P U B L I C H E A R I N G

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

S-2024

(Establishes the "New Jersey Uncompensated Care Trust Fund" and appropriates $7,500,000.00)

July 9, 1986
West Orange Town Hall
West Orange, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman
Senator C. Louis Bassano
Senator Henry P. McNamara

ALSO PRESENT:

Eleanor Seel
Office of Legislative Services
Aide, Senate Institutions, Health
and Welfare Committee

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Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

RICHARD J. CODEY
CHAIRMAN

FRANCIS J. MCMANIMON
VICE-CHAIRMAN

JOSEPH HIRKALA
C. LOUIS BASSANO
GARRETT W. HAGEDORN

State of New Jersey

SENATE INSTITUTIONS, HEALTH
AND WELFARE COMMITTEE
CN-042
STATE HOUSE ANNEX, TRENTON, N.J. 08625
TELEPHONE: (609) 292-1646

MEMORANDUM

July 2, 1986

TO: MEMBERS OF THE COMMITTEE

FROM: SENATOR RICHARD J. CODEY, CHAIRMAN

SUBJECT: COMMITTEE MEETING -JULY 9, 1986

(Address comments and questions to Eleanor Seel, Committee Aide)

The committee will meet on Wednesday, July 9, 1986 at 10:30 A.M. in the West Orange Town Hall, West Orange, New Jersey.

The Agenda will be as follows:

S-2024 (Codey)	Establishes the "New Jersey Uncompensated Care Trust Fund."
S-2229 (Codey)	Authorizes the exchange or transfer of convicted offenders who are citizens of foreign counties to their county of citizenship.
S-2331 (Bassano) A-2339 (Frelinghuysen)	Establishes an Office for Prevention of Mental Retardation and Developmental Disabilities; appropriates $250,000.

SENATE, No. 2024

STATE OF NEW JERSEY

INTRODUCED APRIL 21, 1986

By Senators CODEY, LYNCH, McMANIMON, HIRKALA, DALTON, BASSANO and McNAMARA

Referred to Committee on Institutions, Health and Welfare

AN ACT establishing the "New Jersey Uncompensated Care Trust Fund," and supplementing P. L. 1971, c. 136 (C. 26:2H–1 et seq.), and making an appropriation.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The legislature finds and declares that: access to quality health care shall not be denied to residents of the State because of an inability of the State's general hospitals to finance uncompensated care; there are many residents of the State who cannot pay for needed hospital care and in order to ensure that these persons have equal access to hospital care it is necessary to establish a mechanism which will provide for payment of a hospital's uncompensated care; to protect the fiscal solvency of the State's general hospitals, as provided for in P. L. 1971, c. 136 (C. 26:2H–1 et seq.), it is necessary that all payors of health care services share in payment of uncompensated care on a Statewide basis; and, therefore, it is necessary to establish the "New Jersey Uncompensated Care Trust Fund."

2. As used in this act:

a. "Commission" means the Hospital Rate Setting Commission established pursuant to section 5 of P. L. 1978, c. 83 (C. 26:2H–4.1).

b. "Department" means the State Department of Health.

c. "Fund" means the "New Jersey Uncompensated Care Trust Fund" established pursuant to this act.

d. "Hospital" means an acute care hospital licensed pursuant to P. L. 1971, c. 136 (C. 26:2H–1 et seq.) whose schedule of rates

are approved by the commission pursuant to section 11 of P. L. 1978, c. 83 (C. 26:2H–18.1), but does not include a facility which primarily provides psychiatric care, addictive behavior rehabilitation or skilled nursing care, or a specialty hospital.

e. "Payor" means a governmental or nongovernmental third party payor whose hospital reimbursement rates are established by the commission pursuant to P. L. 1971, c. 136 (C. 26:2H–1 et seq.).

f. "Uncompensated care" means inpatient and outpatient hospital-based care provided to medically indigent persons and bad debts as defined by regulation of the department pursuant to P. L. 1971, c. 136 (C. 26:2H–1 et seq.).

3. There is established the "New Jersey Uncompensated Care Trust Fund" in the Department of Health.

a. The fund shall be comprised of monies collected from hospitals pursuant to this act and monies appropriated from the General Fund to carry out the purposes of this act. The fund shall be a nonlapsing fund dedicated for use by the department to pay for the cost of uncompensated care in the State and the reasonable cost of administering the fund. Interest earned on monies deposited in the fund shall be credited to the fund.

b. The fund shall be administered by a person appointed by the Commissioner of Health in consultation with the Uncompensated Care Trust Fund Advisory Committee established pursuant to section 4 of this act.

The administrator of the fund is responsible for overseeing and coordinating all activities of the fund including, but not limited to, collection and disbursement of fund monies. The administrator is responsible for promptly informing the Uncompensated Care Trust Fund Advisory Committee if monies are not being or cannot be collected or disbursed or if the fund's reserve as established in subsection c. of this section falls below the required level.

c. The fund shall maintain a guaranteed reserve equal to 1/12 of the fund's total estimated annual payment for uncompensated care costs for the prior calendar year; except that, during the first year of the fund, the reserve shall be equal to 1/12 of the estimated annual payment for uncompensated care costs for the current calendar year. If the reserve drops below the required level, it shall be restored through increases in hospital payments and State appropriations and not through any limitation on payment to hospitals for uncompensated care.

d. Interest earned on trust fund monies may be used to finance

the cost of annual uncompensated care audits conducted pursuant to section 8 of this act.

4. a. There is created in the Department of Health a nine-member Uncompensated Care Trust Fund Advisory Committee which shall be comprised of the Commissioners of the Departments of Health, Human Services and Insurance, or their designees who shall serve ex officio and six members appointed by the Governor as follows: one person who represents the Governor's Office of Policy and Planning who shall serve ex officio and five public members who include two persons who represent payors, two persons who represent hospitals in the State and one person who represents the New Jersey Hospital Association.

The public members shall serve for a term of three years and are eligible for reappointment, but of the members first appointed, two shall serve for a term of one year, two for a term of two years and one for a term of three years. Vacancies in the advisory committee shall be filled in the same manner as the original appointments were made.

The advisory committee shall organize as soon as practicable after the appointment of its members and shall select a chairperson from among its members. Members of the advisory committee shall serve without compensation but shall be reimbursed for the necessary expenses incurred in the performance of their duties as members of the advisory committee.

b. The advisory committee shall:

(1) Review the methodology and assumptions used by the department to establish the Statewide uncompensated care add-on pursuant to section 5 of this act, and advise the commission on its conclusions about the accuracy of the methodology;

(2) Make recommendations to the commission on the procedures that shall be used to audit uncompensated care at the hospitals; and

(3) Make recommendations to the administrator of the fund concerning any aspect of the operation of the fund.

5. Prior to the beginning of the hospitals' rate year, the department shall determine a uniform Statewide uncompensated care add-on. The commission shall approve the add-on before it is applied to hospital rates.

The add-on shall be determined by dividing the Statewide projected amount of uncompensated care by the Statewide projected amount of revenue for all payors less the Statewide projected amount of uncompensated care.

The add-on and any increases made to the add-on are an allowable cost and shall be included as part of the hospitals rates as established by the commission.

6. a. The commission shall approve each hospital's uncompensated care costs and shall ensure that a hospital's rates are adequate to pay for all reasonable uncompensated care costs.

b. The commission shall annually determine the amount a hospital shall pay to the fund or the fund shall pay to the hospital, as appropriate. The amount determined by the commission is final, except as provided in subsection c. of this section and subsection c. of section 8 of this act.

The hospital payment to the fund shall be funded by the uniform Statewide uncompensated care add-on determined pursuant to section 5 of this act, which is charged by the hospital to all payors.

The commission shall require a hospital whose uncompensated care costs are lower than the amount the hospital will receive from the uniform Statewide uncompensated care add-on to remit the net difference to the fund. The commission shall authorize a hospial whose uncompensated care costs are higher than the amount the hospital will receive from the uniform Statewide uncompensated care add-on to receive the net difference from the fund.

c. If a hospital finds that its actual uncompensated care costs have deviated significantly from the amount approved by the commission, it may request relief from the commission.

The commission shall review the hospital's request within 30 calendar days of receipt of information required by the department to support the request. If the commission concurs with the hospital's finding, it shall approve an interim adjustment of the hospital's payment to the fund or the fund's payment to the hospital.

7. a. Hospitals required to remit the net difference of funds received from payors pursuant to subsection b. of section 6 of this act shall remit the funds in equal installments at the end of every month; except that a hospital shall make its first payment no later than 75 days after the fund is established.

b. If a hospital is delinquent in its required payment to the trust fund, the commission may, pursuant to department regulations, remove from that hospital's schedule of rates the uniform Statewide uncompensated care add-on or levy a reasonable penalty on the hospital. The penalty shall be recovered in a summary civil proceeding brought in the name of the State in the Superior Court

pursuant to "the penalty enforcement law," (N. J. S. 2A:58–1 et seq.).

8. a. The department shall annually provide for an audit of each hospital's uncompensated care no later than 120 days following the hospital's submission of its final reporting forms as required by regulation pursuant to P. L. 1971, c. 136 (C. 26:2H–1 et seq.).

b. Prior to the department's final approval of the audit, the results of the audit shall be reviewed with the hospital. If a hospital disputes an audit adjustment, the hospital may appeal the adjustment to the commission. The commission shall resolve the dispute within 90 calendar days of the date which the hospital appealed the adjustment.

c. Upon receipt and acceptance of the final audit, the commission, within 90 calendar days, shall adjust a hospital's schedule of rates so that the rates reflect the hospital's actual uncompensated care experience as determined pursuant to this section. The commission may adjust the schedule of rates to either require the hospital to pay to the fund an amount equal to the difference between the hospital's interim payments made pursuant to section 7 of this act and the hospital's actual uncompensated care costs, or provide the hospital with an increase in payments from the fund in an amount equal to the difference between the hospital's actual uncompensated care costs and the amount the hospital received from the uniform Statewide uncompensated care add-on and any additional moneys paid to the hospital by the fund.

9. If the State is not eligible to receive federal matching funds cover the cost of the uniform Statewide uncompensated care add-on for recipients of medical assistance under the Medicaid program pursuant to P. L. 1968, c. 413 (C. 30:4D–1 et seq.), the State shall fund the full cost of the add-on factor for these recipients.

10. Pursuant to the "Administrative Procedure Act," P. L. 1968, c. 410 (C. 52:14B–1 et seq.) the department shall adopt rules and regulations necessary to carry out the provisions of this act.

11. There is appropriated $7,500,000.00 from the General Fund to the Department of Health to provide initial funding for the trust fund and to establish the reserve required pursuant to this act.

12. This act shall take effect immediately.

STATEMENT

This bill establishes the "New Jersey Uncompensated Care Trust Fund" in the Department of Health to provide a stable Statewide funding source for the payment of indigent care in the State's general acute-care hospitals. This trust fund will ensure that no person in the State is denied necessary hospital care due to an inability to pay for the care and that no general hospital in the State will face financial insolvency due to its provision of care to indigent persons.

The trust fund provides that the responsibility for funding hospital care for medically indigent persons throughout the State will be borne equally by all hospitals by means of a uniform Statewide uncompensated care add-on which will be applied to each hospital's schedule of rates. The add-on will be determined by the Department of Health and approved by the Hospital Rate Setting Commission. Those hospitals which collect more than they need to cover their uncompensated care costs will pay the net difference into the fund and those hospitals which collect less than they need to cover their uncompensated care costs will receive additional revenues from the trust fund.

In addition to revenues from the hospitals, this bill provides that the moneys collected by the trust fund will be supplemented by State funds. Accordingly, this bill appropriates $7.5 million from the General Fund as start-up costs for the trust fund. State supplementation is necessary because the hospitals in the State may, within this year or next year, no longer receive payments from Medicare or Medicaid for uncompensated care.

Currently, the cost of uncompensated care is borne equally by all third-party payors, including Medicare and Medicaid, and uninsured individuals. This cost is presently in excess of $250 million a year. Participation by Medicare under the State's all-payor system is permitted through a waiver granted to the State by the federal Health Care Financing Administration. One condition of this waiver is that Medicare's costs in New Jersey under the waiver, including payment for uncompensated care, cannot exceed what Medicare's costs would have been without the waiver. Because of recent cutbacks in the federal Medicare program, it is becoming increasingly likely that in 1986 or 1987 Medicare's costs in New Jersey under the waiver will exceed its estimated costs outside the waiver. Should this occur, the federal waiver may be terminated and Medicare's (and possibly Medicaid's since its reimbursement provisions are similar) current share of pay-

ments for uncompensated care would no longer be available to hospitals in the State. This could result in a substantial loss of revenue to the State's hospitals since Medicare pays for 46% of hospital care in the State and Medicaid pays for about 9% of the care in the State. The resulting shortfall to the State is estimated to range between $60 million and $115 million a year.

Because of the likelihood of the waiver's being terminated, it is prudent to establish in advance of the termination a new mechanism for funding uncompensated care and thereby avert a crisis among the State's hospitals in meeting the costs of uncompensated care and maintaining the financial solvency of these facilities.

HEALTH CARE FACILITIES AND PROVIDERS

Establishes the "New Jersey Uncompensated Care Trust Fund;" and appropriates $7,500,000.00.

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SENATOR RICHARD J. CODEY (Chairman): We are ready to convene our hearing this morning. I would like to start to take testimony on Senate Bill 2024, the New Jersey Uncompensated Care Trust Fund. Our first witness will be Craig Becker of the New Jersey Hospital Association. Mr. Becker?

C R A I G A. B E C K E R: Thank you, Mr. Chairman. With me is Dom Camisi, who is our Senior Vice President for Finance. He will be able to answer any questions you might have concerning the technical aspects of the pool. I am giving testimony today on behalf of my boss, President Lou Scibetta.

As a little bit of background, this legislation is the by-product of over a year of intense discussions between the Hospital Association and the Department of Health. In a nutshell, what the legislation will do is remove uncompensated care as a factor in determining hospital rates. Additionally, the pool will fairly distribute payments for nearly $300 million in uncompensated care provided by New Jersey hospitals last year.

Our main concern, obviously, is continued access to care for the public. Secondly, but no less important, is the fiscal solvency of our hospitals throughout New Jersey.

As you may or may not know, New Jersey may shift its Medicare portion of our all-payer system over to a national rate, which is going to cause some serious maldistributions of dollars throughout the State. This bill you have introduced will basically allow us to continue to distribute those dollars throughout the State. Also, it will even out the rates. It will allow our hospitals which have high uncompensated care to compete with those hospitals which do not.

I would like to clear up one misconception real fast, if I may; that is, this bill will not increase revenues to hospitals, nor will it cause a rate increase. This bill alone will not do that. Its primary function is only to evenly distribute the funds designated to pay for uncompensated care.

However, having said that, you must also be aware that with Federal cutbacks, which include a freeze on the rates, a freeze on the transition, and cutbacks in graduate medical education, there will undoubtedly be a shortfall of Medicare dollars in coming years. What that level will be we are not sure at this time, but that will cause the rates to go up. That will happen whether or not this legislation is implemented.

Again, in the aggregate, there will be no additional revenues accruing to the hospital industry by this. All this will do is allow a hospital that, say, has a 26% uncompensated care rate, and another one that has three-- They will all end up with the same rate of around 7% or 8%, whatever the statewide average is. There will be no additional revenues coming to the hospitals.

Because of the combined efforts of the hospitals in the State, at least through Chapter 83, costs have truly been curbed. New Jersey is 47th lowest in the nation in its rate of hospital cost increase. Last year, we saw a $43 million, or 1.3% revenue bottom line out of a $4 billion system. That is not really a whole lot to play around with. Our numbers compare very favorably with other states in adjusted admissions. Ours was $3,098, which compares with $3,729 for Pennsylvania and $4,126 for New York. There are other states that we are compared with in the testimony, but I won't go through those. Again, these figures came from the American Hospital Association. Clearly, New Jersey residents have been receiving a health care bargain when compared to other states in the nation.

On the bill itself, there have been some last-minute amendments, I know, that have come from the Department and from the Governor's office. The one that causes us the most concern at this point is, it is our understanding that Section 8 of the bill, on Page 5, will basically eliminate the audit procedure. The hospitals feel very strongly that there needs to be an

audit procedure included in this legislation. Basically, what that audit procedure does is require the Rate Setting Commissioner of the Department to audit our uncompensated care numbers no later than 120 days following our submission of the final reporting forms. This is required by law now. Apparently the Department wants this taken out because they feel it cannot be done properly.

We believe, though, that this needs to be done. Right now our hospitals are three years behind in their audits -- the uncompensated care audits. We understand '82 and '83 are just now being done. We feel very strongly that if we are going to be held to certain provisions of this bill, that the Department must be also. In fact, there are sections in this bill that would allow them to beef up their audit section, and I would think that business and industry and the payers would agree with us that auditing is something that should be taken care of, and should be truly addressed in this legislation.

The main problem we have with it, also, is that with the legislation we would end up with interim numbers for our uncompensated care, not final numbers. Therefore, it could be three years before our hospitals would know whether or not they owe the State money, whether the State owes them money, or whether the Fund owes them money. So, I would hope that you would consider, perhaps, not taking that out of the legislation, or that another type of auditing procedure could be hammered out, if not here, in the regulations.

That is my testimony.

SENATOR CODEY: Mr. Becker, how do you feel about the idea of the sunset provision?

MR. BECKER: Your sunset provision, frankly, is a good idea, but the two years may not give us enough time to really see how this moves along. I know there is also another provision in there whereby they could extend it, I assume, if they so chose.

SENATOR CODEY: It couldn't be extended unless the Legislature did it.

MR. BECKER: Yeah, right. But, frankly, two years is going to be a very short period of time for this to be up and running.

SENATOR CODEY: Under the Trust Fund, the redistribution of money, some hospital rates would go up and some would go down. Which would go up and which would go down?

MR. BECKER: When I said that hospital rates in the aggregate would not go up, that was exactly what I meant. Individual hospital rates will go up. Those hospitals that have uncompensated care levels that are below the State average will go up to the State average. Those that have uncompensated care that is above will come down to that. Our membership voted, overwhelmingly, in favor of this. They feel very strongly that uncompensated care is really not a part of doing business, and that it is unfair to penalize a hospital because of its geographic location. They do not feel the same about capital or graduate medical education because those are board decisions, business decisions, that hospitals made.

SENATOR CODEY: Senator McNamara, questions?

SENATOR McNAMARA: Nothing right now.

SENATOR CODEY: Okay. Thank you very much. Our next witness will be Dr. Molly Coye, Deputy Commissioner of the New Jersey Department of Health. Good morning, Doctor. Go right ahead, please.

D E P U T Y C O M M I S S I O N E R M O L L Y J. C O Y E: Thank you very much. Good morning, Senator Codey, Senator McNamara, and members of the Committee. I am very pleased to be here this morning in order to state the Department of Health's support for Senate Bill 2024 to establish the New Jersey Uncompensated Care Trust Fund. As you may know, Governor Kean, in his line item veto message, listed uncompensated care, the need to provide care to the uninsured

in this State, as a top priority. I believe that this demonstrates the strong commitment of this Administration to the issue of uncompensated care and support for this bill.

This bill would significantly improve the existing hospital payment system for uncompensated care by spreading its costs among all consumers in all hospitals, instead of the current system which requires the highest payments of those persons using hospitals which provide the largest amount of care to the poor and uninsured.

The bill is a straightforward approach to a serious, costly problem. The numbers and medical costs of New Jerseyans who lack medical insurance remain high -- almost $300 million annually. Although the amount of uncompensated care as a percentage of total revenues has remained relatively constant, the dollar cost has increased significantly as total hospital revenue is creeping upwards. We believe careful research on the reasons for its increase are indicated.

New Jersey is one of the few states which has shown leadership in dealing with this issue. State law P.L. 1978, Chapter 83, has provided, since 1980, that rates which individual hospitals charge include the reasonable cost of uncompensated care. This system has worked very well. The major constraint has been that the largest care givers necessarily have the highest rate add-ons. For example, there are 18 hospitals within 10 miles of West Orange which provide $87 million of uncompensated care, or about $4.8 million on average, as compared to five other hospitals which provide only $2 million, or less than half a million dollars on average.

Passage of this bill would ensure that the costs of such care would be distributed more equitably throughout the State and would eliminate any remaining tendency not to provide care because a person cannot pay. We also believe that with broader participation comes greater interest in ensuring that the care and its costs are the most appropriate possible. The

Department of Health welcomes this greater interest by the payer and hospital communities.

The Fund which you are considering today would introduce the technique of pooling moneys for reallocation to hospitals which document the highest amount of uncompensated care. This pooling approach is an accepted, tested, successful method of paying hospitals for the care of the uninsured. Massachusetts and New York have successfully employed the technique both in the context of all-payer systems with Medicare waivers and non-waivered rate-setting systems.

The bill is very timely, and we welcome prompt passage. Recent severe and unexpected cutbacks to the Federal Medicare system have made unlikely the continuation of the State's Medicare waiver past Calendar Year 1987. This bill will greatly ease the transition of hospitals, especially those with high levels of uncompensated care and above average numbers of Medicare patients, into a non-waivered system. Absent this legislation, the ability of the current system to reallocate enough dollars to these needed hospitals would be hard pressed.

Existing State law already imposes the responsibility on users of hospitals to contribute to the cost of uncompensated care. The obligation has never been that of the State. Nevertheless, the Department of Health notes that the bill does offer significant additional State financial assistance. It provides for a $10 million repayable loan to, in effect, prime the pool's pump, and a $5 million reserve loan to maintain solvency for the Fund. It also provides for increased support by the State Medicaid Program in the event that Medicare no longer participates in the State's rate-setting system.

The costs of such increased Medicaid participation could approach $20 million annually -- $10 million State, $10 million Federal. These contributions are particularly

significant when it is considered that the State already supports a $390 million State Medicaid Program of hospital care. Those are just the hospital costs for Medicaid. Medicaid is a program for people who would otherwise be uninsured and is ample evidence of the State's financial commitment to pay for care for the uninsured in amounts which, as you all know, exceed the remaining burden of the uninsured.

There are several features of the bill which are particularly important in the Department's view. These are:

1. The concept of a flat rate add-on. This keeps administration simple and cost-effective and promotes the equitable distribution of payment, and will reduce competitive disadvantages among hospitals.

2. Maintenance of the responsibility of the Fund within the existing rate-setting system with its objective means of determining reasonable costs and its checks, balances, and controls on what is bona fide uncompensated care.

3. As the third point, we would welcome encouragement from you for data gathering concerning the reasons for lack of insurance. This is a reasonable cost of administering the Fund and would determine the extent to which other policies may be needed to help segments of the uninsured to obtain coverage.

4. Expanded scrutiny by the Hospital Rate Setting Commission of the reasonableness of the care is indicated, given the high and increasing costs of this care.

The long-term solution to the costs of the uninsured, many of whom are employed, as you may know, is to move as many as possible into the ranks of the insured and to develop comprehensive packages of health care at contained costs for those particularly vulnerable groups who will always need help. The Department of Health is working on these long-term goals, as well as the short-term financing issues. Senate Bill 2024 goes a long way toward creating a climate of mutual responsibility on the part of the hospital industry, the payer

community, and the State administrative agencies to work to achieve these long-term goals via interim solutions.

We feel very pleased, and I am personally pleased in my first appearance before this Committee, to be able to comment on a bill which takes a very progressive step forward and is the result of cooperation and leadership with the hospital industry, as well as the Department of Health.

I would like to introduce Christine Grant, Director of Hospital Reimbursement, who has been directing our efforts in this regard. Christine will be able to provide information that I might not be able to.

SENATOR CODEY: Okay. Doctor, it is nice to meet you, and we look forward to working with you. Senator McNamara?

SENATOR McNAMARA: Just a couple of questions. Have you offered any amendments, because I haven't had an opportunity to look at it? My concern is, how does this impact the county hospitals, such as the University of Medicine and Dentistry, the Jersey City Medical Center, and Bergen Pines? In 1978, when they went into the DRG program, it seemed that the Department of Health, contrary to a statement by the Committee, interpreted it in a manner that that happened to cap at a much lesser rate than the 100% that was promised to all hospitals, and threw an undue burden on the taxpayers in those individual counties.

Now, in the form of the bill that I looked at, it seemed evident that that would not reoccur under this particular program, but having been burnt once, it makes me wonder if the amendments you offered are going to leave it open to an interpretation by the Department of Health which, in fact, can then cause an undue expense to those particular counties. Why should they be penalized? If they are making an effort to provide for those who do not have insurance now, how can you single them out because they're paying-- I mean, it's the same taxpayer who is paying for it in his property tax,

then again is going to pay for it as a user of hospitals, and it's really welfare. I mean, you know, I just want to know if that is buried somewhere in the amendments because I don't think the Chairman intends to move the bill today, and I want the opportunity to study those amendments.

I would like to hear what you have to say about it up front.

DEPUTY COMMISSIONER COYE: Okay. I would like to ask Christine to comment because she was involved in the evolution of the waiver in the last couple of years. It was my understanding that that cap originally was the result of negotiations with HCFA and restrictions they were placing on us because of their concern about the amount of uncompensated care delivered at some institutions. I would like to ask Christine to comment on that, and then on the current bill.

C H R I S T I N E M. G R A N T: Well, Senator McNamara, you may be more familiar than I with the history prior to '84, but there was, indeed, a preexisting Medicare waiver by which the Medicare and Medicaid systems participated in paying a share of the statewide uncompensated care. One of the negotiated conditions of that waiver was, in fact, related to University Hospital and did, in fact, it would appear, require a cap, so to speak, at the preexisting uncomp care level of that hospital. That was essentially implemented via the Hospital Rate Setting Commission, which each and every year approves each and every hospital's total statutory revenue, one element of which is uncompensated care.

So, I would agree that, in fact, there have been historical caps placed on three hospitals in the State. You may be aware that in the last year, Jersey City Medical Center had a great loosening of that cap based on demonstrated and audited information which showed, in fact, that the hospital had made major changes in billing and collection procedures.

The basic dilemma here with respect to this bill-- I would answer you directly that this bill, as proposed initially, and even with any suggestions from the Department of Health, does not explicitly include caps, nor is that our intent. On the other hand, one could read into this bill a general concern that there are individual cases of individual hospitals where the amount of uncompensated care has risen and needs improved explanation before the Department of Health, through the Rate Setting Commission process, feels comfortable in approving that amount.

I think the most candid answer is that that issue, if it would arise, would not be through this legislation or amendment, but through the overriding Chapter 83 legislation, which allows the Hospital Rate Setting Commission to essentially impose an equity requirement on whatever statutory revenue it approves for any hospital. The University Hospital, just yesterday at the Hospital Rate Setting Commission, had its cap for Fiscal Year 1985 -- Calendar Year 1984 -- raised to 10.02. In total, that hospital is now -- for that past year and presumably in future if, in fact, they do maintain the levels of uncomp care -- going to be paid by the patients who use that hospital, or through this pool, up to $20 million a year for uncompensated care.

SENATOR McNAMARA: I guess my basic problem is-- You are now talking about the University Hospital going to a 10.02 cap. It also received direct and indirect subsidies other than through this particular program.

Jersey City Medical Center has a 19% cap, and Bergen Pines is at a 7% cap, which cost the Bergen taxpayers over the last five or six years $42 million. I find that to be a very serious problem when it is left up to a rate-setting commission, which is not the intent of the legislation. It just reaffirms the argument of the first gentleman who testified, the need for audit.

I have no problem if by audit you can prove that there is insufficient evidence to collect those funds, but I have a real problem if a commission can determine, by whatever their-- It seems to be an arbitrary determination, because in the correspondence I have received from them, it's more attitudinal than rather the intent of the legislation. They are picking out of the legislation what they feel it means, not what the statement attached to that bill says. I will have a real problem with this bill unless I am assured that those counties are protected, in that they will be entitled to the same as all other hospitals.

You know, until I look over the amendments, I really can't comment on them. I have to study them.

MS. GRANT: Right. You will see nothing in this bill which would preclude that again. However--

SENATOR McNAMARA: Well, then I want to put something in the bill that will preclude it from happening, if it's possible.

SENATOR CODEY: Maybe.

SENATOR McNAMARA: I'll try; I'll try.

SENATOR CODEY: Senator Bassano, anything?

SENATOR BASSANO: No.

SENATOR CODEY: Doctor, what is the current status of the waiver?

DEPUTY COMMISSIONER COYE: Currently, we still hold the waiver. We are beginning the process of reprojections based on the new budget -- the Congressional budget -- and we expect-- We have notified HCFA of our intention to retain the waiver and that we have begun those reprojections.

We think we will be able to retain the waiver, at least for the next 12 to 18 months, and that it will be to our advantage to retain it, that even though this means that our total costs, including uncompensated care, will begin to exceed -- or have already begun to exceed -- the Medicare PPS

estimates of what they would have been paying, that by giving them some money back, in effect, we will be retaining a larger contribution from them to our uncompensated care. If we give up the waiver now, we lose the significant tens of millions of dollars that now go for uncompensated care.

So, it is a negotiation that we have to undergo with HCFA once we reproject, but we expect that we will be able to retain the waiver. It is in our interest and in the interest of the hospitals in the State to retain the waiver at this time. How long we would want to retain the waiver, as well as how long we will be able to, depends, to some extent, on the economic factor, the inflation factor, that Congress provides next year. If it is slightly more generous, 2%, we will be in significantly better shape than if it is as low as it was this year.

SENATOR CODEY: Doctor, what would happen if the waiver was terminated and there was no Trust Fund?

DEPUTY COMMISSIONER COYE: If the waiver terminated and there was no Trust Fund, the rates for hospitals which provide -- I'm speaking with regard to uncompensated care only -- a significant amount of uncompensated care would soar, and the payers -- the paying patients at those hospitals, especially in the case of HMOs -- might reasonably be expected to transfer to other hospitals with lower rates of uncompensated care. It would be such a significant and drastic effect that I think we would be worse off than we were in the middle '70s and late '70s, with the conditions that led to the passage of Chapter 83.

SENATOR CODEY: Well, could it bring about the death of some of those hospitals?

DEPUTY COMMISSIONER COYE: Well, it would require such massive infusions of aid to prop up those hospitals that, given what the State budget is, I think we are talking about the death of some institutions.

SENATOR CODEY: Okay. Thank you very much, Doctor, and thank you, Ms. Grant. Our next witness will be Rick Lloyd of Blue Cross/Blue Shield. Mr. Lloyd?

R I C H A R D W. L L O Y D: Senator Codey, members of the Committee: Thank you for the opportunity to testify today.

Recognizing that you have a full calendar of people who would like to testify and that you have copies of my statement, I will just briefly summarize what I think are the highlights of our testimony.

First, we would like to say that we are in support of S-2024. We believe that the pooling mechanism that the bill creates to fund the uncompensated care is an improvement over the current methodology. However, we would like to bring to the Committee's attention what we think is a more important point, and that is the potential problems that can occur when and if Medicare does withdraw from the New Jersey prospective reimbursement system.

As Commissioner Coye testified, they believe that the waiver will remain intact for the next 12 to 18 months; however, if the waiver does expire -- when that does occur -- we would anticipate that there would be a significant increase in premiums for our subscribers. Our calculations indicate that were the waiver to expire approximately in this time frame, we would have an additional $62 million increase in premiums for our subscribers. This would raise the amount of premium that our subscribers pay to cover the costs of uncompensated care in the State to approximately $114 million, which translates into approximately 15% of the premiums paid by Blue Cross and Blue Shield subscribers. Both direct pay and, let's say, employers would fund the costs of uncompensated care.

If the waiver were to expire, we feel it would be a mistake to precipitatively shift the costs of uncompensated care onto private payers. We recognize that if the waiver were to expire, most likely it would be necessary for our

subscribers to pick up certin increased costs. However, we would not like to see those costs arbitrarily shifted without any thought to possible alternative funding mechanisms which might be able to reduce the burden on the private purchaser of insurance.

We have basically three suggestions, which I can go into just very briefly:

The possibility of expanded governmental funding for uncompensated care. We recognize that in S-2024 there are provisions made for the State to fund the Medicaid portion of the system. We think that is a good approach. We would like at least the Legislature and the other parties that are involved in the issue to consider looking into greater funding on the part of the State, either via taxes or dedicated State revenues.

Senator McNamara recognizes the contribution that is made in Bergen County on behalf of subsidizing, in effect, Bergen Pines Hospital. Prior to the evolution of the current prospective reimbursement system, many counties were supporting, at least in part, local hospitals. We would like to see some attempt -- recognizing that there are, obviously, fiscal restraints on counties and municipalities -- to at least consider trying to get back into that system to whatever they think is a fiscally responsible level.

We also think that should the waiver expire, the possibility has to be looked into where the hospitals might try to absorb portions of that shortfall. Specifically, issues have been raised in other forums where the Department has addressed the issue of excess hospital capacity, and is developing a task force to determine a policy on capital reimbursement. At this time, we just believe that the State should be reviewing its reimbursement regulations to see if we can get the hospitals to operate at an even more efficient level than they already are. This is not meant to be construed

that we are saying they are not operating efficiently, but if the situation comes where these costs have to be accepted by the residents of the State of New Jersey, we think everybody needs to tuck in their belts a little bit, not just the purchasers of insurance.

Finally, we think the entire area of uncompensated care needs to be examined further. One of the issues that was raised a little bit was caps. We would like the issue of caps to be considered. At least presently the way the system is structured, the level of uncompensated care could continue to rise and rise and rise, and there would be no mechanism to fund it except by asking payers to continue to meet their obligations. We would like at least that some consideration be given to the idea that at a certain point if the level of uncompensated care continues to rise, we would need to examine the system to see if it does, in fact, meet the needs of the residents of the State, including our subscribers.

In general, though, we would like to say that we support the legislation. We think the reforms it is calling for in terms of a pooling mechanism are welcome, but we would just like to make the Committee aware that the real, let's say, underlying problem that could potentially occur if Medicare withdraws from the system, would not be solved by this legislation.

Thank you.

SENATOR CODEY: Thank you very much, Mr. Lloyd. Any questions? (negative response) Thanks again. Our next witness will be Cynthia Zale, Associate Director of the Health Insurance Association of America.

C Y N T H I A Z A L E: Thank you, Mr. Chairman and members of the Committee. I am very grateful for the opportunity to come before you to present the views of the commercial insurance industry on this particular proposal for financing uncompensated care.

This is an issue that I have been actively involved in, both at the national level and within New Jersey, as a member of the Department of Health's Steering Committee on Uncompensated Care.

The Health Insurance Association is, in general, I think, very supportive of the concept of establishing an Uncompensated Care Trust Fund. This is something that we see as a short-term interim solution to address the uncompensated care problem in New Jersey that is potentially going to be caused by some Medicare shortfalls.

We, as an industry, recognize the need to continue to contribute to the financing of Medicare shortfalls and support these types of pooling arrangements because they share the burden equitably among all non-Medicare payers. However, the amount of money that is going to be necessary to make up for the Medicare shortfall may exceed $250 million or more over the next three years. As a result, this makes this contribution on the part of the payers and the commercial insurance industry and its policyholders a significant contribution. I think the industry, or more appropriately our policyholders, will be looking for both an accurate accounting of uncompensated care costs, as well as participation of the hospital industry in assuming some of these costs.

The current system for financing uncompensated care provides for 100% financing of both indigent care and bad debts. We have expressed some displeasure in the past over the inability to separate out bad debts from indigent care, and have become increasingly concerned over some suggestions that hospital collection practices have deteriorated because, in essence, all of their both bad debts and indigent care are funded in total.

I think because the proposed legislation continues this open-ended funding, we would like to suggest some form of modification whereby the Trust Fund would not be intended to

finance 100% of the costs of uncompensated care. I think that in view of the mission of hospitals and their tax exempt status, hospitals should be expected to both provide care to the indigent and assume some of the costs of providing this care, and by creating a Trust Fund that would cover a substantial portion, but not 100% of these costs, it would both require hospital participation in this effort, as well as create an incentive for hospitals to improve collection practices. This is an incentive that we, regretfully, believe is missing from the current system.

With respect to the proposed bill, I think with some caveats, again, as I say, we find this an acceptable interim solution to the uncompensated care problem, but feel strongly that the State should look towards long-term options to this. The convening of interested parties and the uncompensated care steering committee were an excellent first step on the part of the Department of Health, and we feel they should be praised for their efforts.

In order to develop long-term solutions, it is important for us to learn more about the existing problem. The nature and extent of the uncompensated care problem should be explored to determine the kinds of services we are paying for and for what types of patients. Paying for uncompensated care after the fact cannot work to reduce the level of such care. Rather, I think we should strive to identify the factors that contribute to these problems and, hopefully, what will result will be development of some solutions to address these, such as increased Medicaid eligibility or identification of special access programs that would result in a lowering of the uncompensated care costs.

With respect to some specific sections of the bill and the changes proposed by the Health Department, I would like to just offer a few brief comments. We are supportive of the idea of creating a Fund administrator to oversee the Fund and feel

that the administrator should report to the Rate Setting Commission. I think the Commission was established to provide overall responsibility for hospital cost rates and scheduled rates and this would maintain that responsibility.

We are supportive of the change which would eliminate appeals. We feel that in order to plan appropriately, ensure adequate funding of the Trust Fund, and minimize administrative burdens, there should not be an appeals process. However, the proposal which will institute a twice yearly adjustment should account for changes in a hospital's uncompensated care load.

We are very supportive of the language additions to Section a. which the Department of Health proposed, which make hospital receipt of payments from the Uncompensated Care Trust Fund contingent on providing necessary and cost-effective services. The costs associated with uncompensated care in New Jersey are substantial, and with this bill the payers are going to be expected to finance those costs. We feel it is essential that an assurance be made to these payers that these costs be provided in the most appropriate and most cost-effective manner, and such oversight and monitoring should be a function of the Rate Setting Commission.

Also, consistent with our strong feeling that the creation of this Trust Fund be seen as an interim and short-term solution, we are supportive of the sunset provision that has been added to the bill.

With respect to deletion of the audit section, we feel very strongly that there should be an audit of hospital uncompensated care costs that these costs be accurate and appropriate. We feel that having a section in this bill which locks the Department into a 120-day time frame may not be appropriate. Rather, we would like to suggest that the existing regulations for the hospital audit procedure be strengthened and that the Department be required to audit the hospitals in a more timely manner, but that be done through the existing regulations, and not be incorporated into this bill.

So I think in general we would like to suggest that the Committee recommend adoption of some form of this bill, and we would respectfully request your consideration of some of the points we have raised.

SENATOR CODEY: One of the points you raised was on collection practices. There is a proposed amendment, I think, that would hopefully satisfy some of your concerns in that area.

MS. ZALE: Yes.

SENATOR CODEY: Okay? Thank you very much.

MS. ZALE: Thank you.

SENATOR CODEY: Our next witness will be Mr. Charles O'Donnell from the Division of Medical Assistance and Health Services, Department of Human Services.

C H A R L E S O'D O N N E L L: Good morning.

SENATOR CODEY: Good morning.

MR. O'DONNELL: On behalf of the Medicaid Division, I appreciate the opportunity to discuss this proposed legislation.

Our Department agrees that all residents of the State of New Jersey should have equal access to medically necessary hospital care, regardless of their ability to pay. The Department also recognizes the need for a hospital reimbursement system that will enable the State's acute care hospitals to meet their financial needs when they provide care to non-paying patients.

The proposed bill, which creates an Uncompensated Care Trust Fund, will have an impact on the Medicaid Program which is administered by our Department. Since it anticipates the loss of Federal Medicare funds for uncompensated care, there will be a need for Medicaid and other payers to assume Medicare's portion of these costs.

The Department of Health has indicated that if Medicare withdraws from the DRG waiver and no longer covers uncompensated care, then Medicaid's costs for uncompensated care will be approximately $20 million. Under the current DRG

system, this $20 million cost would be shared equally between the State and the Federal government. If the DRG waiver is lost, the Department will not obtain Federal Medicaid dollars for uncompensated care. The Division, therefore, projects a need for an additional $10 million in State dollars to make up for this loss of Federal Medicaid matching funds.

There are additional implications to the State in reference to the Medically Needy Program, which went into effect on July 1, 1986. This Program does not pay for any inpatient or outpatient hospital care, except for services to pregnant women.

If the Medicare DRG waiver is terminated, the Medically Needy Program law requires Medicaid to cover both inpatient and outpatient hospital care for these medically needy individuals. This will require additional funds which are not currently appropriated. It is projected that approximately $103 million will be needed to fund these costs, which includes $51.5 million in Federal funds, $18.5 in State funds, and $33 million in casino funds.

There is, however, another side to this. If the Medically Needy Program begins to cover acute care hospital services, then it will decrease to some extent the amount of funds required for the Uncompensated Care Trust Fund.

The net result of these interactions will be an increase in costs to the State to fund the acute care hospital part of uncompensated care by the Medicaid Program.

The Department supports this concept as long as adequate funds are provided for this purpose, since the current appropriation makes no provision for funds in this area.

The uncompensated care issue is certainly a major one. It is a very complex issue that requires a great deal of study and consideration before a final decision can be made, since it could have long-range impact on the citizens of the State, payers of acute care hospital bills, and the State

budgetary process. The Department will be happy to provide your Committee with essential data in cooperation with the Department of Health, and to offer any assistance as may be necessary.

SENATOR CODEY: Thank you very much, Mr. O'Donnell. Our next witness will be Mr. Jeffrey Stoller of the New Jersey Business and Industry Association.

J E F F R E Y S T O L L E R: Thank you very much, Mr. Chairman. My name is Jeffrey Stoller. I am with the New Jersey Business and Industry Association. I am here today representing Les Kurtz of our staff who prepared this statement, but who then had a conflict and asked me to present it to you.

Before I read this statement -- some copies have been provided -- I would like to make a comment or two based on some of the years I have been working with BIA on cost containment issues. First, I would like to say that while this is technically being characterized as a statement in opposition, I think it would be wrong to characterize it as wholesale opposition to the entire approach. On the contrary, BIA, the New Jersey Business Group on Health, the State Chamber, and many others in the business community have been active literally for years in support of the DRG system and, in particular, the waiver that assured that this kind of indigent care coverage would be kept in place.

Back in September, 1984, when this was first in jeopardy, we got a group together and approached the Commissioner and really made it clear that we wanted to be seen as a resource in the fight to preserve that waiver.

The second thing is, I think that even though several years have passed, the business community -- and this is certainly not unique to New Jersey -- is still very much committed to ensuring that indigent care is taken care of as part of any cost-containment scheme. If you go to Washington

and sit in at some of these business conferences on this topic, over and over again, whether it is from New Jersey, or Denver, or Massachusetts, there has been a very strong feeling that if the business community is going to get what it wants, which is a shift away from the old regulated system of health care to a more competitive market, an oriented market-driven system, you can't leave the indigent along the wayside, that any hope of moving toward that kind of competitive system requires that indigent care be taken care of as part of that overall scheme.

So, having said that, I would like to proceed with the basic statement:

The New Jersey Business and Industry Association, the largest Association of employers in the State, takes this opportunity to convey its opposition to Senate Bill 2024 in its present form. This bill establishes the New Jersey Uncompensated Care Trust Fund for the purpose of funding uncompensated care provided in the State's general acute care hospitals, in order to ensure that no person in the State is denied necessary hospital care due to an inability to pay for such care and that no hospital in the State will be forced to discontinue operations due to providing such care.

With the establishment of the State's Diagnostic Related Group -- DRG -- system for hospital reimbursement, the cost of providing uncompensated care was shifted to the payers who use the hospital system. The business community thus incurred a substantial increase in hospital costs through payment of increased benefits, pemiums, and direct reimbursements. Similarly, under an agreement to waive Federal Medicare and Medicaid reimbursement rules, the Federal government also contributes to the cost of uncompensated care. The probability of the termination of the Federal waiver, under which Medicare and Medicaid reimburse New Jersey hospitals, means that the current State DRG reimbursement system will have a shortfall of revenue needed to keep hospitals whole with respect to the cost of uncompensated care.

Senate Bill 2024 proposes a pooling and Trust Fund arrangement to assure equitable collection and disbursement of funds to hospitals for their share of uncompensated care. The New Jersey Business and Industry Association supports these concepts as a basis for resolving the hospital revenue crisis which will occur when Medicare and Medicaid funds are withdrawn from the State.

Except for an initial appropriation of $7.5 million from the General Fund, the mechanism for funding the Trust is to be a uniform add-on factor for each hospital's DRG rates equal to the average statewide uncompensated care rate. Hospitals which receive funds from the add-on factor greater than necessary to cover their own uncompensated care costs would contribute the difference to the Trust. Those hospitals in a deficit position will draw funds from the Trust to be made whole for uncompensated care.

The effect of this funding mechanism is not to have costs borne equally by all hospitals as stated in the descriptive statement of the bill. The effect is to charge these costs to the ultimate payer of hospital bills, primarily business and the individual subscriber, through premium and direct claim payments. The cost to business will be twofold: First, the increase in claim dollars, and secondly, the increase in cost for claims administration based on the inflated claims. In addition, hospitals will have increased administrative and accounting problems which will add to hospital costs factored into the basic DRG rates.

The New Jersey Business and Industry Association believes that the social responsibility and financial burden for that responsibility should be shared by all taxpayers in the State. The problem of uncompensated hospital care is analogous to welfare, and the support for both should be similar. Since welfare funds come from general revenue, it is entirely appropriate to fund uncompensated care from general

revenue. We submit that imposing this additional cost, estimated at $60 to $115 million per year, primarily on business, will seriously hamper cost-effective business operations in this State, reduce competitive advantages New Jersey has been developing, and will be counterproductive to State and employer efforts to control health care costs.

Therefore, we propose that funding for this Trust be made through General Revenue Funds and responsibility shared by all the taxpayers of the State. We recognize that current law requires the cost of uncompensated care to be borne by payers subject to Department of Health regulations, and believe it would be in the best interest of the State to amend that law and this bill in order to equitably fund for uncompensated care.

Another serious problem of Senate Bill 2024 relates to the Hospital Rate Setting Commission's mandate to pay the appropriate amounts to each hospital. The HRSC now approves allowances for uncompensated care; however, there are no controls or safeguards to determine what is appropriate with respect to cost or care. The bill should require the Department of Health to review the utilization of uncompensated care and report its findings within a specific time frame so that the program can be administered efficiently and any needed changes made promptly. Peer review organizations are now in place in this State and are currently doing this review for Federal Medicare, Medicaid, and State Medicaid patients. The Department of Health should be able to use available data for such a study.

Thirdly, the nine-member Advisory Committee which is composed of four members of the State government, three members from hospitals, and two members representing payers is seriously skewed. The three hospital members have no financial interest since they are to be made whole, and payers in the form of Blue Cross or private carriers pass their costs on to the policyholders in the form of premium increases. Neither

the public nor business is truly represented in this process, and they are the ones who must pay the cost.

In conclusion, the New Jersey Business and Industry Association agrees that a solution to the potential revenue shortfall for uncompensated care must be found and supports the pool and Trust Fund concepts. However, we urge that the Senate seriously consider and implement our recommendations for an equitable sharing of both cost and responsibility in funding and administering this Trust.

Thanks very much.

SENATOR CODEY: Mr. Stoller, I don't know if I would agree with the analogy of welfare, the way you look at it in today's society. We can talk about that some other time, I guess.

MR. STOLLER: Okay, very good.

SENATOR CODEY: Thank you very much, Mr. Stoller.

SENATOR McNAMARA: May I have a copy of your statement?

MR. STOLLER: I believe Eleanor has several copies.

MS. SEEL: I'll make more copies.

SENATOR McNAMARA: I have a suggestion, Mr. Chairman, which you indicated before you thought was a little bit hairbrained. Since the Governor's move to repeal the Ford bill, if Dr. Coye can go back and convince him to repeal that, and let that fund this, that would not only fund the entire exposure, but it would leave additional moneys for the surplus.

MR. STOLLER: That is one possibility, I suppose.

SENATOR CODEY: We have a surplus already and he wants taxes repealed, so--

Thank you very much, Mr. Stoller.

MR. STOLLER: Thank you.

SENATOR CODEY: Our next witness will be Mr. Lawrence Merlis, President of the East Orange General Hospital.

L A W R E N C E M E R L I S: Good morning. Senator Codey, Committee members, ladies and gentlemen: I have a short statement.

SENATOR CODEY: Your concern is the definition of "primary" in the bill?

MR. MERLIS: I'm sorry; I didn't hear you.

SENATOR CODEY: The definition of "primary" in the bill -- the definition of the word "primary"?

MR. MERLIS: No.

SENATOR CODEY: No, okay, I'm sorry.

MR. MERLIS: My name is Lawrence Merlis. I am President and Chief Executive Officer of East Orange General Hospital. We are one of the 18 hospitals within a 10-mile radium that Dr. Coye highlighted.

As a urban hospital that has a strong commitment and history in serving the urban community, we wish to indicate our endorsement of the concept of an Uncompensated Care Trust Fund. It is imperative that the bill's intent is that it will pay actual uncompensated care dollars for each year and not an unreasonable capitation for uncompensated care. Strong management, as with strong government, encourages and looks for a strong audit function.

The need to provide high quality health care services to all patients, regardless of their ability to pay, is at the heart of the New Jersey health care system. However, the geographic location of the hospital, and its subsequent service area of population, should not be the determining factor towards its survivability. Providing quality services, responding to the needs of its community, being competitive, and good management are factors that should have greater weight.

This legislation, if enacted, triggered by the Medicare waiver's eventual demise, will help to ensure the survival of those hospitals serving a disproportionate share of indigent patients when the waiver expires and we enter Medicare's PPS system. It will also result in those hospitals being competitive with hospitals serving fewer indigent patients. The need for urban hospitals to continue to respond

to their communities and provide needed services to populations that truly need health care services is essential, and we believe this bill is an excellent effort to preserve payment for indigent patients.

Thank you.

SENATOR CODEY: Thank you very much, Mr. Merlis. Our next witness will be Charlotte Vandervalk, Freeholder from the distinguished County of Bergen.

F R E E H O L D E R C H A R L O T T E V A N D E R V A L K: Wonderful. Good morning, Senator, Committee members. It is very important for the State to address the uncompensated care reimbursement issue now, while there is time for proper planning. If New Jersey loses the Medicare waiver that allows our hospitals to be reimbursed for uncompensated care, we must provide a mechanism to take its place. Without such a mechanism, hospitals will not be reimbursed for treating the indigent and recovering on their bad debts. This would ultimately discriminate against the poor or those people who could not meet certain criteria. It would also permit people to select the hospital of their choice, which should ultimately stimulate quality service in the long run.

It was determined in 1978 by the New Jersey Legislature that Chapter 83 would provide reimbursement for uncompensated care. Therefore, the precedent has been set, and such a provision in the future should not increase health care costs overall.

On March 24 of this year, the Assembly Health and Human Resources Committee held a hearing to plan State options for hospital-based indigent care. The Assembly members present at that hearing acknowledged the original intent of the Legislature in 1978 to include all New Jersey acute care hospitals in the Chapter 83 system. The Legislature, in 1978, considered the point of historic support shown by some counties for providing health care. In its statement attached to the

bill, the Senate Institutions, Health and Welfare Committee pointed out that counties should not be penalized for being generous in their payments supporting indigent care. The Chapter 83 system was intended to bring equity into the area of uncompensated care. It was even said that without such equity, some hospitals could face possible bankruptcy.

Now that a new system is being considered, it must be set up in such a way to assure equitable treatment under the system. It is, therefore, important to pay attention to details in this bill.

Section 2 d. is redundant towards the end, where it states: "...but does not include a facility which primarily provides psychiatric care," etc., etc. In fact, if that wording remains in the bill, it might be construed to mean other than the original intent, which is to include those same hospitals that fall under the 1978 Chapter 83 system, which is currently in effect. I would ask that that part be stricken from the bill which reads: "...but does not include," etc. up--

SENATOR CODEY: That will be taken out.

FREEHOLDER VANDERVALK: Very good; thank you.

Although the Legislature intended to provide equity for all hospitals when the Chapter 83 system was formed, the Department of Health took another position. Three hospitals were singled out and capped at substantially lower levels of reimbursement. Therefore, I would ask that the names of those three hospitals be written into the bill to avoid any future misinterpretation. Those hospitals to be specifically included for equitable treatment are: Bergen Pines County Hospital, University Hospital of Medicine and Dentistry, and Jersey City Medical Center.

I must commend the Legislature for addressing this entire complicated subject, and I heartily endorse the concept of a Trust Fund.

There is one remaining problem I would like to bring to your attention. Nowhere in the bill does it address the problems relating to switching from one system to another. I am asking for the following wording to be included in the bill:

"In order for a smooth transition from the current uncompensated care reimbursement system to the one contemplated by this act, the Legislature wishes to express its intent that nothing in this act shall be construed to deny a hospital uncollected uncompensated care to which it was entitled for any rate year prior to the rate year in which this act takes effect."

Thank you very much for giving me this opportunity.

SENATOR CODEY: Thank you, Freeholder.

FREEHOLDER VANDERVALK: I would like to point out that the mikes were not working very well at the beginning of the hearing and I did not hear the Department of Health's comments. So, I would just like to go on record--

SENATOR CODEY: We will make a transcript available. Our next witness is Dr. Frank Primich.

F R A N K J. P R I M I C H, M.D.: I would like to thank you all for this opportunity. I am here representing the missing links, the practicing physicians of New Jersey. No one has asked us anything either before or after much of the legislation was enacted. This created the state of chaos we are now operating under.

I have heard many people testify here today. I tried to anticipate some of the testimony. It seems to me that it has been relatively ambiguous. Everyone said, "Yes, we've"-- Not everyone, but almost everyone said they would testify in support, "however," and the general drift of what came out of all of this, to me, was that everybody is all for doing nice things for poor people, as long as either someone else pays for it, or someone else offers that service free of charge. I think this is the common feeling.

If I may, I have tried to run off a little preparation here this morning because I and the Medical Society-- Incidentally, when I checked with them on this at the end of last week when I received the notice of this hearing, they were essentially unaware of the fact that this hearing was taking place. Now, there is a horrible lack of communication between the various branches of this health care community, such as the Hospital Association and the Medical Society, and an even greater failure of communication between the Legislature and the doctors who are trying to provide the care which we are discussing.

A major issue under consideration is reimbursement of hospitals for indigent or uncompensated care. What is being proposed is a relatively covert cost shift. My contention is that it also represents a blame shift. Politicians have glibly promised the American people high quality health care for all, without any appreciation or concern for the costs involved.

This is somewhat comparable to pronouncing an entitlementl to a Cadillac, a mansion, and an expense account at Brooks Brothers or Christian Dior, along with food stamps redeemable at gourmet eateries.

I am scheduled to testify next week at a public hearing of the State Assembly Committee on Health and Human Services, to at long last evaluate the DRG Program and explore options to resolving the problems created by the impending loss of the Medicare waiver. Independent studies will finally substantiate my longstanding and disregarded criticism of the current reimbursement process.

The big issue, here as well as there, is how did we get into this mess? I believe the answer to that question is fairly simple. The special interests, most of whom are represented here, sought and were able to obtain short-term advantages at the expense of long-term consequences. That term is running out, and we are now offered still another stopgap Band-Aid to stem the hemorrhage.

Sandy Freedland (phonetic spelling), in last Sunday's New Jersey section of The New York Times, gave a very comprehensive report on the views of many of the interested parties. No one considered it to be a definitive solution. There are gross ambiguities in many of the statements. I would like to focus on just a few of the most significant.

Uncompensated care costs in 1980 were roughly $100 million. In 1985, they approached $300 million. That is an annual increase of 40%. In view of New Jersey's supposedly improving economy during that time frame, it is obvious that this aspect of cost containment is an abject failure. It has been made to sound as if we are not increasing costs, but the anticipated $130 million shortfall the loss of the Medicare waiver will create is not disputed by anyone. It is conceded that the only ones who will be directly hurt are the 2% who pay their own bills. Now, 2% might sound small, but we're talking about those individuals who still honor their responsibilities. They would be wiser to declare bankruptcy and climb on the gravy train.

My major argument is that food stamps are not paid for by a tax on groceries. The cost of housing the homeless is not an add-on to real estate taxes. It is, therefore, reprehensible to burden the ill and the injured with the welfare health care costs. If indigent health care costs are a legitimate societal responsibility, they should be paid for out of general revenue.

SENATOR CODEY: By the way, Doctor, the Medical Society is on our list, and they were advised of the hearing. Okay? Thank you very much for your testimony.

SENATOR McNAMARA: I clearly understood what you had to say, Doctor.

DR. PRIMICH: Thank you.

SENATOR CODEY: This ends today's hearing on the uncompensated care bill. This Committee will take up the bill

at a later meeting this summer, and any of you who have amendments which you wish to have considered by the Committee, please forward them to Eleanor Seel so they can be considered at that meeting.

(HEARING CONCLUDED)