for hospital care.

To appreciate the centrality and power of categorical inequalities to services, consider a national health service that has none. Everyone has access but no one has insurance, except for a minority who buy top-up supplemental private insurance (Keen, Light and Mays 2001). In a national insurance system, nearly everyone is also categorically equal. Many universal health care systems have *categorical compensations*, that is, extra programs, funding, or provision to compensate for disadvantaged groups. In the UK NHS, for example, primary care providers receive extra pay for treating patients who catalogued according to an index of functional disadvantages such as low income, difficulty speaking English, living alone, lacking transportation, having a disability, and so forth. Categorical compensations are not considered at all by Tilly or Massey, and they are based, not on exploitation or opportunity hoarding, but on compassionate paternalism.

In the United States, by contrast, four basic categorical inequalities among coverage plans interact with three main kinds of categorical inequalities among immigrants. There are preferred immigrants, sought after for their advanced skills and immediately hired at good salaries with good health insurance (Portes and Rumbaut 2006:20-27). Refugees, asylees, and certain other special categories are also given preferential treatment and made eligible for Medicaid. Second, regular immigrants are allowed in but treated with considerable indifference. They may or may not work for an employer who offers commercial insurance, and probably do not qualify for Medicaid if their income is low. Third are undocumented immigrants with no access to health insurance. One could add naturalized citizens as a fourth category. Each has unequal legal and regulatory rights to medical services when needed, aside from other attributes that greatly affect access for all Americans: income, education, type of job, and other socio-demographic characteristics and cultural-linguistic deficits or resources described above. As pointed out by conservatives who hate laws interfering with the market and liberals who want open borders for labor as well as goods, removing the laws would remove the categorical distinctions (Griswold 2007; Massey, Durand and Malone 2002).

Among coverage plans, five major types of “insurance” facilitate access to services for some and block it for others are Medicaid, Medicare, relatively comprehensive commercial policies, “barebones” policies (high deductible, high co-payment, limited coverages), and charity care.¹ The oldest, with the deepest roots in medical ethics, moral philosophy, tax code, and actual practice is charity care (Stevens 1971; Stevens 1999), a point forgotten by most but rediscovered in this research. All other coverages arose to address the inadequacies of charity care; for with a few exceptions, there was no public or private insurance before the 1940s (Somers and Somers 1961). The millions of immigrants who arrived between 1880

¹ By “insurance” we mean generically any policies or programs that pay health care providers or facilities, or help patients pay for services. These range from the original Blue Cross plans that paid in kind, to prepaid group plans that pay staff in various ways, to traditional insurance plans that pay a certain amount for a certain service either to the provider or the patient, to government programs like Medicare or Medicaid, to government service organizations like FQHCs or public hospitals.

and 1930 were treated with charity care, paying a small consideration for the kindness if they could, or not at all.

This point requires a new concept overlooked before, *categorical restitution*, the institutional effort to remove or mollify the inequalities imposed by institutional inequalities. Categorical compensation, by contrast, refers to institutional efforts to compensate for inequalities outside the institutional domain. Traditional charity care was for those too poor to pay, or pay very much, and charity care hospitals or clinics were common in the 19th century. But charity care subjects people to prejudices, values, and capacities of paternalistic benefactors. Medicaid and Medicare transformed medical charity care from a gift to an entitlement for those who qualified and thus restituted some of the inequalities built into charity care but created new ones (Starr 1982; Zelizer 1994). Formal aspects of charity care today, discussed in the second half of this paper, are aspects of categorical restitution.

Health “insurance” in general and the categorical inequalities built into different kinds embody different kinds of money, infused with different meanings. The two chapters on money for the poor and charity in Zelizer’s (1994) classic treatise, lend insight into the nature of a program like Medicaid. It compensates providers for services – no cash – after patients are thoroughly catalogued as sufficiently “American,” deserving, poor, and sick enough to receive those specific services. Bordering between a gift from taxpayers and an entitlement, it rejects as ineligible most poor adults and all near-poor, but with exceptions of special deservedness. The below-cost compensation signals an institutional ambivalence between feeling these patients should get treatment and feeling they are less worthy than people with private insurance and a taxpayers’ burden. Many physicians and clinics refuse to treat patients on Medicaid because it pays so poorly; so patients have comprehensive coverage but “Medicaid money” is worth so little that few outpatient specialists accept it.

...access to subspecialty care, this is the most difficult, along with access to costly meds.

11/16/07:5

Medicaid money compensates hospitals much better, as if to signal that becoming *really* sick increases the deservedness of poor patients. One could analyze the meaning and types of “money” in every other categorical program for health care coverage. For example, certain disorders like renal failure receive special monies that are generous and apply to anyone who has them, while other disorders like mental problems get earmarked for little or no compensation. Thus special monies favor immigrants who have renal failure, get pregnant, or become HIV positive, but not those who have major depression, diabetes, or a physical handicap. Thus categorically unequal insurance schemes interact with categorically unequal service areas. The proliferation of categorical inequalities and special monies are what make access so opaque.

The obverse to categorical restitution is *categorical entrenchment*, seen most clearly in the 1996 laws in which Congress barred all new immigrants for five years from publicly funded services. Congress declared, “...it is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits” (in Kullgren 2003). The sweeping declaration of ineligibility to any health benefit provided by any federal, state, or local government, however, elicited objections and protests from a variety of parties that constitute countervailing powers, a framework from John Galbraith’s concept in economics (Light 1995). States retain extensive jurisdiction over matters of health and safety, and some responded that implementing the ban interfered with their public health mandates and responsibility to spend public money efficiently. Many physicians and nurses objected that the ban was a violation of their duty to help those in need and impeded good medical management. Was one to “manage” the diabetes or asthma of an undocumented or legal patient from emergency crisis to crisis? Advocates for children said the ban raised a significant barrier to reaching native-born children of undocumented parents and enabling them to exercise their rights to Medicaid and related programs. Clinicians and administrators found the reality of what Congress imagined distasteful: were they supposed to determine which sick patients had entered the U.S. less than five years ago, only to then send them out the door untreated? Nearly half the states made the difficult decision to allocate their own funds to compensate for Congress’s restrictions and improve access for some or all excluded immigrants (Fremstad and Cox 2004). Many decided to simply employ a “Don’t ask. Don’t

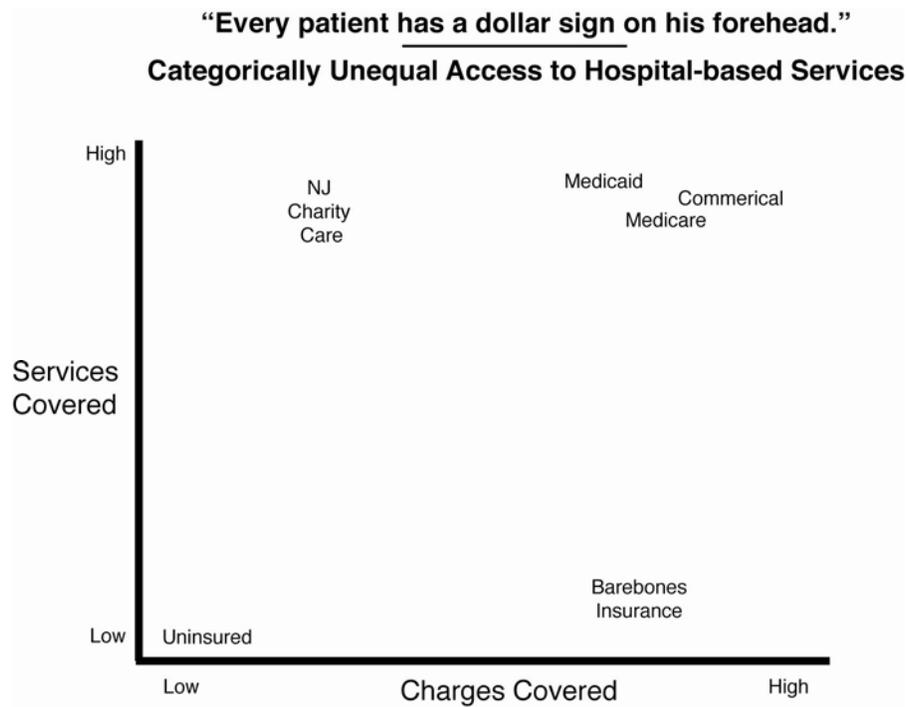
know” strategy towards the legal status of immigrants to create a safe haven for undocumented people with health problems – they wanted them to come in, even though they lost money. In New Jersey, intake staff and hospitals help immigrants qualify and take almost anything as proof of income or residence, like a declaration that one is living in a car, signed by the patient. In New York, a thorough neighborhood-by-neighborhood study of the least advantaged, undocumented Mexican immigrants found patterns of actual access (vs coverage by Medicaid) quite similar to those of documented immigrants (Nandi et al. 2008). In Miami, by contrast, even the publicly funded system has created unrealistic requirements for documentation to qualify for treatment (Portes, Light and Fernandez-Kelly 2009).

“Every patient comes in with a dollar sign on his forehead,” said an administrator in Florida; but the meaning is quite different from a salesperson saying that of every person who walks into Tiffany’s. There, the question is how big a rock can she afford? In health care, the question is what proportion of the cost for the service she needs can she or her coverage pay? Given that hospitals and doctors are not on a budget, as they are in the armed services, the Veterans Administration, or a national health service, the question is how much of a procedure that actually costs \$2,500 but is billed at the rake rate, or sticker price, of \$8,700, will the provider get back – the negotiated \$3,000 with high-volume commercial insurers, or \$1,725 that Medicaid pays (69% of costs), or \$1,000 that NJ Charity Care pays (as explained later) or what the patient can pay in cash? Figure 1 illustrates these payment inequalities from a hospital’s point of view. At the top right are patients with commercial insurance, Medicare, or Medicaid. They cover a high proportion of services and pay more than, about 90%, and about 70% of estimated costs, respectively. Patients eligible for the special money of Charity Care cover most hospital services but at an average of about 40% of estimated costs. Patients with barebones policies cover fewer services and do not pay well. Uninsured patients are seen as covering nothing and paying little.²

² This view of how well uninsured patients reimburse costs will be challenged later in the paper.

Because there is not universal health care, every low-income immigrant threatens a facility's ability to break even. Providers blame Medicaid for not covering all low-income people, regardless of legal status, and not paying their actual, estimated costs.³ It is Congress that categorically excludes most immigrants and the states that largely set payment levels below estimated cost. In the handful of states like Massachusetts that have tried to create universal access, failed, and kept trying again, physicians and hospitals work as hard as legislators and employers to make health care a right rather than a commodity.

Figure 1 about here



Institutional Ambivalence

³ After 40 years of health economics, actual hospital costs remain elusive. Researchers, like accountants, end up settling for conventions of counting and allocation, factors, and formulas. One of our graduate students went to a university hospital for surgery in 2008 and was billed \$15,932. for one night of what the bill described as “room & board.” The commercial insurer claimed the overnight stay cost \$1,932. and the rest was sticker-price overbilling. It paid 80%, leaving out student owing \$386.40. But what did the overnight stay actually cost the hospital, perhaps \$900? The answer depends on who is counting and how.

The layers and complexities of categorical inequalities become reified in *institutional ambivalence*. Welfare services help the needy, but not so they become dependent or stop trying to take care of themselves. Medicaid covers medical services but pays providers less than their cost and excludes half the uninsured, low-income people who need it. Institutional ambivalence comes from Merton and Barber's (1976) explication of sociological ambivalence by extending it to the institutionalization of conflicting interests, values and goals. Although Merton and Barber (1976:5,11) focused entirely on "the ways in which ambivalence comes to be built into the structure of social statuses and roles" at the interpersonal level, they lay the groundwork for analyzing ambivalence at the institutional level and reflect Robert Lynd's (1939) famous but now forgotten explication of cultural ambivalence, as do categorical inequalities. They identified five ways which have equivalents at the institutional level. There one can find embedded the conflicting normative expectations of stakeholders (Quadagno 2004), conflicting statuses and programs within an organizational set, and conflicting roles. Contradictory cultural values (for example, concerns about "moral hazard" and free riders versus concerns about treating patients in need), disjunctures between aspirations and opportunity structures, and the two cultures of commerce and medical ethics or of markets and community, co-exist without a clear hierarchy of priorities. Institutional ambivalence stems from not having a clear hierarchy among priorities because no one party or coalition has the power to overcome opposition and prevail. Thus institutional ambivalence and conflicting values reflect the interplay of *countervailing powers* as a force-field concept. It can be applied to access as well as provision of health care (Light 1997b).

Figure 2: Sociological and Institutional Ambivalence

Institutional Ambivalence

(Light, Portes & Fernandez-Kelly)

Sociological Ambivalence

(Merton & Barber)

Conflicting cultures & stakeholder expectations

Conflicting normative expectations

Conflicting statuses within an organizational

Conflicting statuses within a status set

field

Conflicting roles associated with statuses	Conflicting roles associated with a status
Contradictions between functions & structures	Contradictions between aspirations & opportunity structures
Permeated with tensions of different categorical inequalities	Experiencing tensions between two cultures

Categorical inequalities underlie institutional ambivalence, and this paper illustrates the struggles around those ambivalences through an institutional and political account of New Jersey's efforts to alter its bundle of categorical inequalities – mostly inherited from the wider world of commercial insurance, federal policies and the historic institutionalization of medicine. Governmental bodies such as states develop an institutionally ambivalent bundle of programs and restrictions which embody categorical inequalities. Immigrant access therefore would depend quite a bit on whether one lives in Amesbury Massachusetts, or up the road in Hampton New Hampshire, or farther on in Kittery Maine. Immigrants are confronted by quite different bundles if they live in Needles California than if they live up the highway in Arizona. States manifest what James Morone calls “Tocqueville’s ambivalence” (Morone 2001). They invent and try new policies, yet are greatly constrained by federal law, policies, and funding (Sparer 1996; Sparer 2003).

Institutional ambivalence applies to health care services as well, especially hospitals. Originally, they aimed to provide a clean, protected, and nursed environment for the seriously ill, but then physicians turned them towards generating revenues for their burgeoning practices (Rosner 1982). Clinics and ambulatory services were added over the decades, and by the 1970s a wide range of other services as well. Their name changed from “hospital” to “medical center” and more recently to “health center.” Most were started by communities or religious orders to serve those in need and are tax-exempt. Yet they have become commercialized and oriented towards serving those who can pay. These characteristics embody differing if not conflicting values, different “clients” and different goals.

Institutional ambivalence helps to explain why attempts at reform often fail or result in new layers of organizational and regulatory complexity (Gordon 2003; Starr 1982). One category may exploit another, or one may hoard resources through rules and practices of exclusion or priority that restrict or block another category's access to them. For example, in a companion paper we discuss how the American obsession with the 'moral hazard' that covered patients might overuse services can lead to categorically denying access to health care by the most vulnerable immigrants through eligibility criteria, even in a program explicitly set up and funded to serve uninsured immigrants. (Portes, Light and Fernandez-Kelly 2009).

Ambivalence between serving all the poor and servicing only an affordable and more convenient proportion of the poor is embedded in the criteria. The concept of institutional ambivalence pertains to a number of other domains, such as welfare policy, the military, environmental protection, and especially immigration policy itself (Massey, Durand and Malone 2002; Portes and Rumbaut 2006). Although instability may result from conflicting priorities, rules, and roles that lead to institutional shifts regarding health insurance, institutional ambivalence may persist for long periods.

Permanently Failing Systems

The growing presence of immigrants needing health care highlights the institutional ambivalences of embedded categorical inequalities that make the American health care a *permanently failing system*. This concept extends and adapts Meyer and Zucker's (1989) brilliant analysis of why many organizations neither succeed or go out of existence but rather carry on for years performing in suboptimal, partially dysfunctional and inefficient ways. Why? One reason is that different groups and constituencies use an organization, or in our case an institution, for their own purposes and block reorganization or bankruptcy. A related reason is that organizations, or institutions, attract multiple, conflicting goals. Third, most officers are concerned with maintaining the *status quo*, not maximizing performance. Finally, the interests of owners diverge from dependent actors, and isomorphism replaces efficiency as an imperative.

Permanent failure also results from the logic of vested interests protecting or advancing their concentrated benefits and opposing the less organized and more dissipated societal benefits of reformers who want more general benefits of greater equity and efficiency through reorganization (Olson 1982:Ch 3). From our interviews, we could write another paper about hospitals as permanently failing organizations and how because the resulting waste could pay for access to all immigrants. In human services, *an unanticipated consequence of categorical inequalities institutionalized into the organization and financing of health care is less access to the insured through spiraling costs.*

If we take a time capsule back to 1971, we can appreciate the tragic irony of this insight. Senator Edward Kennedy had introduced a single-payer, Medicare-for-all plan wrote a best-selling book reporting what citizens around the country told his committee at town meetings:

Do you know that medical costs force Americans of every income level to mortgage their families' future, sell their homes, give up their children's college education, and even declare bankruptcy? Many are hounded by collection agencies hired by hospitals and doctors.

One out of seven Americans has no health insurance at all because he can't afford it or has a health problem that makes him uninsurable.

Finally, are you aware that America's \$17-billion-a-year health insurance industry takes enormous salaries, commissions and profits out of the premiums you pay, and does little or nothing to control physicians' and hospitals' charges or stimulate them to deliver better health care to Americans?

I am shocked to find that we in American have created a health care system that can be so callous to human suffering, so intent on high salaries and profits, and so unconcerned for the needs of our people.

The health care industry seems by its nature to give most freedom and power to the providers of care – and very little to the people. It is an industry in which there is very little incentive to offer services responsive to the people's needs and demands.

Indeed that is how the industry was set up. Kennedy (1972:12-16) provided a vivid portrait of health insurance as a permanently failing institution, despite the maturity of Blue Cross and Blue Shield plans in every state by then, the widespread offering of commercial health insurance policies by employers, and Medicare/ Medicaid to fill two gaps for the elderly and the poor. Despite internal changes and the managed care revolution, Kennedy's depiction applies as much today as it did nearly 40 years ago, except that coverages have thinned out and the number of uninsured has increased. Slowly, the health insurance non-system has been unraveling, and about 4,000 more people lose health insurance each day.

Laying the Foundations

Although current health insurance organizations and programs did not start until the 1930s, important foundations were laid down earlier that are still central to access for immigrants today, especially in the case of New Jersey. As explained in an earlier paper (Light 1989), the medical profession faced intense competition on multiple fronts around 1900, none more feared than what was called “contract practice.” This was one of two early, more equitable and efficient forms of health care that county, state, and national medical associations boycotted and blocked in the name of “autonomy” and “quality.” Contract practice was a primitive form of prepaid group practice that gave free access to primary care or hospital care to everyone working for a company, initially the railroads, lumber, and mining, but increasingly a growing number of other businesses, as well as by the national and regional fraternal organizations that were so prevalent at the time (Schwartz 1965; Williams 1932). Many of these workers and members were immigrants. State and county medical societies representing private practitioners and loathed them. “No middlemen” became the cry of fierce campaigns that forced employers to drop contract practice (Light 2004). “No middlemen” and the specter of “Kaiser medicine” during World War I and later “Communist medicine” after World War II set the AMA and most state societies against various forms of prepaid group health insurance (Leland 1932).

The medical profession’s view resonated with a wider belief that health care is a private matter between patients and doctors that prevails today and contracts with health care as a social good or human right (Gordon 2003). Access depended on how much a doctor decided to charge poorer patients. Charity care was offered at the physician’s discretion. When the pressure for health insurance became too great to stop, “no middlemen” led hospitals and the organized profession to seek a kind of insurance that would not interfere with physicians’ freedom to set their fees. This unique feature persists to this day and is even enjoying a revival as more and more physicians refuse to take any insurance, leaving reimbursement of their charges to their patients. Had contract practice continued to grow, it would have led to more efficient, coordinated services at substantially lower costs so that universalizing the design would not be difficult. Ironically, President Nixon came to the same conclusion in

1971 when he proposed a national health insurance program organized around 1600 sophisticated versions of prepaid group plans (Nixon 1972 (1971)).

Equally important was organized medicine's successful campaign against public health dispensaries that provided free clinical services. The great advances from applying germ theory and early scientific medicine had their greatest impact through city departments of public health as water purification, pasteurization, sanitation, and control of epidemics developed, especially in low-income areas. A next natural step, given the huge influx of immigrants, was to open dispensaries, or free public health clinics. The Commissioner for New York City, S.S. Goldwater (1915), reported that their numbers had increased from 100 in 1900 to more than 700 in 1915.⁴ Patients received more than 3 million treatments, "and the number of consultations is steadily increasing." These public health clinics were much superior to solo practices, he averred, because they offered the coordinated skills of internists, surgeons, and pathologists, "working together in a comprehensive organization." Dispensaries were, in effect, a public medical service with salaried staff, free to all immigrants and other indigent patients. Their superior quality started to attract private patients, and medical societies and the AMA put intense pressure on public health departments to leave clinical medicine to private practitioners and stop invading their market (Rosenberg 1974; Stevens 1971).

Charity care was a third, though inequitable source of health care for immigrants, the paternalistic gift by private practitioners and hospitals that complemented public hospitals and dispensaries. Community medicine for poorer patients had long been provided by physicians in an *ad hoc* charitable manner as they decided how much to charge patients of different means and waived the fee for indigent patients. Charitable hospitals were founded in the 19th century, largely by benevolent groups as a sanctuary for the poor, since people of

⁴ Like a general, Goldwater led one successful campaign after another against contaminated water, slurry milk, foul foods, rat-infested tenements, infectious diseases, and plagues. Compared to these, clinical medicine and surgery were skirmishes that hardly affected health status and were as likely to kill as cure.

means had inpatient care done in their homes. But as modern surgery developed in the early 20th century, specialists transformed them into fee-based institutions, though they also retained their tradition of free care to the poor, especially immigrant groups for which many of them were founded (Rosner 1982). They became institutionally much more ambivalent in precisely the way that Meyer and Zucker identify, yet the major source of serious hospital care for millions of immigrants for decades after the 1880s.

Rosemary Stevens (1982) documented how “voluntary” or “community” hospitals, as they were called, had an institutionally ambiguous status “simultaneously both (and neither) public and private institutions...”(p 580). County and state governments paid them grants to help with epidemics and care for the large immigrant populations to supplement or substitute for public hospitals. All hospitals, even private ones, were regarded as “public,” which meant serving public ends. Physicians were expected to treat hospital “charity cases” without fee. When the tax-exempt status of “voluntary” private hospitals was challenged, courts upheld it because they made profits on some services (e.g. surgery) to cross-subsidize others (a public clinic). In 1903, government subsidies to “benevolent” hospitals ranged from 24.5 % of revenues in North Carolina, to 12.4% in New Jersey, to 5.5% in Virginia. As special money for treating poor patients, subsidies paid less, a tradition embodies in Medicaid. For example, in New York City, hospitals received 62 percent the average cost per diem in 1906 for treating indigent patients. By the 1920s, hospitals operated more like businesses so that “...the poor became the residual beneficiaries of care in voluntary hospitals....[and] increasingly became a nuisance” (p 569). Thus the creation of the Charity Care program in New Jersey after 1971 that is featured in the second half of this paper as supporting open access for immigrants to hospital services, is in fact the reinvention of well-established practices that resonate with the older view of non-profit hospitals as both commercial and charitable institutions receiving special monies for the latter.

Categorical Inequalities in Patient Care and Moral Hazard

A categorical inequality also developed between hospital-based specialty care and general practice that has marginalized the latter ever since. Behind this lay the medical profession’s

drive for specialization that highlights its technical prowess and justifies higher fees (Stevens 1999). Giving specialty hospital care priority in insurance and payments has been *the* major driver of escalating costs and inequitable insurance coverage through *provider moral hazard* – the risk that providers exploit insurance to order more tests and procedures. “Technology” is often identified as a major cause of rising costs, but this mis-identifies the deeply embedded institutional causes in specialists eager to order the latest device, drug, or piece of equipment and charge for it MAHAR.

When hospitals were renovated and expanded after World War II through the large massive Hill-Burton program of federal funding, the money came with a binding commitment to serve any indigent patient, forever. As “community hospitals” became increasingly commercialized and profitable, their tradition of giving care to the poor faded further. Advocates for the poor found later that many hospitals put their Hill-Burton notice in the back on the loading dock, rather than by the front entrance (Gordon 2003; Starr 1982). Critics on the right also accused tax-exempt hospitals of shirking their charitable obligation to give back the value of taxes, leading to a revival of charity care in some states to preserve tax-exempt status. This obligation has played out quite differently in different regional cultures of the nation, but as we shall see, it became the prevailing culture among hospitals in New Jersey. Nationally, uncompensated care to immigrants and other uninsured patients continues beyond the federal obligation to stabilize any patient who comes to the emergency room. Tax-exempt non-profit hospitals report spending 3-7% of patient revenues on uncompensated care, and for-profits report spending 2-5%, some of which is truly services to the uninsured poor (GAO 2005). A given immigrant, however, cannot be sure whether he or she will receive free hospital services or a large bill.

Sub-specialization accelerated during the 1950s and 1960s, unfettered by concerns about who would pay the bill (Somers and Somers 1961; Starr 1982). Soon, studies began to appear documenting large portions of unnecessary, excessive diagnostic tests, operations, hospital admissions, bed days, and prescription. Manufacturers of medical technology and devices realized that any new device that was slightly more convenient or had a new feature

would be bought, since hospitals could include their costs in charges. Medical arms races (competing to have the latest equipment and subspecialty units) still take priority over using funds to treat uninsured patients. A hospital administrator explained how specialists keep patients in longer and do more tests to increase their incomes at the expense of the hospital, so that less money is left to treat poor immigrant patients:

Medicare pays doctors per visit, while it pays hospitals per case; so there's a basic conflict of incentives. And doctors work the system by keeping their Medicare patients in longer so they can collect more fees. ... We can't challenge their clinical judgment. They keep Medicare patients in for 11 days with a disorder that can be treated in 3! 11/12/07:10

Provider moral hazard is much more prevalent than moral hazard by patients, as explained in a companion paper (Portes, Light and Fernandez-Kelly 2009).

Also relevant is *insurer moral hazard*, as insurers delay and deny legitimate payments that further reduce hospitals' margin for treating poor patients (Light 1992a). Insurer moral hazard plays a key role in swelling the ranks of the underinsured and uninsured by companies not covering known risks and using a number of techniques to cover less than subscribers believe. The relevance of these two unacknowledged forms of moral hazard today is that they explain the huge amount of unnecessary expenses and subsequent unpaid bills that both reduce funds to treat the poor in a system that does not recognize health care as a right.

Medicaid and Medicare as Categorical Restitution

American health insurance developed in such a hospital-centered way that by 1964, private insurance covered three-quarters of the population, but only a third of patients' medical costs, most of which occurred outside hospitals (Gordon 2003:30-31). No other industrialized country allows employers to decide whether to offer health insurance at all, how much to provide, and how much risk selection to build in. None other allows insurers to use risk selection, denial, exclusion clauses for pre-existing conditions, occupational relining, new deductibles and waiting periods each year, policy churning, and high co-

payments as forms of categorical inequalities that reflect the *inverse coverage law* by which American commercial health insurance operates: other things being equal, coverage is inversely related to need (Light 1992b). The range of resulting techniques is illustrated by Figure 3.

Figure 3 here on insurer techniques?

The insurance-backed escalating costs of provider moral hazard made modern medicine increasingly unaffordable to the elderly and poor, and finally campaigns for categorical restitution the old and poor succeeded with Medicare, “the noble heir to Social Security,” and Medicaid, “the stigmatized spawn of public assistance...replete with interstate disparities in eligibility and coverage...” (Brown and Sparer 2008:1187). The hospital and medical lobbyists made sure that Medicare, and to a lesser extent Medicaid, used the same provider-designed structure of passively reimbursing charges and focusing on hospital services and specialty care so that, despite universal coverage of the elderly population, only a third of their bills were covered (Starr 1982). Coverage has improved over the years, but ironically has created a widening categorical inequality of access between people who can afford supplemental insurance and those who cannot as more physicians refuse to accept Medicare or Medicaid payments. A senior hospital physician said,

Medicare is pathetic [in the way to underpays]. We are becoming inundated... because doctors are not accepting Medicare payments for outpatient services; so elderly patients come here as a last resort....There are two tiers now. 3/14/08:11

These two major public insurance programs also reinforced the categorical inequalities between hospitals and outpatient services, and between high payments for medical technology and low payments for clinical time with patients. These institutional features plague efforts to provide health care for immigrants and other disadvantaged patients.

Medicaid and Medicare were also carefully designed not to “crowd out” commercial insurance by serving as gap-filling supplements to cover older and poorer people that the commercial insurers had not covered for years. Both were designed to provide new markets

for the commercials, in Medicare by leaving enough uncovered so that insurance companies could sell “Medi-gap” supplementary policies to any elderly who could afford them, and in Medicaid by leaving all the working poor, laid-off, and unqualified still uncovered and potential customers for individual policies with high margins. In these ways, both Medicare and Medicaid were institutionally ambivalent from the beginning. The term, “crowd out,” reflects a bias towards private, employer-based health insurance and the fear that expansion of a public program will crowd it out. Public programs are stigmatized and grudgingly acknowledged, while employer-based insurance is honored. Yet employer-based insurance provides less coverage to those who need it most and impoverishes workers when they become sick through co-payments and payment caps, especially in policies for smaller businesses.

Finally, Congress passed a major extension of Medicaid in 1997 for children called SCHIP, State Children’s health Insurance Program. Children continued to be a primary national and state focus. Like Medicaid, SCHIP is riddled with categorical inequalities which each state varies according to their political preferences – a waiting period of 0 or 3 or 6 or 12 months (to minimize “moral hazard”); presumptive or retroactive eligibility; co-payments on none, or some, or all service visits; coverage if income is below 150%, or 200%, or 300%, or 350% FPL, and so forth (Mathematica 2005). These categorical inequalities perpetuate the historic patterns and concerns with “crowd out” of commercial insurance and “moral hazard,” concerns that few other countries would recognize. Contrary to such concerns, SCHIP was serving children from lower-income, working families. An evaluation of SCHIP in New Jersey and other major states found that 92 percent of the children had at least one parent employed, and 58 percent lived with two parents. Forty percent of these parents had some college or a college degree, but 91 percent had household incomes of less than 200% of the FPL (Mathematica 2005). While most of the children were in good health, a quarter had an “elevated health care need,” 15.5% of them with asthma. These children go in and out of SCHIP depending on changes in family income across the categorical lines of eligibility.

An exception to how the Great Society legislation was co-opted by industry lobbyists was a little program to fund neighborhood health centers in poor urban and rural areas. It too had to carefully steer away from “crowding out” other insurance programs, but the design emphasized integrated primary, preventive and social services (Light 1997a; Sardell 1988). Despite a bumpy history, these have survived, and they play an important role in the New Jersey story of serving immigrant populations in the least-served urban and rural areas.

Federally qualified health centers (FQHCs) embody a distinctive vision of interdisciplinary health care that includes general medicine and preventive dentistry, ob-gyn, diagnostic laboratory and radiological services, hearing and vision care, family planning and well-child care, mental health and substance abuse care, a wide range of preventive services, chronic disease and case management, home visits, and barrier-reducing services such as transportation, translation and interpreter services. The annual cost per medical patient was only \$438 in 2008, plus referred services or tests which the centers negotiate on a sliding-fee basis with willing specialty groups and facilities through a memorandum of understanding. This can be a challenge when Medicaid pays so little, another categorical barrier that needs to be addressed if cost-effective care is to be provided.

Community health centers have a long history in the United States of being formed by physicians with an alternate vision from the mainstream of private practice (Hiscock 1935; Wilinsky 1927). But the current era embodied the most powerful model for addressing the source of poverty and illness (Sardell 1988). H. Jack Geiger, the father of today’s FQHCs, describes how his visit while a medical student to centers developed in South Africa by Sidney and Emily Kark led him to propose an American adaptation after the 1964 Mississippi Freedom Summer “...not only for the provision of personal medical care but also, through public health interventions and community organization, as levers for change in the social determinants of health” (Geiger 2005:314). All people in an area should receive services, regardless of ability to pay. Centers should be governed by those using them and “provide community-targeted public health interventions to address such social determinants

of population health status as housing, nutrition, water supplies and sanitation, health illiteracy, and lack of educational and employment opportunities” (pg 315).

Remarkably, within a year this vision received federal funding, and Dr. Geiger used the first center not only to treat patients but to reorganize Mississippi cotton pickers into partners of a large commercial vegetable farm, arrange for using his prescription pad to order needed foods for malnutrition, establish education programs that led children to become physicians and nurses, and to create a bus transportation service for the region. This larger vision, which stopped in the mid-1980s when “community development” was removed as an essential feature of FQHCs, is worth remembering because the billions now spent on “reducing health disparities” has never had such a practical, democratic base that empowers the disenfranchised to help themselves climb out of poverty. It reminds us that the current preoccupation with access to health care is a limited part of a larger need to address the socio-economic determinants of health disparities as an integral part of health care.

The health centers also illustrate the important distinction between not having insurance and having access to services. Evidence here and abroad show that access and being insured are complements, not alternatives, and FQHCs treat patients with a variety of coverages, plus a cash co-payment on a sliding scale (Wilensky and Roby 2005). Lack of access, even if insured, defines the *medically disenfranchised*, an important concept beyond “uninsured.” An estimated 56 million people in 2006 were medically disenfranchised (The Robert Graham Center 2007). A telling example of insurance with poor access is being on Medicaid and needing specialty care, because the payment schedule is so low that few specialists will participate. New Jersey’s Medicaid fees for physicians are about half as much as the low national rates, a key access barrier that needs to be addressed.

The Hidden Irony of Institutional Ambivalence Towards Charity Care

The moral dilemmas and economic burdens that immigrants pose to hospitals and other providers highlight the conflicting feelings about providing uncompensated care and charity

care. How will the costs for treating poor uninsured be paid? Hospitals continuously claim that rising uncompensated care is bankrupting them (Wolf 2008 (Jan 21)). For example, the New York Times reported that in 2005 California hospitals “spent at least \$1.02 billion on health care for illegal immigrants that was not reimbursed by federal or state programs” (Preston 2006 (July 18)). How much does this care actually cost and who pays? No exact figures match the clear rhetoric. So far as the best researchers can probe the murky waters of hospitals costs, many sources actually make treating the poor profitable.

When hospitals claim they “spent at least \$1.02 billion...”, it usually refers to *charges*, billed at the maximum retail or rake-rate to patients or any party with whom a hospital does not have a discount contract. We often use “cost” this way, as in saying “That operation cost \$12,000.” The actual costs of hospital services are usually 1/3rd to 1/4th the retail charges or \$4,000 in this example. Thus, even if federal and state programs to reimburse hospitals for charity and uncompensated care were to cover all the actual costs, hospitals could – and do – claim that most of their “costs” are not covered and they are going bankrupt. One also usually does not know what the denominator is to a claim that a billion dollars were spent on health care for uninsured immigrants. Was it \$1 billion out of \$4 or \$40 billion dollars? What is the proportionate loss, 25 percent or 2.5 percent?

If we turn from theoretical speculation to the actual opaque ways in which hospitals get paid, a comprehensive and authoritative effort to find out how much hospital treatments for uninsured patients cost and how much hospitals receive for them concluded that nationally in 2001 the uninsured received hospital-based services worth \$38.6 billion in charges, and patients responded by paying \$14 billion, a huge personal burden and a major cause of medical impoverishment (Hadley and Holahan 2003). These services, however, actually cost the hospitals about \$10 billion; so uninsured patients were made to pay 40% more out of their meager earnings and savings than needed to fully pay for the *costs* of the services they received!

Hospitals, meantime, claimed that they bore the burden of the \$24.6 billion difference between \$38.6 and \$14 billion. To recover these “losses” in charges, they have lobbied hard for decades and won at least four forms of special payments that shore up the permanently failing system by compensating for inadequate coverage for lower-income patients and a voluntary insurance system that leaves serious medical needs uncovered (Zelizer 1994). Care of lower-income patients tends to be concentrated in urban and some other hospitals, which receive DHS or disproportionate health share payments from both Medicare and Medicaid. Additional funds come wrapped inside payments for hospitals running residency training programs. (These are important incentives behind many elite hospitals treating large numbers of lower-income patients.) State tax appropriations are a third source, as are local indigent care programs. Finally, tax exemptions and other tax concessions constitute an indirect form of compensation for treating uninsured patients. Thus, “charity care” is compensated in at least four ways besides direct billing uninsured patients full charges and collecting what one can.

When Hadley and Holahan totaled the four sources of compensation, they concluded that hospitals received \$26-28 billion, almost all of it from legislative programs “with the intent of providing care to the uninsured.” Thus the \$10 billion in costs for treating the uninsured yielded \$14 billion in cash from uninsured patients plus \$26-28 billion in government payments. This sum and impoverishing the poor with bills for paid up services are rarely discussed in the health policy literature. Complex gaming may add to total revenues. For example, Michael Sparer (2003) reports that states have found ways to generate billions in additional federal Medicaid dollars, such as increasing Medicaid reimbursement to public hospitals and nursing homes, charging the federal government, then having the facilities return some or most of the funds to the states.

The ambivalence surrounding “charity care” – who is to treat the poor and how is it going to be paid for within a deeply commercialized and revenue-driven system? -- is embedded in these legal ambiguities, earmarked monies, and institutionalized practices. The belief that such clinical treatment is uncompensated leads patients with serious symptoms to stay away

from hospitals for fear of getting large bills and being plagued by collection agents. Doctors and clinical administrators wring their hands over whether to treat a given costly case, and the overall system spends far more than it needs to in highly inefficient and unaccountable ways – all to avoid the “socialized medicine” of universal access, which in many other wealthy, capitalist countries consists of private care paid for by everyone in proportion to their ability to contribute to a shared funding system.

This concludes our conceptual framework and history of the institutional context in which states address the health needs of immigrants and other people with no or partial coverage. Medical impoverishment is official U.S. policy. No other industrialized country requires people to use up their life savings and income paying health care bills before they become eligible for the kind of broad coverage that Medicaid provides at below-cost payment rates to reflect that its patients are deserving of treatment but less worthy than people with a full-time job with an employer who chooses to provide adequate insurance. Although most Americans believe that access to health care should be a right, American health care evolved around the conservative, paternalistic practice of charity care and the professional emphasis on physician autonomy and fee for service (Katz 1996; Starr 1982). Health insurance developed late on a voluntary basis, centered on unionized workers and salaried employees, and focused on specialty medicine in hospitals (Gordon 2003). This provided financial relief but also accelerated the cost of hospital-based specialty care because insurance design incorporated conflicting desires, to help patients pay their hospital and specialty bills yet make them pay enough cash to discourage overuse, and to not interfere with professional autonomy to order services and set fees. Immigrant and minority workers without unionized and salaried jobs became even more medically impoverished and subject to institutional forms of racism (Gordon 2003; Quadagno 1996). The categorical inequalities reified in institutional ambivalent services and financing make American health care a permanently failing system that, like Sisyphus, is condemned to struggle against rising costs and inequities.

Figure 4



Sisyphus:
Reforming American healthcare to be equitable and efficient

Part II New Jersey: Broadening the Base to Access for All

The administrators and clinicians we interviewed at New Jersey hospitals about access for immigrants quickly focused on the practical issues of categorical inequalities: do given patients qualify for Medicaid or another program? How much of needed services do they cover and pay for? A blunt hospital Chief Operating Officer explained,

Medicare pays 90 percent of cost. Medicaid pays 80 percent of Medicare, and charity Care pays 57 percent of Medicaid or 41 percent. So in effect, most of the “bad debt” is not the parts of bills that patients don’t pay but the portions of actual costs that government programs don’t pay. 11/12/07:8-9

This reflects the frustrations and contradictions of ways in which each part of the jerry-built American insurance system was established so that it paid for some of the costs and some of the services, for some kinds of patients without commercial insurance. Yet all New Jersey hospitals asserted their full commitment to treat any patient for any condition, regardless of

ability to pay, not just for emergencies but for diabetes, heart disease, and other serious disorders. As one Vice President put it,

We take everyone and pay for everything they need, even if it's for years for diabetes patients or months for pregnant patients. 10/23/07:11

Services outside their domain, however, like care or procedures by specialists in the community, are much harder to arrange.

This commitment to serve the poor dates back to the early 20th century, when most hospitals were built by local or religious communities on a tax-exempt, non-profit basis. New Jersey has no public hospitals, and this institutional feature has contributed to a greater shared responsibility for the poor than in states where a hospital administrator can say, "Send this case to the public hospital." A major report on the state concluded, "New Jersey has historically had a wide array of public programs designed to assist low-income populations, with support from both Democrats and Republicans" (Bovbjerg et al. 1998:23). While many feared a "race to the bottom" during the market-oriented reforms of the mid-1990s, for example, New Jersey officials seemed engaged in a "race to the top" by maximizing the number of legal immigrants and others eligible for Medicaid, especially for children. The evidence supports the view that states, and sometimes counties like Miami-Dade or San Diego county, vary by shared norms and expectations in a political culture so that some states consistently tend to be more generous and compassionate towards the vulnerable and poor than others (Cantor et al. 2007). Some states try to create a medical commons accessible to all, while others do not (Ostrom 1990).

Institutional ambivalence was built into the 1938 enabling legislation for Blue Cross in New Jersey and other states, because this quasi-public, voluntary response to the widespread need for insurance was called a "non-profit hospital service corporation," not an insurance company. Its purpose was to help hospitalized patients pay their bills by collecting premiums at risk-blind community rates from subscribers in employer groups. The ambivalence became manifest as overall health care expenditures tripled during the 1940s, doubled again

in the 1950s, and tripled again in the 1960s (Light 2000). Health care became a booming business, and Americans have been ambivalent about its cost ever since. A headline celebrating a major healthcare corporation's 12 percent growth one day will be followed by a headline the next day concerned about health insurance becoming unaffordable.

Mandating Universal Access

The rapid expansion of the Blues and commercial insurance in the 1950s and 1960s exacerbated this growth, and successive New Jersey commissioners of insurance responded by trying to set limits on what hospitals could charge per bed-day and firmly setting limits on Blue Cross premium increases. But a loophole enabled New Jersey hospitals to gain exemptions from the limits on charges (Dunham and Morone 1983). For a while, charges provided sufficient margin to treat uninsured patients. But the insurance commissioners held down Blue Cross's ever larger premium increases, and this shifted increasing costs to commercial policies, putting them at a competitive disadvantage against the Blues. Pressure mounted for system-wide solutions. An important commission recommended *prospective* review of hospital budgets and a shift from reimbursement of charges to a bundled payment per case (Dunham and Morone 1983; Powell et al. 1974). The hospital association, however, opposed more regulation and arranged to do the prospective reviewing. Rate increases continued.

These new arrangements failed as the conflicting interests of stakeholders and the ambivalent relationship of Blue Cross to hospitals, forcing them to shift more of their costs not covered by Blue Cross to commercial insurers. Hospitals in poorer areas also had fewer insured patients on whom they could shift uncompensated costs. As a result, they shifted more costs, leading insurers used them even less, which further reduced their base and increased cost shifting to them in a "death spiral." In response to this permanently failing syndrome, the legislature passed the Health Care Facilities Act of 1971 and gave sweeping powers to the commissioner of health to review line items in budgets, control institutional licensure, and issue certificates of need for new capital expansions. Hospitals supported the bill in hopes of restraining the entry of competitors (Volpp and Siegel 1993). The Act also

mandated that all hospitals provide necessary care to all patients regardless of their ability to pay. What had always been a gift, though to many a duty, became a mandate and an entitlement (Zelizer 1996), yet in the middle of a commercial system based on compensation – large bills, collection agents, and bed debt.

New Jersey's commitment is tragic as well as noble because its hospital base makes charity care a permanently failing institution and permanently threatens to sink the 25-30 hospitals in urban areas that bear most of the burden. New Jersey is one of the most affluent and densely populated states, and it lies between two world centers of great medical institutions in New York and Philadelphia. While 36 percent of the nation lives below 200% the federal poverty level (FPL), only 17 percent of New Jersey's residents do (Forums Institute for Public Policy 2004). It has several smaller cities, most quite poor, and scores of affluent suburbs. Many physicians organized after World War II to open hospitals in this fertile soil, and by 1972 there were 108 general acute hospitals and 28,905 beds, with an occupancy rate of 81.3 percent (American Hospital Association 1972-2008). New Jersey has long paid low for Medicaid so that every Medicaid case lost money. The commitment to charity care threatened the solvency of urban hospitals, and episodic treatments in the emergency room or hospital clinic is the worst and most costly way to provide care to patients. Yet this non-rational commitment reflected the institutional history of charity care at non-profit, tax-exempt, "community" hospitals (Stevens 1999). Looking ahead, by 1980 New Jersey still had an oversupply of 108 hospitals, 31,453 beds, and an occupancy rate of 81.6%. As Congress, employers, and insurers clamped down on high New Jersey hospital costs, and by 1990 there were 96 hospitals with 30,934 beds, an occupancy rate of 79.9%. Since then, the squeeze on revenues and margins has worsened, as we shall see.

Making Universal Charity Care Work

The means for implementing universal access have undergone numerous organizational changes since the 1971 commitment in an effort to "keep the mission" even when there was no margin. A long process began of crafting and revising system-wide rules to enable institutionalized charity to be practiced on hospital-based care for the sickest patients. This

reduced the greatest inequity and financial burden in the American voluntary insurance system, but in a costly and inefficient way (Daniels, Light and Caplan 1996). In New Jersey, one sees “what can happen when a state attempts to ‘piggyback’ a universal access scheme on a fragmented system based on private employment insurance, Medicaid, and Medicare. As long as these entities act out of concert, some people will wind up picking up the tab for others. This will rarely be sustainable” (Volpp and Siegel 1993:65). Every threat to any part of the payment-delivery complex affected access for categorically unequal persons like minorities and immigrants.

Hospitals added mark-ups to bills of covered patients that ranged from 1-25 percent, which made urban hospitals less attractive to the insurers on which they depended to cost-shift (Bovbjerg, Cuellar and Holahan 2000). Blue Cross continued to experience premium shortfalls which jeopardized its solvency, and commercial insurers continued to experience large cost-shifts, forcing them to have premiums higher than Blue Cross as a byproduct of partial regulation. A new governor removed the hospital association from the review of its members’ budgets and instituted a more stringent state review process. Nevertheless, it became clear that “...all payers would have to be regulated if real reforms were to be made” (Widman and Light 1988:9). Congress had been funding a project at Yale to identify diagnostically related groups (DRGs) in terms of cost, and a new commissioner of health from Yale, Joanne Finley, persuaded political leaders to try it out first in New Jersey. The powerful Hospital Association resisted giving up the autonomy of members to set their own rates but faced the threat of open revolt by the urban hospitals if some form of cross-subsidy was not put in place. The prospect of being paid in an entirely untried way terrified the hospitals, and they insisted on a number of fail-safe concessions, including that all charity care and bad debt be included in the DRG bundled payments. Finally, in 1978 the all-payer, all-hospital Chapter 83 was passed. Medicare agreed to accept NJ DRG rates and even awarded a grant to fund this historic experiment. Thus hospital-based charity care was transformed from an unfunded to a fully funded mandate.

By 1980, then, New Jersey had hospital commons, a universal payment system binding to all payers for access by any patient to hospital-based services. The new system introduced the concept of fairness across the entire system (Daniels, Light and Caplan 1996). Yet it was fated to keep failing because of cost-increasing incentives, no control over non-hospital charges, and no primary-care foundation for the system as a whole. “Charity Care” was affirmed as an explicit part of the state’s political culture and an integral part of the new statewide payment plan (Forums Institute for Public Policy 2004). What had been generic and lower case became institutional and upper case, but Charity Care is a nickname. More accurate and revealing is its real name, the Hospital Payment Assistance Program.

The cost of uncompensated care was added to each hospital’s DRG rate schedule made inner-city hospitals increasingly unattractive for employers to send their insured patients, thus reducing the already-smaller base of commercially insured patients. In response, the legislature created in 1987 an Uncompensated Care Trust Fund. A uniform surcharge of 19.1 percent was applied to all payers, which flowed into the Fund for all hospitals and was dispersed to hospitals in proportion to the amount of uncompensated care they provided (Volpp and Siegel 1993).

It was not long before problems began to arise. The surcharge made the cost of uncompensated care much more visible and subject to criticism. Meantime, Medicare adopted the DRG system nationwide and held down its rates more tightly than New Jersey, until their DRG payments were less than New Jersey’s so that Medicare was losing millions paying New Jersey DRG rates on hospital care for seniors. As a result, Medicare stopped accepting NJ DRG payments in 1989, leaving a large hole in the state’s all-payer system that required the Trust Fund to add \$710 million to the surcharges on the remaining payers (Volpp and Siegel 1993). The unexpected rise of HIV/AIDS, increased costs due to the growing shortage of nurses, and increased costs of disposing of medical waste added further financial burdens and jeopardized the ability to treat uninsured patients. A fatal flaw was and is that DRG payments perpetuate the old categorical distinction going back to the 1930s between hospital costs and specialists’ fees, which are not included. They make more money

by keeping patients in longer and ordering more procedures, while the hospitals lose money as length of stay and hospital procedures increase. Said one medical director,

Our length of stay is long because doctors exploit the system, and since DRGs were created, the incentives for doctors clash with the incentives for hospitals. Doctors are paid by fee, so when a patient comes in, a doctor looks into this problem and that problem and does a bunch of tests – all of which generate more fees, and costs for the hospital. Then he calls in his buddies in related specialties to check out other aspects of the case. –Since the patient is in, shouldn't he get a colonoscopy? All this generates fees, but the hospital is paid a flat total for the stay... 3/14/08:11

By covering all costs for uncompensated care, the New Jersey system created its own excesses and pathologies. During the 1980s, hospitals exhibited provider moral hazard by not chasing down patients who did not pay their bills (bad debt), and they did not bother to identify all the patients eligible for Medicaid. A state study found that 80% of uncompensated care went to bad debt so the Fund “was increasingly perceived as a fund for deadbeats...” (Volpp and Siegel 1993:61) and as a hospital solvency fund. Moreover, an independent study found that more than 50 percent of uninsured people in New Jersey worked full time or were the dependents of full-time workers (Kronick 1990). Uninsured patients received approximately 30 percent *more* hospital services than insured patients, while nationally they received 47% less. Kronick found that a large percent of hospital-treated diagnoses could be treated effectively on an outpatient basis. He concluded, “Financing hospital care for the uninsured through a tax on the insurance premiums of the insured is ineffective for a variety of reasons: it raises the price of insurance, and encourages additional people to move into the ranks of the uninsured; it pays for care for the uninsured in the most expensive setting; and it does not contribute to continuity of care for the uninsured.”

In 1990 the Governor created a commission that reaffirmed the state's 1971 commitment: “The people of New Jersey have long since determined that no one should be denied health care coverage on the basis of ability to pay. Fiscal strains on the Uncompensated Care and

Medicaid systems, however, threaten the ability of the medically indigent to gain access to appropriate care, causing unnecessary suffering and, perversely, forcing them into higher cost health care settings” (CARE, 1990). REF?? The hospital association and the new Governor started to develop new ways to fund charity care on a broader base than before. Leaders proposed that funding for the Uncompensated Care Trust Fund be broadened from a surcharge on the bills of patients with commercial insurance to all employees through a small payroll deduction. This would make uninsurance like unemployment, subject to a payroll deduction for the uninsured. The revenues would support a state health plan based on primary care.

The Hospital Association’s Task Force reframed the problem of services to poor patients. “The uncompensated care problem is not *hospital* based but *society* based, and must be solved where it originates. There are many sources of governmental and other financing that could be explored to fund care for the poor, some of which are more viable than others” (New Jersey Hospital Association President's Task Force on Regulatory Reform 1990:35-36). Caring for the poor has been “inappropriately identified as hospital costs...” Hospitals can be “accountable only for what they control, those expenses they actually incur” and not the costs of bearing a social burden no one else is willing to bear” (p. 30-31).

“Hidden and Illegal Taxes”

Broadening payment for charity care from holders of commercial health insurance policies to all employees through their unemployment trust funds was brought to an end by union members claiming in a lawsuit that surcharges on their hospital bills were illegal. On May 27, 1992, the case was upheld with a stern ruling about the “hidden and illegal taxes” that effectively made both the DRG system and the Uncompensated Trust Fund impossible to continue. The court ruling that cross-subsidizing charges to support a health care commons were “hidden and illegal taxes” occurred during the era of managed competition and the belief that regulated approaches like the all-payer DRG system were wrong-headed, unfair, and less effective at holding down costs than de-regulated competition. Although studies showed that all-payer state systems held costs down better than any other approach

(Anderson 1991; Rice 1992; Rosko 1990), they were out of fashion and ignored by the now-dominant market reformers. Republicans gained control of the legislature and governor's office for a decade. "Cross-subsidization," a term indicating that those with more helped those with less, had been replaced by "cost shifting," a term indicating that those with less were shifting their costs to others through underhanded tactics.

It didn't used to be that way. ...we were colleagues, and all the hospitals helped each other. Then the Governor decided we should compete. In football, you play on a level playing field. But it's not a level playing field in health care. 11/12/07:9

As the case went through U.S. District Court and was then appealed to gain time, the state undertook a number of actions, especially since a growing number of employers self-insured and thus were not subject to state mandates. Medicare and Medicaid also did not participate. Governor Florio called for all insurance companies to accept anyone who applied for coverage at a uniform or statewide 'community rate' ... like many countries with universal access through health insurance. He also proposed that six hospitals and several units close to reduce the millions wasted on carrying the 35 percent of unused beds in the state (Gonzalez 1992 (March 31)). Local opposition to closing each hospital was, as usual, intense. He began measures to develop what experts characterized as "the most sweeping changes to date of any state's individual health insurance market..." to increase the number of uninsured who would buy health insurance (Swartz and Garnick 2000:46). Reforms of the small group market also helped businesses on the edge offer health insurance to their employees. In other ways, the state tried to reduce the number of people needing charity care. These measures benefited some legal immigrants (Borjas 2003), but the open door for the growing number of undocumented immigrants remained the hospitals.

Market reforms to make competitors more effective and efficient is largely a myth because few of the requirements for such markets are met (Light 2000; Rice 2007). Instead of there being many buyers and sellers, there are a few, leading to monopolistic behavior. Instead of information about quality, products and services being free and complete, it is very costly and notoriously incomplete. Instead of markets efficiently being open to new competitors

and shedding losers, barriers to entry and exit are extremely high. During the 1990s, hospitals throughout the nation coalesced into large sellers to match the large buyers of managed care and insurance companies in oligopolies so that the power to discount and control services shifted to the power to name one's price and exploit sub-specialty care for profits. Many specialists turn their back on the market by refusing to take any insurance so they can bill what they like and leave it to patients to get what they can from their insurer.

No Margin, No Mission?

Despite the political shift to market competition and away from welfare subsidies, leaders in the Department of Health and the Hospital Association invoked social fairness for how charity care should be funded. It was "unfair" that Medicare had pulled out and did not pay its share. It was "unfair" to charge some patients more than their actual costs of care. The problem, then, was not the "hidden and illegal taxes" that had enabled hospitals to treat uninsured patients, but the need to get everyone to help out. As Uwe Reinhardt said, "Ethics, not efficiency, is the overriding goal of healthcare reform but nobody ever talks about it. Once America decides what it wants, figuring out how to get there won't be so difficult" (Ellerbroek 1992 (Sept 30):2).

This moral stance contrasted with the prevailing view in the United States captured in the slogan, "No margin, no mission." Without a financial surplus one cannot help the uninsured. It sounds like a natural law of charity and generosity. But the opposite prevails throughout much of the world. When most countries with universal health care systems run in the red, leaders seek ways to keep universal health care going, that is, *Mission First, Find the Margin*. New Jersey leaders too manifested this commitment to fund health care for poor patients, an increasing percentage of whom were becoming immigrants in the 1990s.

The Health Care Reform Act of 1992 ended the regulatory model of setting rates that included uncompensated care expenses for all hospitals. Funding for charity care was thrown into jeopardy, and making cost-effective health care available to all could have been rebased

around primary care in community health centers or contracts with managed care organizations. But instead, hospital-based charity care was reaffirmed, and new efforts broadened the base of contributors again by using \$500 million a year from the state's (not the union's) Unemployment Insurance Fund and by creating a 0.62% payroll tax trigger should its reserves fall below \$1.5 billion, as well as a 0.53% tax on hospital revenues. The bad debt portion of uncompensated care was given to the hospitals to collect on their bills, thus greatly reducing what had to be paid. This entailed more detailed documentation of patient qualification – a hardening of the categories. The new Health Care Subsidy Fund included not only charity care for indigent patients in safety net hospitals, but also \$100 million in a “Medicare shortfall” fund, \$110 million for a relief fund for hospitals in particular distress from patients with high-risk diagnoses, and a health access fund to subsidize uninsured persons buying health insurance that failed (Bovbjerg et al. 1998). Several million dollars was allocated to FQHCs to extend their hours in hopes that this would divert some ER visits. These changes reflect a general pattern to a focus on only charity care at safety-net hospitals and broader sources of funding. While the legal mandate remains, the new arrangements did not support the ethos of a hospital commons, and safety-net protections can shore up more inefficient or lower quality hospitals (Bovbjerg, Cuellar and Holahan 2000).

According to Figure 5 from the Hospital Association, the Charity Care portion stayed at \$320 million a year for 1998-2000 as their adjusted services to indigent patients rose from \$463 to \$518 million. The state then increased payments to \$381 million through 2004, but the rising volume of services as the provider of last resort meant they lost more every year (New Jersey Hospital Association 2009). How much hospitals received from other streams identified in the section on unpacking charity care is unknown and not discussed anywhere, including the 2008 comprehensive review.

Figure 5

N.J. State Charity Care Shortfall Trend

State Fiscal Year	Charity Care Documentation	Charity Care Funding	Charity Care Shortfall
	(Services @ Medicaid Rates) (\$ in millions)	(Payments to Hospitals) (\$ in millions)	(Payments vs. Services) (\$ in millions)
1994	\$327	\$383	\$56
1995	\$327	\$400	\$73
1996	\$403	\$310	(\$93)
1997	\$407	\$300	(\$107)
1998	\$463	\$320	(\$143)
1999	\$483	\$320	(\$163)
2000	\$518	\$320	(\$198)
2001	\$601	\$356	(\$245)
2002	\$624	\$381	(\$243)
2003	\$578	\$381	(\$197)
2004	\$778	\$381	(\$397)
2005	\$812	\$583	(\$229)
2006	\$910	\$583	(\$327)
2007	\$942	\$583	(\$359)
2008	\$946	\$715	(\$231)
2009 *	\$950	\$573	(\$377)

Because the all-payer system not only paid for all hospital-based services to patients, regardless of legal status, but also kept all hospitals solvent, its demise constituted a radical threat to both. The suburban hospitals lobbied for market competition, each confident it would be a winner in an oversupplied market. But the urban, safety-net hospitals knew they would lose in market competition, in part because they treated so many immigrants and low-income patients and received back inadequate payments; so they lobbied for a more charity care model and formed their own Hospital Alliance of New Jersey (Mechanic et al. 1997; Volpp and Siegel 1993). They called themselves “essential hospitals,” defined as a hospital that “provides large amounts of charity care, Medicaid and self pay, where underpayment of Medicaid and charity care are the driving factors to poor financial health and whose closure would result in material barriers to care” (Hospital Alliance of New Jersey 2007:8). The major teaching hospitals formed a University Health System. In the ensuing open market, commercial insurers made a “huge profit windfall” as they used market competition to reduce payments to hospitals. Nevertheless, there is no evidence that hospitals did not continue to provide general services to uninsured immigrants, regardless of their legal status.

During the second half of the 1990s, funding of charity care came from a series of short-term extensions of money from the Unemployment Insurance Fund, a tobacco tax, the application

of DSH funds for charity care, and the use of tobacco settlement money that constituted a major reduction in support (Bovbjerg and Ullman 2002). Unlike many other states, New Jersey made a number of provisions to compensate for federal reductions in disproportionate share (DSH) payments to inner-city hospitals (Bovbjerg et al. 1998). A community-based program allowed thousands of nursing home patients to be discharged, saving millions in Medicaid. A well-run Medicaid managed care program increased efficiency and quality and held down cost increases. A “managed charity care” model was designed and won a Medicaid waiver in 1998 that for the first time would have hospitals design a managed care plan for indigent patients that would direct them to the most appropriate, cost-effective settings, often *outside* the hospital, to shift the mandate towards community-based charity care. But the hospitals objected to diverting charity care funding, even though a managed care approach would be more cost-effective and provide continuity of care, and the plan withered (Bovbjerg and Ullman 2002). As Mancur Olson (1982) predicted, an organization’s staff focus on protecting their turf, even if productivity is lower and society worse off. Yet opposing the managed charity care model subjected hospitals to the growing number of uninsured immigrants needing medical attention.

Countering the Anti-Immigration Backlash

In 1996, the “Contract with America” Congress passed two draconian anti-immigration laws, one aptly titled the Illegal Reform and Immigrant Responsibility Act, and the other aimed at Personal Responsibility and Work Opportunity (Chang 2006; U.S. Department of Health and Human Services 2009). The first required much more aggressive documentation of immigrants and the expedited removal of “illegal aliens,” not only by federal agents but by deputized state and local police. The second eliminated welfare as an entitlement program, fundamentally restructured welfare by increasing requirements to work, and barred all new immigrants from all public services, including medical care for 5 years. This categorical entrenchment applied to states and localities, even if they paid for them without federal dollars unless they reauthorized those services (Costich 2002). Health care providers were particularly upset because of their long tradition and moral commitment to treat all people in need. “Before the 1996 restrictions, publicly-funded health care providers and practitioners customarily provided necessary health services regardless of immigration status” (Costich

2002:1047). A 1982 ruling by the U.S. Supreme Court (*Plyler v. Doe*) also “required state and local governments to extend basic public benefits to residents regardless of immigration status.” Since the 1996 laws only affected new, legal immigrants who might have qualified for TANF (Temporary Assistance for Needy Families) and Medicaid, subsequent studies found they did not reduce coverage much but had a general “chilling effect” of fear and confusion that led to more immigrants getting covered whether prohibited by the law or not (Borjas 2003; Kaushal and Kaestner 2005).

In response to these anti-immigrant laws, Republican Governor Christie Whitman and New Jersey legislators took some measures of categorical restitution to make Medicaid benefits available to legal immigrants. They used tobacco settlement money and ironically drew on new federal funds made available in 1997 as part of the Balanced Budget Act. They felt that poorer people in need of medical care should have it, regardless of where they were born. The legislature also agreed to provide Medicaid benefits following the five-year federal ban, and it initiated a large naturalization program so that more immigrants would no longer be “immigrants” and become eligible for Medicaid. It also took full advantage of expanded eligibility criteria for Medicaid, and it continued to make TANF cash assistance available to eligible immigrants (Tumlin, Zimmerman and Ost 1999). The state mandated that all Medicaid and SCHIP patients be in managed care programs as more cost-effective and superior to episodic treatments. Governor Whitman committed herself to covering all children by 2001. The state also decided to reconstitute the funds eliminated by Congress for teaching hospitals through GME (Graduate Medical Education) and IME (Indirect Medical Education) payments (New Jersey Commission of Investigation 2007:15). This was critical for immigrants because nearly three-quarters of specialized care for them is done in residency programs.

Although Congress drastically reduced welfare and prohibited new immigrants from welfare programs in 1996, the next year it launched SCHIP, a major expansion of Medicaid coverage that provided greater federal subsidies and allowed states flexibility (Sparer 2003).

Reflecting a longer state commitment to children, the Governor initiated significant

expansions of Medicaid for children, first by requiring that all TANF children enroll in Medicaid managed care so they would benefit from a comprehensive health maintenance approach at lower cost and then by developing NJ KidCare and then NJ FamilyCare as it became clear that enrollments would increase if parents were covered too. These contributed to many other states expanding and innovating to cover more of the uninsured (Sparer 2003).

In a short period, 1998-2000, the state undertook several categorical restitutions. It raised eligibility for Medicaid from 133 percent of the FPL to 350 percent, close to the median income of the economy and “the most generous in the nation” (Bovbjerg, Brennan and Bruen 2002:46). It removed several categorical inequalities by including children in non-Medicaid families, shortening the waiting period for the uninsured, and greatly simplifying the application. Enrollments grew so large the state had to cap new enrollments, but it was lifted a year later. These measures helped thousands of legal immigrant families gain broad coverage and reduced those needing charity care from hospitals. Both programs were made part of the state’s successful Medicaid managed care program which provided a more holistic approach to health maintenance than traditional episodic care.

As cost pressures from managed care plans and insurers drove down payment levels to hospitals, the urban hospitals struggled to stay afloat because by their nature they could not compete effectively. They adopted a rhetoric of neglect and being part of a “hemorrhaging system.” A review team from the Center for Studying Health system Change commented that “...it is unclear whether inner city conditions will deteriorate further or whether some combination of state intervention and investment in inner city hospitals by suburban health care networks will stabilize a hemorrhaging system” (Mechanic et al. 1997:1). Any future solutions would have to blend “the complex interaction of the invisible hand of the market and the visible hand of New Jersey State government” (Mechanic et al. 1997:2-3). During the complex, ensuing years, the Charity Care program kept being rescued from collapse.

It was not just the urban hospitals that were struggling to find the margin to provide health care to immigrants and other low-income patients. Deterioration in the late 1990s led

Governor Whitman to convene an Advisory Commission on Hospitals and to order a study by Pricewaterhouse Cooper. It found that margins had been solid in the early 1990s but dropped steadily to 0.55% in 1998, with half the hospitals reporting operating losses (New Jersey Department of Health and Senior Services 1999). “On any given day, one out of every three staffed acute hospital beds in New Jersey is empty,” and the estimated cost of \$1 billion a year put New Jersey hospitals “at a staggering competitive disadvantage” (New Jersey Department of Health and Senior Services 1999:1). High lengths of stay and staffing levels interacted with reductions in Medicare payments, the growth of managed care and its pressures to reduce payments, and a growing number of uninsured needing charity care. The study concluded New Jersey had 4,849 excess beds in 1997, which would rise to 6,316 by 2002. If those beds were closed and admissions redistributed to remaining hospitals, the study optimistically concluded that \$1 billion would be saved. The Commission recommended that a Hospital Transition Group be formed and a Hospital Asset Transformation Program be started.

Despite a state recession, the state maintained its funding and commitment to charity care and Medicaid in 2002 and 2003 (Ryan 2002 (March 29)). Hospitals submitted \$624 million in cost-adjusted charity care services in 2001 and received back \$381 million in charity care payments. Their operating margin averaged only 1.6 percent, up slightly from losses in 1998 and 1999, and reflected low occupancy in the surplus of hospitals remaining from the halcyon days of the 1950s and 1960s. The growing number of uninsured increased hospital charity care costs to \$778 million in 2004, widening the shortfall from reimbursement (see Figure 5). New Jersey hospitals provided about 1 million visits for patients who were ineligible for private or government coverage such as Medicaid and met income and asset eligibility criteria for Charity Care (Forums Institute for Public Policy 2004). These figures, together with the high percent of unoccupied beds, characterize a permanently failing, institutionally ambivalent arrangement (Meyer and Zucker 1989). Sean Hopkins, NJHA’s senior vice president of health economics, said “By necessity, hospitals must operate like businesses to remain fiscally sound and continue providing quality healthcare to their communities. But by mission, hospitals are caring institutions”(NJHA 2004).

The legislature mobilized itself to craft and then pass P.L. 2004, chapter 113, the largest single increase to the state's charity care program in over 10 years, with a 53 percent increase in funds for charity care. For the fiscal year 2005, \$583.4 million was allocated for charity care. This amount was allocated for 2006 and 2007, then increased to \$718 million in 2008 as well (New Jersey Commission of Investigation 2007). Funding for charity care was broadened once again to general taxes as well as special taxes to providers who escape state mandates, such as HMOs and the growing number of spin-off non-hospital ambulatory medical facilities (Forums Institute for Public Policy 2004). Thus the funding base for New Jersey charity care had broadened since the 1970s from extra charges on hospital patients' bills, to part of the cost to everyone covered, to all union workers, to all employees, and finally to anyone paying taxes. A new tax on HMOs, and a charge to the new crop of sub-specialty clinics with beds that skirt the definition of a hospital are concrete examples of the belief that it is unfair for some organizations not to participate, and everyone should contribute their fair share. Complementing this commitment were decisions to widen universal access from hospital care to primary and ambulatory care.

The law also addressed the issue of disproportionate share of charity care among New Jersey's hospitals by devising a formula using a "relative charity care percentage" to allocate the charity care funds according to the amount of charity care delivered through legislation. Hospitals with the largest burden of indigent and uninsured patients would receive the highest amount of reimbursement from the state, as much as 96 percent of costs. The least-reimbursed hospitals would receive no less than 43 percent. The law re-affirmed the state's commitment of 1971 to make hospital services available to everyone through cross-subsidizations, a right rather than a commodity sold to those who could afford it.

The state joined many others in maximizing Medicaid coverage options and getting qualified patients to sign up (Sparer 2003). Medicaid embodies the moral mandate of society and health care, such as it is. Uninsurance rates had been climbing, and the rate among residents earning less than 200% FPL was unusually high, more than twice the overall rate. The state strengthened Medicaid managed care to provide coordinated treatment plans that would

minimize hospitalizations. The state supplementary programs, NJ Kid Care and NJ Family Care, also had these goals. An independent assessment praised the coverage but noted that it spent proportionately much more on hospital-based services and much less on community-based services (Sparer, Glied and Vanneman 2006). It paid the highest rate in the nation for prescription drugs and spent much more overall on drugs. This contributed to Medicaid expenses per patient being high and growing.

A serious problem, however, is the low payment rates set by the state to physicians and hospitals. While Medicare rates are set nationally based on a detailed study of time, skills, training, and costs, adjusted for geographical factors, Medicaid rates are set by each state and vary from being close to Medicare's rates to being less than half. New Jersey is among the lowest, only \$20.60 for a 15-minute office visit in 2007 compared to \$65.65 from Medicare (Arellano and Wolfe 2007; Public Citizen 2007). Payment for an EKG test was only \$16.00. These categorically unequal payments greatly reduce access because so many physicians refuse to accept patients.

The Moral Commitment to Charity Care

This account may lead one to think of charity care as a state program and legal mandate, and we had this impression too. But such an analysis cannot explain why hospitals have not used the familiar tactics of passive resistance or circumvention to resist a legal mandate for services that lose so much money. It cannot explain why, as one of the most powerful lobbies, hospitals have not removed the mandate and let uninsured immigrants shift for themselves. And it particularly cannot explain why we found that *most hospitals go out of their way to find immigrants in the community* who need screening or need primary care where more with a costly, serious condition will be found. One such inner-city hospital described how they set up a primary care clinic in the South Ward and paid staff on salary "because you can't recruit good people without a salary." We asked why they did this? Most people there have no insurance.

No they don't. We knew going in that we were going to lose money. That was not the purpose of it. This is a mission-driven organization as a 501c3, and we take that mission very seriously, which is why, subsequent to [another inner city hospital] closing down their maternal and child health services, which historically lose money, we came to a decision point. 12/11/07:11

They opened up replacement material and child services. The hospital funds a family health center that takes only patients without commercial insurance, as do most of the hospitals we visited. Payments from Medicaid and Charity Care do not begin to cover costs, though one goal is to reduce losses from the number of patients who use the emergency room and to provide them with a medical home. This hospital-subsidized family health center, like others, was spacious, clean, inviting, and had dedicated clinical staff and specialists who held weekly clinics. Intake staff try to qualify unregistered patients for Medicaid or Charity Care and there is no co-payment, as is the case with most hospital-sponsored family or primary care centers in the study.

The maternal unit staff described a remarkably comprehensive set of services. They work with city-wide programs to find pregnant immigrants early, get them registered for Charity Care, and started on a schedule of pre-natal activities. The hospital's secret to financial sustainability is "Rosa." Highly organized yet compassionate, she makes sure that every pregnant mother gets covered by Charity Care up to the seventh month, then switches over to "emergency Medicaid" for childbirth expenses and 8 weeks thereafter, then back to Charity Care. Once the baby is born, she makes sure it is registered as a native with Medicaid. Mothers get baby showers, other mothers teaching them about infant care, nutritional care, and legal services if they need them. More widely, the hospital has won prizes from immigrant groups like the Guatemalan Civic Association for its community outreach, health fairs, and cultural sensitivity training program for staff. The larger point is that the state Charity Care program reimburses hospitals for some of the charity care they decide to give and nothing for going out to find more patients in need.

The exception proves the rule. One hospital took a hard-nosed view:

We treat charity care patients and send in the bills, but the hospital gets nothing because it's 75th in the least percent of charity care cases, and the Charity Care fund never gets past the 65th hospital. ...it does not pay to try to move up. 3/14/08:5

It tries to avoid and discourage poor uninsured patients.

By contrast, an officer at another hospital located on a campus away from low-income areas that also does too little charity care to receive state payments used this fact to underscore its moral commitment to serving immigrants. Its foreign-born physician-executive said,

We don't get any money from the government...but we always take care of these patients. 10/23/07:1

This hospital runs an attractive family care center at its own expense where “everyone is seen, even if they arrived last week. No one is denied.” There are no bills, co-payments, or sliding scale fees. We asked the nurse-administrator if anyone was signaling to her to set limits, and she said no. She described a woman from Nigeria who had breast cancer, “...and her whole treatment was done here...chemo, radiation...” The hospital’s outreach efforts include health education and screenings at inner-city public schools. It found one third at risk for diabetes and sought a grant to fund their being seen by a multi-professional diabetes team in a regular program.

With the one exception, all the hospitals and clinics regarded treating anyone who needed medical attention and following through with managing chronic conditions as core to their mission. One Catholic hospital went further:

We give priority to those whom society ignores...No one is ever turned away. ...There is only one standard of care for everyone.[How do you pay for it?] It's very hard. The days of cost-shifting have gone...The rising number of uninsured is certainly an economic threat to us. 10/9/07:5

This organizational, institutional, and political commitment explains open access and outreach to immigrant communities in New Jersey better than the state’s program to

reimbursed part of hospitals' charity care expenses. To use Zelizer's (1996) distinctions, they are partial compensation for entitlements and gifts. But this commitment and moral ethos are difficult to sustain in a system dominated by cost containment and commercial competition.

The Plight of New Jersey Hospitals and Charity Care

If past were not prologue and institutions not path-dependent, no sensible person would guarantee universal access to needed medical services at hospitals, when ninety percent of people's problems can be treated in an office or clinic. But the plight of New Jersey's hospitals reflects the national history of hospital-based specialists being categorically favored at each critical turn in how services were organized and insurance structured. Rather than planning one hospital for each area with a budget to cover expenses, as national health systems do, they grew up wherever groups of doctors or communities energy put them, like new restaurants, each thinking it would be a winner but glutting the market. Meantime, hospital admissions and lengths of stay have been declining, thanks to advances in pharmaceuticals and technology, so that the national vacancy rate of hospital beds has risen from 20% in 1980 to 34% in 2000, a huge expense in carrying unused capacity. Despite levels of admissions, medical procedures, and intensive care being higher than in the nation, New Jersey's vacancy rate is 28 percent and ranges as high as 41% in Trenton (New Jersey Commission on Rationalizing Health Care Resources 2008:2,57). For example, the vacancy rate in Trenton is only 1% for the suburban hospital, RWJUH Hamilton, but 41% for St. Francis, 49% for Capital-Fuld, and 59% for Capital-Mercer (New Jersey Commission on Rationalizing Health Care Resources 2008:60). The result is "an oversupply of hospital beds in every market area of the State..." The average operating margin had dropped to -0.9% in 2006. The surplus of unused beds is projected to increase because of declining lengths of stay. Yet another study showed that beds for admission from ERs were tight and occupancy varied greatly, from over 90 percent on weekdays to about 20 percent on the weekends (DeLia 2007). Twenty six hospitals had occupancy rates of 95% for over half the year, and ambulances are diverted at least once an hour in New Jersey.

This is the official view of New Jersey's plight, but some hospital executives thought the causes lie elsewhere. "Baloney," said the Chief Operating Officer quoted before who described how the first problem is that government programs don't pay actual costs, especially for treating poorer patients. The hospitals going bankrupt are the hospitals treating more immigrants and uninsured, he said. New Jersey pays half the national average for Medicaid and even less for charity care. "The public doesn't know because politicians don't tell. The politicians would have to step up and do something if people knew." The other big problem behind the state's high length of stay, he continued, is physicians organizing referral networks to run up visits and procedures on patients and make each other money. They also exploit New Jersey's generosity. "Our foreign doctors bring their relatives over." Interviewees at other hospitals described in detail the strategies by which professional-grade immigrants fly in relatives, establish them as "residents" with no income and no assets, and get them admitted for costly procedures.

... and they ask, "Dr. Portes, when are you on duty?"

"Fridays"

"OK, I will send you my mother from India." ...then you will admit her as a service patient, meaning she will not have to pay. 10/23/07:6

Between 1992 and 2006, 14 hospitals closed and two more converted to nursing homes. In 2007, 5 more closed, and in 2008 another 5 hospitals closed. A new threat comes from the hospital-based specialists that initially transformed charity hospitals into charge-based facilities for their work in the 1900s, and now run up hospital costs to collect more fees. They have been creating their own for-profit ambulatory surgical centers (ASCs) to profit from charges for them as well as their practice fees. They divert highly profitable procedures from general hospitals and practice "economic triage" by directing well-insured patients to their own facilities. This leaves general hospitals financially less able to pay for treating immigrants on Medicaid and Charity Care. These centers avoid legal requirements of hospitals to serve any patient in need, to be open 24/7, to provide emergency services, to treat more complex or intensive cases, or to provide specialty "coverage" comparable to full-service hospitals. Critics accuse them of "cherry-picking" and "skimming" as they open up

nearby hospitals. By 2007, 307 of these physician-owned, for-profit centers were in operation.

“Physician-owned for-profit ambulatory care centers have made significant inroads into the traditional profit base of many acute care institutions. It is increasingly difficult for traditional acute care institutions [hospitals] to derive sufficient income from insured patients and high-value procedures to offset the costs of uninsured charity care” (New Jersey Commission on Rationalizing Health Care Resources 2008:Appendices p.78).

Hardest hit, thirty five years after the 1971 commitment, are still the essential urban hospitals. Their Hospital Alliance (2007:1,4) testified, “While suburban hospitals are competing for market share of the insured populations and are able to participate in a medical arms race to get the latest and greatest technologies (which leads to unnecessary proliferation of services),” they testified, “...no one is competing for the care to the poor and uninsured [and] market competition is eroding NJ’s safety net by contributing to the demise of essential hospitals.” Market competition bankrupts the wrong hospitals for the wrong reasons. As the Commission’s (2008:vi) chair, Uwe Reinhardt, points out, it “allocates resources not to individuals most in need of them, but to those who have the most money.” Those least able to fend for themselves lose, and the morally flexible win, especially when the less able trust them. Rampant, non-transparent price discrimination “rewards neither efficiency nor superior outcomes...” The underlying reason is that little is known either about actual costs or prices, and the Commission details imply that as with the generous payments for uncompensated care (see Part I), hospitals may get well paid for charity care, protests notwithstanding (New Jersey Commission on Rationalizing Health Care Resources 2008:Ch 6-7).

The Subcommittee on Access and Equity for the Medically Underserved of the state Commission on Rationalizing Health Care Resources (2008:Appendices p.26), identified the gaps and barriers as “over-reliance and/or inappropriate use of hospital emergency rooms, in the absence of other appropriate venues for the delivery of healthcare services;...a dearth of

primary and specialty healthcare providers; ...availability of healthcare insurance; and historically low Medicaid reimbursement rates.” The Subcommittee emphasized that 70 percent of hospital care to the categorically uninsured and underinsured is done at teaching hospitals so it is critical to strengthen residency programs and minority recruitment, and offer loan forgiveness for treating underserved populations.

The Commission reported several pieces of evidence that New Jersey’s hospital-centric, permanently failing institutional structure wastes large sums and keeps margins low. Hospital days for Medicare patients during the last two years of life were substantially higher than U.S. averages, and inpatient reimbursements higher still (New Jersey Commission on Rationalizing Health Care Resources 2008:Appendices p.49). Quality was no higher and often lower. This huge waste directly affects the ability to afford and provide needed services to immigrants and other categorically unequal persons. It also “has driven more and more hitherto insured Americans into the ranks of the uninsured, whose numbers are rising inexorably and will do so with ever greater speed in the decade ahead” (New Jersey Commission on Rationalizing Health Care Resources 2008:viii). More of those uninsured are likely to be immigrants, and swelling ranks reduce the capacity to provide charity care to undocumented immigrants. Closing more hospitals would save money, increase margins and raise quality. In addition, nearly half of all ER visits that do not lead to admission, or about 500,000, are potentially avoidable with improved access to primary care (DeLia 2006). Half of these arrive between 8 and 5 when physicians’ offices are open. A much greater number could be avoided if patients had been under good care focused on keeping patients healthy.

Quite a different, no-holds-barred report came from the New Jersey Commission of Investigation (2007). First, it reported that the Charity Care program has been defrauded by patients who failed to disclose they had more than \$7,500 in assets and earned more than the income ceiling of 200% of the FPL. A Bergen County man, for example, “received \$267,215 in free medical services by failing to disclose \$2,100 in monthly rental income from the three-family home he inherited.” Such fraud harms hospitals because they recover less of their expenses. Unlike Medicaid, which requires obtaining an identification card in advance,

eligibility for Charity Care is determined by hospital staff at the point of service, and the application process can be completed up to two years after treatment. If a person cannot complete the forms, the staff do it for them, and translation services are provided. Verification is “spotty and weak,” and the one time external reviewers were hired, they concluded that fraudulent claims ran about 7.8%, or about \$45.5 million a year. But the Department of Health and Senior Services (DHSS) did not have a fraud unit, and the legal grounds for investigation were in dispute. DHSS spent over \$2 million a year administering Charity Care, yet conducted only cursory validation checks. Finally, budgetary language undermined the intent to fund primarily the urban, safety-net hospitals and produced wide swings in payments levels. For example, St. Francis Medical Center received \$706,586 less than its Charity Care cases warranted in 2005, but \$969,135 more in 2006. In the 3-year period, the University Hospital in Newark and St. Joseph’s Hospital received \$50 million less than was due them for treating charity care patients. The Commission recommended that clear powers and sanctions be established to investigate fraud and that manipulative budgetary language end. The overall Reinhardt Commission recommended blending the state’s charity care moneys into the Medicaid program. While this would simplify administration, it would seriously reduce access to medical care by immigrants.

Promoting Community Health Centers

Complementing the efforts over the years by leaders like Governors Florio and Whitman, and Senator Vitale, the state has been supporting the expansion of community health centers that provide comprehensive primary and social care for about 350,000 low-income, often uninsured, patients in medically underserved areas or populations (New Jersey Center for Primary Health Care 2008).⁵ Three quarters of the patients have incomes at or below the federal poverty level (FPL), and only 4.8 percent have incomes above 200 percent. “Hispanics” make up 53.6 percent of patients served, African Americans 30.7 percent, and

⁵ This discussion of major state efforts will not include stand-alone and notable community clinics outside the FQHCs, often supported by a church and celebrated as “angels” in Portes, Light and Fernandez-Kelly 2009.

whites 12.5 percent. Children 0-19 constitute 39 percent of patients seen, adults 20-44 another 39 percent, and the rest older.

From their origins in 1969, the number of federally qualified health centers (FQHCs) in New Jersey has grown from 7 in 1992 to 12 in 2003 to 19 in 2008 (New Jersey Primary Care Office 2006). Each center has several sites, totaling 70 primary sites, 23 school-based sites, and 5 mobile units providing a million visits in 2008 (New Jersey Center for Primary Health Care 2008). As a result, New Jersey has an FQHC in 96 percent of its 28 medically underserved areas (MUAs), while California has an FQHC in 79 percent of its 167 MUAs, and Florida has one in only 57 percent of its 35 MUAs (GAO 2008). Unlike free or family clinics that hospitals have to subsidize to relieve the burden of ER costs, FQHCs have a much more solid and sustainable financial base from federal as well as state money. One problem, however, is that they start only where and when entrepreneurs try to start one.

When asked, leaders of FQHCs in this HIS study said their goals were to serve the poor, be sensitive to cultural disparities, and to provide high-quality care. Besides primary care, FQHCs provide obstetrics, pediatrics, mental health, and HIV-AIDs services. Legally, FQHCs have advantages. As one director explained,

FQHCs are regarded as public health programs, in contrast to Medicaid and Charity Care, which are entitlement programs. As a result, we can see undocumented patients. We can submit expenses and get paid...A provision in Charity Care allows FQHCs to be paid, even though they are not hospitals, at [reasonable] cost rather than the lower Charity Care rates.
3/12/08:4

Unlike other, indigenous community “free clinics” or physicians in the community, FQHCs receive a much higher fee from Medicaid because they must have dental, mental health, ob-gyn, social work, and other services available. They receive about \$125 per visit, and most lose money on Medicaid patients. One reason is that Medicaid managed care companies routinely use old strategies (Light 1992b) (see Figure 3 – part 3??) to reject submitted claims

for a variety of reasons such as the provider on duty not being the patient's primary care provider, or the procedure being done by the wrong person, or some error in the form, and all Medicaid patients must be enrolled in a managed care plan. A "Medicaid wrap-around" brings payment up to a center's contracted level, but only on approved claims.

Besides this ongoing battle, Medicaid managed care companies negotiate terms of pay and service with specialists; so such referrals are out of the FQHC's hands, and the contractual terms are secret. In addition, many services are not covered, some because they are covered by other programs (Vaccines for Children covers immunizations; a CDC program covers certain women with cancer) or because they are not clinical visits (e.g. labs, radiology), or because they are excluded. "I can't get paid for nurse visits," complained one medical director, nor for a clinical educator to teach patients how to manage their chronic illness, like diabetes. (2/20/08:13)

By contrast, FQHCs have considerable leeway in how they use the \$40 million that the state gives them to treat uninsured patients who do not qualify for Medicaid, most of whom are immigrants. They can contract with specialty groups in sophisticated and favorable ways, as some have. This funding strikes us as functionally equivalent to Charity Care, that is, state money to pay for treating any uninsured patient but in a primary-care setting that provides integrated care in a continuing, health-promoting relationship at a multi-lingual, multi-cultural medical home.

Besides these two sources, centers receive substantial federal FQHC "330" funding (about 17% of their revenues in New Jersey), special federal and state grants, deep discounts on prescriptions from the 340B drug pricing program, free drugs from manufacturers for qualified patients through applications facilitated by Rx4NJ (a facilitating application web service), and patient fees (New Jersey Center for Primary Health Care 2008). Patients must contribute on a sliding scale, a barrier for some but required by Congress to avoid the "moral

hazard” of patients overusing free care.⁶ FQHCs provide a universal right to health care, even for undocumented immigrants, but patients must contribute and they are located only where someone has the initiative to start one.

FQHCs realize they could treat most of the patients coming to ERs who are not medically unstable for less cost and with greater continuity, but they are respectful of hospitals as “sister institutions” and do not poach. Nevertheless, several FQHCs have taken up patients when hospitals have closed or partially closed, and some hospitals realize that if they can get an FQHC going on site, much more of the cost of care for ambulatory patients can be covered. One or two of the FQHCs have staff in a hospital’s ER.

Training residents is a key strategy for getting specialty care on-site, but it lengthens visits considerably and reduces productivity. Young doctors can receive loan forgiveness for working at FQHCs. Residency training also ties a clinic into a teaching hospital, thus providing affordable access to any other specialty with physicians on staff. Even better is to have a medical school and university hospital as one’s sponsor. At one center,

All attendings [clinical faculty] practice here as well. No attendings just come to teach the residents. 3/14/08:6

Some community health centers are not so lucky. At a new FQHC, the medical director replied when asked what are his major challenges,

Not having full-time physicians. There are three putting in a total of 30 hours in one case...serious logistical problems arise...The problem is that doctors can call six figures from another organization. I have to get people who want to work in the community, who want to be part of something that’s not just providing care and going home and playing tennis. JRC 2/08:16

⁶ The myths of this prevalent policy theme are addressed in a companion paper Portes, Alejandro, Donald W. Light, and Patricia Fernandez-Kelly. 2009. "The American health system and immigration: an institutional interpretation." *Sociological Forum* forthcoming..

Unlike the university-sponsored FQHC, this one has no dedicated specialists.

We waste a lot of time searching for sub-specialists...Last year we spent \$300,000 on locums [sessional doctors]. They cost about \$900 a day. 2/20/08:16

Said another about the same problem getting specialists,

They are in business to make money, while we are not. 11/16/07:5

Patients must have “some proof of who they are” and residency – “We do not require them to establish their legal status” (Anderson 2009 (Feb 9)). “Residency” sometimes consists of people who rent a room for a shift, vacating before the next shift’s occupant. Proof of income for people who work in the informal economy (Portes and Haller 2004) can consist of a statement by the patient that they work for certain people or at certain places where they earn certain amounts, signed and witnessed on intake. Flexible rules allow centers to do up to four visits even without basic proof of residency and income. Patients used to be predominantly African-American, but in two of the three FQHCs in our area, immigrants from Mexico, Central America, and the Caribbean make up about 70 percent of the patients now. Two serious problems mentioned by medical directors are low literacy and compliance [their word].

We have a 40 percent no-show rate. I have to schedule 14 patients to see 10. And then some days most them show up; so we get all backed up. 3/12/08:5

He expressed understanding – they have so many other problems to deal with.

The state has made special efforts to expand sites or access points. For example, “special State appropriations have been made available each year since FY 2004 to increase the capacity of FQHCs and to establish new access points in medically underserved areas” (New Jersey Primary Care Office 2006:1). These have resulted in 19 new access points and 13 capacity expansion projects. Nevertheless, a critical weakness in the payment structure is lack of funds for capital improvements, replacement, expansion, or equipment upgrade.

Our greatest problems are new mandates with no funds to do them and an expectation that we grow every year with no capital funds to do it with. 11/16/07:10

The centers we visited are older and cramped. Nevertheless, considerable ingenuity and risk (large debt) has gone into finding capital funds, and new sites have been built in Perth Amboy, Paterson, Plainfield, and Camden, some with over 40 examining rooms. At the heart of enabling centers to grow and renew is Capital Link, a national non-profit organization founded in 1994 that advises, assists, and also raises capital funds through tax-exempt bonds, forgivable loans, loan guarantees, lines of credit, grants, and other means.

Migrant workers are the focus of what originated as migrant health centers, in 1962 before FQHCs. In 2002, the category, “migrant worker” was expanded to include year round workers, and *any* center can now apply for additional funds to serve migrant workers. Initially, most migrant workers were blacks from the south, but today they are primarily undocumented immigrants from the Caribbean, Mexico, and Central America. Courtney Crane-Sherman (2005), who did extensive field work as a student for CMD in the migrant camps and communities in Bridgeton, Vineland, and Salem, describes the typical syndrome: workers are hired for their good health and ability to work and then become injured or ill during a season. They bear any symptoms they can and self-medicate until they need urgent care. Workers often do not know where or how to obtain care when they can no longer tolerate their condition. This syndrome means clinics are underutilized. Migrants do not have transportation, find phone lines busy, lack documentation, are scared and confused, and feel helpless. The centers that are to serve them are not near the camps. All have evening hours, and some have outreach programs and vans that visit the camps, do blood tests, ask about health problems, arrange appointments and transportation, and leave flyers. But these episodic visits do not usually match the episodic break-points among sick or injured workers when they urgently need help. Frequent turnover of outreach team members is another problem; so migrants and staff do not come to know each other and build trust. The experience of their children, however, can be quite different – screenings through local schools, coverage through Medicaid, and good treatment of even costly problems. Worst off are single men, and a dangerous condition is pesticide poisoning, often treated symptomatically for a skin rash or burning eyes.

Unlike Medicaid managed care, community health centers treat immigrants and others not qualified for Medicaid. Their physicians have admitting privileges to provide 24-hour care, and their social service staff network with a range of service organizations to carry out holistic, life-cycle treatment plans. Thus FQHCs could play a key role in restructuring both insurance and service organization from its historic emphasis on hospital-based specialty care to community-based primary care that takes a whole-person, team approach. Strongly promoted by President Bush, new federal funding doubled the number of sites between 2002 and 2008 and led to 38 new or expanded sites in New Jersey, expanded hours, and more services for migrant workers (New Jersey Center for Primary Health Care 2009 (Jan 22); Sack 2008 (Dec 26)). The potential for growth is reflected in about ten times more centers applying for the new federal funds than received it. States have increased their funding for FQHCs, largely from general revenues as a cost-effective investment, and they have relaxed regulations for spending it (Wilensky et al. 2005). Federal limits on Medicaid payments, however, could more than offset these increases, leaving the newly doubled network struggling to make ends meet.

By 2007, FQHCs served 1 in 9 Hispanics, 1 in 8 uninsured, and 1 in 7 American residents living below the poverty line (U.S. Bureau of Primary Care 2008). They could provide the primary-care foundation for more universal access either in the state or for the nation by the simple change of providing them with funds to contract for the specialty services their patients clearly need (National Association of Community Health Centers 2009). This would go a long way towards shifting the center of power and purse from a hospital-specialty system to building a community-based, primary-care system of centers with a majority of local users on the boards. The English have been transforming their system just this way, by giving the primary-care “trusts” the funds to contract for specialty services and hospital care. A recession can be an occasion to make this shift to a more cost-effective base as the number of uninsured accelerates from employer-based deterioration of commercial coverage.

From hospital-based charity care to community-based comprehensive care

Senator Joseph Vitale and a dedicated band of legislators developed and steered the Family Health Care Coverage Act into law in 2005. It allows parents of children in NJ KidCare and childless adults to enroll at very favorable rates. For example, a family of four pays no premiums or copays up to a gross income of \$31,800, and assets are not considered. Premiums are only \$76.00 a month for families earning up to \$62,000, and less for families earning less, with copayments of \$5-\$35 per service (New Jersey FamilyCare 2009 (Feb)). Qualified immigrants include lawful permanent residents, refugee, asylees, undocumented residents whose deportation is being withheld by USCIS, immigrants paroled for over one year, and a few other categories (http://www.njfamilycare.org/pages/rest_who.html).

This expansion not only reduces the number of uninsured but reduces the problem of children disenrolling (Gaboda et al. 2008). It brings in significantly more people who rate their health as excellent or good, which makes the managed care programs more workable (N.J. Department of Human Services 2006). It also draws a significant number of insured employees with modest incomes who have less coverage and episodic care into managed care programs that are not subject to employers raising premiums and copays, or dropping coverage. Such efforts to increase the number of qualified immigrants and others enrolled in Medicaid and SCHIP prompted the Bush's Secretary of Health & Human Services to issue a letter that appeared to require states to employ "five crowd-out strategies" to be sure generous extensions did not "substitute for coverage under group health plans" (Smith 2007 (Aug 17)). This reflected the long history of government coverage helping those that commercial insurers did not want but not covering anyone who might buy insurance. In response, New Jersey sued the federal government, claiming the HHS letter "constitutes illegal rulemaking...is an arbitrary and capricious exercise of the Secretary's authority...and therefore is without force and effect..." (Attorney General of New Jersey 2007). New Jersey and other states prevailed. One of the first acts of President Obama and the new Congress was to reauthorize SCHIP to 2013 and increase its funding by about 50 percent (Iglehart 2009).

Senator Vitale, Governor Corzine and legislative leaders continued working, and in July 2008 an expanded family health care law was passed that mandates universal coverage for all children. Those not covered by commercial health insurance must to be enrolled in NJ FamilyCare or its Advantage buy-in program by July 2009. As a way to break out of charity care being hospital-based, ERs can no longer submit their costs to Charity Care for treating children under age 19, but must bill NJ FamilyCare or Medicaid as a strong incentive to make sure it does not happen again. An enrollment initiative by the Department of the Treasury and Human Services, as well as by NJ FamilyCare was announced as well. “...New Jersey is taking a dramatic step forward in ensuring that quality health care is a fundamental right – not a privilege – for all State residents,” said Senator Vitale. “The system of forcing the uninsured to seek costly emergency care, rather than see a doctor for regular medical checkups and preventive health care, is dysfunctional and unsustainable.” (Office of the Governor 2008 (July 8)). The urban, essential hospitals are “working with community based groups to identify potential families, distributing gifts with promotional literature and dedicating staff for enrollment” (Hospital Alliance of New Jersey 2007:5). Beyond these initiatives in one state, Congress would only need to remove a few categorical inequalities to open up Medicaid to any resident with an income of under 200% the federal poverty level, funded from general revenues but with state flexibility (Brown and Sparer 2003). New Jersey’s moral mandate could then become the nation’s, solidly funded and redirected to a more cost-effective design.

Discussion and Policy Implications

The path-dependent efforts by one state to honor a long tradition of charity care to indigent patients, long after it had been relegated to the periphery of the world’s most corporate, commodified health care system, illustrate the central role of categorical inequalities that underlie the institutional ambivalences of immigration policy, health insurance policies, and the inequitably wasteful ways in which services are organized. They reflect competing values and prejudices among parties of different power which become manifest in the contested efforts to reduce, increase, or merge different distinctions that determine how accessible health services are when needed.

Ever since New Jersey legislators committed themselves in 1971 to guarantee universal access to all hospital-related services, hospital and political leaders of both parties have worked to make it a reality, despite two recessions, draconian cuts in welfare and access by Congress in the mid-1990s, and a market-driven health care environment. Like a dozen other states, New Jersey made up the difference and got smarter about improving access to coverage. In the past few years, it has figured out ways to shift access to programs that provide integrated, primary-care programs through Medicaid managed care and community health centers. Uninsured immigrants have full access to all hospital care and at these centers. Neither asks or cares about legal status. When we asked for figures on the number of immigrants in these programs, no one knew because no one keeps track. The new expanded FamilyCare includes a forceful shift for children away from episodic care at hospitals, which saves money and provides more integrated care.

None of these efforts, however, can compensate for the growing number of uninsured and underinsured from the permanently failing commercial health insurance system. Uwe Reinhardt famously characterized policies as “unsurance,” illustrated by Denzel Washington in the feature film *John Q*. Our case study is supported by a longitudinal analysis of all state reforms that concludes that “the only policies that had a positive effect on coverage were those directly expanding public programs” (Kail, Quadagno and Dixon 2008). But even then, James Morone observes, “The states operate largely within the broad boundaries set by federal choices....partial devolution from Washington and growing citizen demands – often with a diminished governing capacity” (Morone 2001:2-4). Two central barriers are a federal law that prohibits states from regulating self-insured employer plans and the unique exemption of insurance companies from anti-trust laws against collusion, tying-relations, or cartel activities.

How well has all this effort to improve access worked? To get a comparative overview of state differences, researchers from the Maternal and Child Health Bureau used the 2003 National Survey of Children’s Health to gain greater detail on how the 6 states with the

greatest proportion of immigrants differ (Yu, Huang and Kogan 2008). They compared children 0-17 from nonimmigrant families with US-born children with one or both parents foreign-born, and foreign-born children using several measures of access barriers, including having no insurance and not seeing a doctor in the last 12 months. They adjusted for income, educational level, language spoken at home, and ethnicity. New York set the benchmark for having the most comprehensive programs and arrangements for access, and New Jersey was comparable for children of nonimmigrant families. But US-born children with one or both parents foreign-born in New Jersey were 1.5 and 1.8 times respectively more likely not to have health insurance than children with parents who were citizens. Actual access as measured by not seeing a physician was much better, 0.6 and 1.1 times respectively.⁷ For Florida, these children had adjusted odds ratios of 1.4 and 2.2 respectively for no medical insurance. The odds of no doctor contact were 0.9 and 2.2. For California, these children had odds ratios of 1.4 and 1.6 for no medical insurance. For no doctor contact, the odds ratios were 1.4 and 3.0 and also much higher for children in nonimmigrant families. For the relatively small number of foreign-born children, access was much worse in all three states than in New York. The odds of no medical insurance rose to 2.2-3.3, and no contact with a doctor in the last 12 months ranged from 1.4 for New Jersey to 3.1 for California.

Thus access to care in New Jersey for children, at least, ranked at the top with New York among the “big six.” However, an all-state analysis of access, quality, and cost-effectiveness ranks New York in the middle of the pack at 22nd, with New Jersey 26th, California 39th, and Florida 43rd. Again, measures of direct access to care versus being insured rank New Jersey much higher and New York higher still. Top ranking are states like Hawaii, Iowa, Vermont, and Massachusetts (Cantor et al. 2007; Shea, Davis and Schor 2008). Sherry Glied concluded, “The State’s ambitions often seem to exceed its actions” (Glied 2005:11). In another major assessment, California came out much better (14th), Florida better (26th), and New Jersey much worse (39th) (Arellano and Wolfe 2007). The great recession of 2007-2010 jeopardizes all these efforts, and immigrants are already being blamed. It is notable,

⁷ This means New Jersey children with one foreign-born parent were substantially more likely to see a physician than such children in New York.

therefore, that the President of the New Jersey Hospital Association, Betsy Ryan (2009 (Jan 21)), dismissed them as

“a small part of New Jersey’s uninsured problem and reaffirmed that beyond federal law requiring hospitals to provide emergency care, New Jersey law “...requires hospitals to provide care to *all persons in all settings* – not just in the emergency room – regardless of their ability to pay.”

She might have added, regardless of legal status.

This account has several limitations. It has focused on those parts of one state’s efforts to improve access to health services that seemed most pertinent to lower-income documented and undocumented immigrants. The high cost of commercial health insurance in New Jersey, for example, and the troubles with its small-group and individual policies are not discussed (Glied 2005; Glied and Broughton 2006). Left to the side are many other changes in hospital and managed care regulations, other access programs and their many contested changes, and even the details of the Charity Care program itself. Its rule book takes up 34 single-space pages about criteria, write-offs, claims in relation to DSH considerations, bases for pricing the services, how to handle partially insured services, and the like (N. J. Department of Human Services 2009). Another 10-page manual details costing, billing, and data submission by a hospital. Each rule categorically defines what patient, service, and cost is or is not “charity care.” Given that the entire enterprise has been permanently failing without collapsing for over 35 years and carries out its noble mission in a wasteful and clinically inverted way, one wonders whether it would not be better for all parties if all the categorical distinctions were simply removed for all services and patients. This is, after all, the policy advantage of categorical inequalities as socially constructed realities: they can be categorically removed. But given the vested interests of different stakeholders in existing regulations and exclusions, the effort to provide universal access is more likely to look like Figure 6.

Fig 6



FIGHTING OVER TERMS FOR UNIVERSAL ACCESS

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Figure 3: Techniques of Risk-rating by Private Insurers to Minimize Risks Covered and Payments

Front-end Techniques of Direct Risk Rating

Basic:

- Charge higher premiums
- Deny coverage altogether
- Insert exclusion clauses for specific disorders or risks
- Redline entire occupations or industries

Elaborated:

- Policy churning (change policy each year)
- Within-group exclusion clauses
- Renewal underwriting
- Selective marketing to avoid higher risks

Techniques of Indirect Risk Rating

- Waiting periods (before paying for any existing problem)
- Deductibles
- Co-payments
- Payment or service caps
- Benefit design (to attract some classes and put off others)

Back-end Techniques to Reduce Claims Paid Once Insured

Claims harassment

- No response
- Delayed response
- Can't find; send again
- Detail missing or wrong; redo
- Denial of valid claims
- Difficult to read forms; obtuse explanations
- Gotcha Clauses – (e.g. call this number before a procedure)
- Complex procedures, signature protocols, coordination of patient, physician and facility information
- Unwritten rules of procedures and accounting
- Claims "hot potato" (btwn auto and health insurance)

Exclusion by association (a different problem was affected by an excluded condition, like diabetes)

Phony, fraudulent schemes

Pyramid schemes (take your money and run)

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