# PUBLIC HEARING

before

## ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

To Examine Access to Health Care in New Jersey

May 24, 1990
Auditorium I
John F. Kennedy Medical Center
Edison, New Jersey

**MEMBERS OF COMMISSION PRESENT:**

Assemblyman James E. McGreevey, Chairman
Assemblyman Nicholas R. Felice
Assemblyman John V. Kelly

**ALSO PRESENT:**

John J. Fay, Jr.
Special Advisor

Eleanor R. Miller
Office of Legislative Services
Aide, Assembly Health Care Policy Study Commission

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New Jersey State Legislature
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625-0068
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May 3, 1990

NOTICE OF A PUBLIC HEARING

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
ANNOUNCES A PUBLIC HEARING
TO EXAMINE ACCESS TO HEALTH CARE IN NEW JERSEY

Thursday, May 24, 1990
Beginning at 10:00 A.M.
John F. Kennedy Medical Center
Auditorium I - Basement
65 James Street
Edison, New Jersey

The Assembly Health Care Policy Study Commission will hold a public hearing on Thursday, May 24, 1990, beginning at 10:00 A.M., in Auditorium I (Basement) at John F. Kennedy Medical Center, 65 James Street, Edison, New Jersey to examine problems relating to access to health care in the State. The focus of the hearing will be the determination of a threshold level of health care which should be provided to all citizens of the State. The commission will hear testimony from representatives of the hospital industry and health care professions to determine: 1) the requisite level of health care coverage necessary for the uninsured to offset the need to utilize the Uncompensated Care Trust Fund, and 2) which specific medical and health related procedures should be included within such coverage.

Address any questions or requests to testify to Robbie Miller, Aide to the Commission (609-292-1646), State House Annex, Trenton, New Jersey 08625. Those wishing to testify are asked to submit 15 typed copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses and the time available to each witness at the hearing.

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**ASSEMBLYMAN JAMES E. McGREEVEY (Chairman):** Good morning everyone. I'd like to thank Assemblyman Kelly, Assemblyman Felice, Senator Fay, and two other legislators who will be joining us. I'd like to welcome you to the John F. Kennedy Hospital on the second hearing before the Assembly Health Care Policy Study Commission.

Just briefly, the total health expense for New Jersey is obviously difficult to calculate. The acute care hospital component that is gross hospital revenue has risen from approximately $3.8 billion in 1983 to $5.6 billion in 1988. It is expected to increase to approximately $5.9 billion in 1990. Costs for specialized hospitals reached $176 million in 1988. After hospitals, professional services are probably the second largest portion of health care costs.

If New Jersey is following national patterns then hospital costs in 1988 were 39% of total health care spending, indicating that total New Jersey health care spending in 1988 was approximately $14.4 billion. Assuming then that New Jersey is following national trends, the growth in hospital care expenditures is probably lower than for any other category of personal health care expenditure. This has been the case since 1984. While nationally, hospital care in 1988 still was the largest portion of personal health care spending, it shrunk considerably due to more rapid growth in other sectors of the health care economy.

Thus, by 1988, hospital spending accounted for 39% of U.S. health care expenditures; down from 44% only two years earlier. Hospital expenses in New Jersey rose at a rate lower than the national average prior to 1985. However, in 1986 to 1988, hospital costs per admission have risen more rapidly in New Jersey compared with rates in the United States and neighboring states.

Our concern for the uninsured which confronts us immediately, is that 840,000 New Jerseyans were estimated to be

without insurance in 1986, and this number has almost certainly grown since. Since this represents approximately 12.4% of the population and is lower than that for the nation as a whole, it suggests that New Jersey has fewer uninsured persons, yet provides them with more care than that of the uninsured received elsewhere.

Using New Jersey definitions for uncompensated care, approximately 75% of it is generated by people without any insurance. The remainder is generated by people with minimal benefits or unable to cover out-of-pocket deductibles and copayment. Most of the uninsured are under the age of 25 and fully a quarter are children under the age of 18. Most are actually employed or are dependent on someone who is employed.

Indeed, over two-third of New Jersey's uninsured are either working or in a family with at least one working adult. Under New Jersey's system, hospitals are paid in full for uncompensated care and at a rate equal to that which they receive for the insured patients they treat. This is believed to explain the greater excess to care for the indigent seen in New Jersey than elsewhere.

A Robert Wood Johnson Foundation study on access to health care released in 1986, found that the uninsured in New Jersey exceeded national averages for most indication of access to health care. Three points I'd like to note: 74% of the uninsured in New Jersey reported an ambulatory visit during the prior 12 months, as compared with 58% nationally; 78% reported having a regular source of care, as compared with 70% nationally. The uninsured in New Jersey reported 6.6 ambulatory visits over the prior 12 months, as compared to 3.2 visits for the uninsured nationally.

As noted earlier hospital care provided to individuals who have low incomes or fail to pay their bills is fully reimbursed under Chapter 83. Reimbursement for these services to these patients has been fully funded since 1980 to rates charged to purchasers of inpatient and outpatient services.

From 1980 to 1986, each hospital had its rates increased to reflect the amount of uncompensated care it delivered. This is the focus of today's hearing. Thus, some hospitals were forced to charge very high rates if they served large numbers of indigents. The subsequent creation of the Uncompensated Care Trust Fund in 1987, in effect, created a pooling mechanism for the payment of uncompensated care.

The uncompensated care add-on is uniform across all hospitals and is applied to all non-Medicare patient bills. Hospitals with a higher-than-average share of uncompensated care draw down on the Fund, while those with lower-than-average uncompensated caseloads are net contributors to the Fund. The Trust Fund lessens the competitive disadvantage that had previously existed for hospitals serving disproportionately large numbers of the uninsured.

Today's hearing will focus on the determination, if you will, if it is possible, of a threshold level of health care which should be provided to all citizens of this State. The Commission will hear testimony from representatives to determine: One, the requisite level of health care coverage necessary for the uninsured to offset the need to utilize the Uncompensated Care Trust Fund; and secondly, which specific medical and health-related procedures should be included within such coverage.

At this time, I thank you for your attendance, and I'd like to call upon our first witness, our host for today's proceeding, Mr. Michael Kornett, President and CEO of the John F. Kennedy Health Systems.

**M I C H A E L T. K O R N E T T:** Thank you, Mr. Chairman. For the record, my name is Michael Kornett. I'm the President of the JFK Health Systems and have been a part of this organization for the past 16 years. I've also had the good fortune of working for three other health care institutions in New Jersey, two in the inner city and one in an urban setting,

and have spent time as a health care consultant with a Big 8 public accountant firm. All my experience in health care has been in the State of New Jersey.

I'd like to thank you for the opportunity to speak to you today. I'm here to tell you what I believe you should know about some of the problems with New Jersey's health care delivery system. Although there are many problems we can discuss today, I'm going to dispense with a lot of them and focus on two issues. One is the problem and complications we have with Chapter 83, the hospital payment system. And of course, I'm going to conclude my remarks today with the Uncompensated Care Trust Fund and bring some recommendations to this Commission.

First, I'd like to talk about Chapter 83 -- hospital payment system -- because I think it is very important for you to know the tenet of that system and how it relates to uncompensated care. In 1978, when Chapter 83 was introduced-- Effective 1980, Chapter 83 called for some new tenets that were introduced to New Jersey. It called for the financial solvency of the hospitals in the State of New Jersey. It allowed hospitals for the first time to receive payment for free care and for bad debts. It also created a State Hospital Rate Setting Commission by which hospitals could appeal their rates, and it established a new method of payment in the State of New Jersey from the old billing type payment to something they referred to as DRGs, or Diagnostic Related Groups, wherein every payer would pay the same amount for a specific disease and to be in the hospital. And this system, incidentally was a perspective system.

In 1987, the Chapter 83 act was modified to include the Uncompensated Care Trust Fund, which was signed into law on January 5, 1987 by Governor Kean. There have been several studies made of access to care in the State of New Jersey and they all point out statistically that the State of New Jersey

has virtually-- The residents of the State of New Jersey have virtually more access to care than any other state in the nation.

I'm also proud to say that health care has been provided to all those needy in the State of New Jersey prior to the adoption of the Uncompensated Care Trust Fund, by every institution in this State as far back as my memory serves me. In 1987 when the Uncompensated Care Trust Fund was established, there were two major changes to the system. The new Uncompensated Care Trust Fund was a collection and distribution system. It mentioned early that each hospital in the past could markup their bills to collect for their specific uncompensated care, which created a lot of unfairness in certain areas. In order to put equity into the system, the system was changed where on a broad-based basis now, every hospital would be marking up their rates at the same level. Those that didn't collect an appropriate amount to cover their own compensated care costs received a check monthly from the Uncompensated Care Trust Fund and vice versa. Those that collected in excess, paid a check for the Uncompensated Care Trust Fund.

The second tenet of the Uncompensated Care Trust Fund Act was a reaffirmation that all payers would participate in payments for uncompensated care. For the sake of getting my point across to you clearly, it's difficult to divorce Chapter 83 payment systems and its problems from the Uncompensated Care Trust Fund and its funding sources.

Rather than explain the complexities of Chapter 83, I'd like to show you what we believe are the results of these regulations. Over here we have a chart which indicates the number of days of cash available in the health care system; nationally in the lighter stripe, and in the darker stripe that's the State of New Jersey. At the end of 1989, the State of New Jersey's hospitals had approximately 6.1 days of cash

available. Now, we tested that number from many sources, and we've also found that some corroboration on that number through the New Jersey Health Care Financing Authority actually had it at 5.7 days. So it's safe to say six days of cash was all that existed at the end of 1989 in this system, which meant some hospitals had a little more and some had a little less because it's an average. And on some days, hospitals had less than 6 days.

It reminds me of an analogy that it's pretty tough to get paid on a Friday and try to hold yourself cash-wise until the following Thursday. And that's what hospitals had been doing through 1989. Let's put things into perspective, what that number actually means. JFK had the good fortune in 1987 to receive an A plus rating from the rating services of Standard and Poor's. At that time we had 37 days of cash available, which didn't qualify for an A plus rating, but we argued that. To be qualified for an A plus rating by Standard and Poor's you need 88 days of cash available as one measure. To be A rated you need 66 days available, and to be A minus, 49 days available.

There's a flip side to days of cash because a lot of people think then there's cash under rocks in this industry somewhere. I want to show you where it's not. This particular chart shows you the long-term debt-to-equity ratio, which is the flip side to cash availability which means how much money you can borrow; what's your borrowing capacity in the State of New Jersey? In 1987 you see JFK, and we had a very low debt capacity. We argued we could convert our equity into long-term debt and bring up our days of cash.

The bars you see that exceed 1.0 which means negative ratio of long-term cash -- a long-term debt-to-equity -- indicate that the State of New Jersey has no borrowing power. In fact, the State of New Jersey owes more than it's worth. It's safe to conclude when you draw at these numbers that there's no cash available in the system. There's no ability to

borrow heavy money in the State of New Jersey. I don't want to use the "B" word, but this industry could very well be on the brink of bankruptcy.

Speaking as a hospital CEO, I can tell you that I have a priority of payments to the system. Not unusual, we pay payroll first. We pay our payroll taxes. We pay our mortgage on our bond indentures, and then we pay our check to the Uncompensated Care Trust Fund that we collect. Now mind you, we don't have the cash available necessary to do this all the time. During the year 1989 we borrowed -- and we consider ourselves somewhat of a financially solvent organization, $3.2 million in operating cash just to meet basic expenditures -- and we absorbed $300,000 worth of operating interest, which, in effect, is not reimbursed at all under this new payment system.

We did all of this and still had to worry about paying for our utilities; still had to pay our leases on our equipment, and still had to pay for all the goods and services that we supply people who come to us for health care on a daily basis.

Now I'd like to get into the Uncompensated Care Trust Fund issue. Again, this is a chart showing payers' sources. It's graphic because you have to understand where money comes from in the health care industry. JFK is dependent upon the Medicare program for approximately 40% of its revenue. Now, although the slices of this pie may change from hospital to hospital and industry wide in the State of New Jersey, it's safe to conclude that 40% of all the revenues for hospitals in New Jersey come from the Medicare program. With that thought in mind, we can start talking about where we are with the Uncompensated Care Trust Fund.

Medicare was the one rubber leg of the table that made the system shake and bring so much additional attention to the cost of health care premiums. The engineers at the Department of Health in 1987, in their documents said, "There is a

possibility that Medicare may not continue participation in the payment of uncompensated care." But what they neglected to come up with or address, was what would happen if Medicare decided to be a nonparticipant of the Uncompensated Care Trust Fund payments. And that's where we find ourselves today. Fifty percent of the payers are left to pay, because in that slice, there's approximately 11% of the people that are in the Uncompensated Care Trust Fund for one reason or another.

Fifty percent of the people are now paying for 100% of the Uncompensated Care Trust Fund, either through direct payment to the hospital or through health care premiums. And the fund has doubled in the last two years. It's important to also point out to you that New Jersey Blue Cross was a very rapid payer to the hospital, paid us on a regular basis, and New Jersey Blue Cross used to insure in 1982 42% of the population in the State of New Jersey. Now they insure 27% of the population in the State of New Jersey.

People are banning health insurance. Employers are creating large coinsurances and deductibles, all of which are finding their way into the Uncompensated Care Trust Fund. A new phenomenon in the last couple of years is, we find that a lot of employers are using temporary help -- what they call "independent contractors," to avoid paying any benefits at all.

The increase in the cost of health care insurance premiums, I want to make perfectly clear, is not a reflection of the increase in hospital costs. Again, I'm going to speak for JFK, but I'm going to make an analogy to the rest of the health care system for the State of New Jersey. We have a chart here for adjusted admission on the growth of a cost of a hospital visit at JFK. Some years it's low single digit; other years it was into double digits. On an average during that six-year period of time, JFK increased an average of 9-1/2%, which has no correlation to the amount of moneys that have been charged in health care premiums that have been passed along to the consumer.

What has happened, in effect -- on our next chart -- is the consumer, by paying the bill, whether it be a commercial carrier or self-pay, is receiving less product for the money they pay. Back in December of 1988, 91% of product and services was actually purchased for 100 cents of dollars that were spent here at JFK. In April of 1990, people who have purchased services here at JFK received 74% of product. The rest was add-ons. And therein lies the problem that we have to address with health care insurance premiums, most of which you can see have come from the Uncompensated Care Trust Fund, only because those people that are around to make payments into the Uncompensated Care Trust Fund have doubled up since the withdrawal of Medicare.

As members of the Assembly, I know you're faced with a lot of health care issues, and I'd like to tell you that in my belief, there is not enough time to deal with the sunsetting law of Chapter 83 and all its complexities. There's nothing in line to take its place, and I think spending a lot of time on that issue would be for naught, if you want to address something for 1991. There are two issues however that you can address with respect to Chapter 83 before 1991. It may surprise you, but we would like very much to have an insurance where we would receive our rates for 1991 from the State Department of Health well in advance of the year, so we could plan our year; so that commercial carriers that write their book of business before the beginning of the year would know what the hospitals were going to be charging so they could address their business sensibly.

And, along with that, we would like a methodology by which we could settle 1991 in advance, and not have rates paid to us as we have right now, without knowing how much of these rates we will actually keep or have to pay back the system in future years. With respect to the Uncompensated Care Trust Fund issue, there's still time to introduce change to the structure of funding before that law sunsets.

I'd like to offer some realistic recommendations. There's no one simple solution. I think you all have to accept that. People who have looked into this issue realize that. We've come up with a program of chipping away at the problem, because the problem didn't get there in a very simple way. More money is needed for the system. More money is available for the system.

The Medicaid eligibility levels in the State of New Jersey are among the lowest in the country. Medicaid eligibility equals the same level as welfare payments, which means the 60% of the uninsured in the State of New Jersey who are working could possibly be qualified for Medicaid benefits. The Medicaid eligibility benefits would bring in 50% funding from the Federal government.

I use the analogy of a man who wakes up in the morning who makes the per capita income in the State of New Jersey of $22,000. He throws his tools in the back of a truck and off he goes for a day. He has 2.2 children at home and a wife. His priority payments are his mortgage or his rent. He's got to put food on the table. He's got to provide for clothing. He's got to provide maintenance for his truck and put fuel in that tank and buy himself a cup of coffee at the 7-Eleven. The last thing he's going to think about doing, if he can struggle to pay his automobile insurance-- He's not going to lay out $3400 for a family plan for health care insurance. It's just financially impossible.

What we have an obligation to do in this State, is to make an honest person out of that man so he doesn't have to rely on becoming a part of the bad debt structure, and raise the eligibility of Medicaid as they have done in many other states in this country. Instead of finding 100 cents on the dollar in your Uncompensated Care Trust Fund, at least 50 cents on a dollar would be picked up by the Federal government.

Another area where I think we have to make some changes is the manner in which we register Medicaid recipients. When people go to the welfare office and they clearly are eligible for Medicaid, they don't receive a Medicaid card at the time they register. What happens is, they show up at a hospital and they receive care. That care is 100 cents on the dollar charged to the Uncompensated Care Trust Fund. The Medicaid application cryptically is taken in the hospital. It's sent on to the county Medicaid board for their screening and ultimate approval. Counties vary, and the time it takes to get that Medicaid application approved is anywhere between eight weeks, six months, or it gets lost. In the meantime, those recipients of welfare are going to hospitals, accumulating costs where 100 cents on the dollar gets into the Uncompensated Care Trust Fund, when 50 cents of it could have been paid right up-front if we had the sense to issue a Medicaid card at the time someone came in for welfare.

I believe it's been a very popular thing to say that mandatory health insurance should be supplied by employers over a certain number. The number six seems to be a number that is almost universal. That's the number they use in the State of Massachusetts. That's the number that's being contemplated in the State of New Jersey. Massachusetts has taken that one step further. They also offer a 20% credit on the Massachusetts tax return for those employers who supply basic hospitalization to their employees. Those who choose not to supply hospitalization to employees are assessed what basic coverage would cost. In Massachusetts that number comes out to $1680 per employee that goes into their Uncompensated Care Trust Fund.

A similar tact could be taken in the State of New Jersey. For those individuals who buy their own or elect to buy their own health care insurance, the State of New Jersey should allow them, without a threshold or a limitation, to take

that as a deduction against their New Jersey State tax return. And because they've complied and they have their own health insurance, they should, in addition to that, be allowed an additional credit on their New Jersey tax return as an incentive for them to keep renewing their insurances.

All of the states in this country that are considering uncompensated care arrangements are determining what services they plan to cover. In the State of New Jersey we started off right from the word "go" to cover everything. As absurd as this may sound to you, you and I can come to this hospital for cosmetic surgery, not pay our bill and become a bad debt, and wind up in the Uncompensated Care Trust Fund. I don't think that was the original intention of this Act.

As an example: You should realize that the base of the Fund has shrunk in half. That means those people that are paying the Fund and those people that have to pay the Fund are doubled up, and there has to be a broad-based something. Now, I was going to use the "T" word here, but there has to be a word to put in there that can offset the moneys that are not paid by those who were originally designed to pay this money.

For example, some states are doing different things. In Delaware and Missouri, coverage for the uninsured -- what they call universal health care -- is being proposed through an hourly rate assessment for each employee's work. Fifty cents to 75 cents an hour has been proposed. In Ohio they're also proposing a payroll tax and a cent tax on tobacco and alcohol to cover theirs. In Rhode Island they're setting up something different. They call it their "no-frills package." They plan to cover only emergency room. They plan to cover maternity, pediatrics, and some additional services, but they plan to do that as a start-up through, again, a tax on alcohol and tobacco.

The State of Washington is considering adopting the Canadian plan. The Canadian plan, like a lot of socialized medicine in this world, becomes a two-care plan; one for the

rich and one for the poor. We're not suggesting that. I don't think the State of Washington will eventually adopt that either. Oregon is considering a basic benefit package and, again, is planning to do it through an employer tax. And all of the states, except New York and Florida which are either implementing or have implemented health care through an uncompensated care arrangement, do it by a variety of tax bases.

Now, after reviewing every possible recommendation I can leave you with today, I have what I believe is a viable recommendation. I'd like to recommend that we deal with the existing Uncompensated Care Trust Fund by capping the amount the hospitals pay into the Fund and generating the balance from another source. I would recommend capping that amount that is required annually to 50% to be generated through hospital collection. And I would strongly recommend that the balance of that funding be assessed among all other employers in the State of New Jersey who don't provide health care insurance to their employees.

The 50% has a logic. The 50% is the balance that was left on the equation after Medicare pulled out, allowing for a minimum of 10% of those people who would still be in the Uncompensated Care Trust Fund. And if you just think about it for a minute, Blue Cross just received a 24% rate hike. If they didn't have to double up on their Uncompensated Care Trust Fund payments which Medicare now doesn't pay, there is a good likelihood that that rate increase may have been 10% less.

The only other alternative, and one that's not being recommended here to you, is to ration health care in the State of New Jersey, and I don't believe that's what we're all about. I'd like to commend all the members of the Assembly who passed the Uncompensated Care Trust Act in 1987. The citizens of New Jersey, through studies provided by the Robert Wood Johnson Foundation, are assured that they have more access to care than any other state in the nation.

We've taken a giant step, and it's been a positive one. It has worked well. The withdrawal of Medicare as a funding mechanism has become significantly noticeable in the increase in health care premiums paid by all of us. The next step the Assembly should take is to give relief to that 50% of funding that no longer exists. You will not only be doing this for the hospitals and for the employers who pay for health care premiums in the State of New Jersey, but you'll be doing it for all of the people in the State of New Jersey.

I thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you, Michael. If you could stay for a few questions. At the outset, one of the things that a number of us are concerned with is not only the unfair hidden tax that's levied on a broader base of payers, but the mechanism -- and you touched on this -- by which uncompensated care is financed. You talked about the ability of employers to step forward who presently offer no insurance. I'd like, just for a second, to focus in on that mechanism. Would you recommend requiring a threshold dollar expenditure of health care, say for example, something similar to the Massachusetts plan, creating a separate fund, say for example, within the Department of Labor, or would you recommend specific procedural coverage to be mandated by employers?

MR. KORNETT: I think both, Jim. And I'll tell you why: In the Massachusetts plan, incidentally, which was a nonsuccessful plan, there were tenets of that plan which were workable-- They came out with what the cost of a basic plan would be. Naturally that would move from year to year in terms of costs or assessments for those employers who didn't carry health care insurance for their employees. I think the flip side of that is offering an incentive for people to do that, rather than view this as a negative approach. And if you do it with an incentive tax credit in addition to complying, then I

think you'll probably find more success and less on the other side when you're actually accessing people or, in essence, fining people for not providing that coverage.

I think you'll find, as we have in the Unemployment Trust Fund, that over a period of time it could be actuarially sound and carry itself into the future.

ASSEMBLYMAN McGREEVEY: You said both regarding the specific level or, say, looking at the Oregon approach-- Is that something you're advocating?

MR. KORNETT: Oregon is looking at a payroll tax. I don't believe we should be having a payroll tax. I don't believe the people themselves should be paying for it. I think it's already been pretty much a given that employers are bearing the responsibility for health care insurance; there is no escaping that. There are some people who say, "You'll be driving business out of the State of New Jersey," when all of the surrounding states are considering something. The funding mechanism is either going to come through an employer tax of some sort or an employer assessment on those who don't comply. I think this is a national movement, considering all the states that are adopting different uncompensated care trust arrangements.

ASSEMBLYMAN McGREEVEY: So in the absence of national leadership on the question, how would you formulate this fund, also mindful of the fact that we're confronting a $600 million deficit, so we don't have a lot of credits to spread around? How would you formulate this fund, and with what specific procedure, or would you require specific procedures to be covered under this substitute health care insurance policy?

MR. KORNETT: Again, basic hospitalization is something that all states are looking at. The Rhode Island situation only applies to emergency medicine. I think that's unfair. I think that wouldn't do anything for the people of the State of New Jersey when they required a hospital stay --

the base line insurance coverage which may or may not include items that are necessarily covered, except in those policies where people elect to have it covered.

You could put a ceiling on psychiatric care. You could put a ceiling in a basic coverage on those cares that you know are a little bit outside the range of basic. And I'm not going to sit here, Jim, and prescribe exactly what those should be. There are other states that are studying that issue. I think we can learn a lot by looking at what they've already accomplished, and why they arrived at certain conclusions on those services that should be covered.

ASSEMBLYMAN McGREEVEY: The criticism that's been levied by certain circles, Michael, is that if you're going to continue that, that's payment for a hospital base setting, which is, as you know, the most expensive setting. And there's a concern that primary care services which make up the bulk of the needs for indigents, would not necessarily be addressed in the acute care center.

MR. KORNETT: Well, I think that's absolutely true. I think that's one of the reasons why Rhode Island, even though they talk about the no-frills package, is including maternity and child care as one of the items. We all know prenatal care saves us lots of money in the long run when it comes to expensive intensive care nursery stays for newborns. And I also believe that a lot of preventive medicine for children will prevent a lot of problems in the future.

ASSEMBLYMAN McGREEVEY: This would be funding, again, through the use of-- What would be the mechanism that you would use? Could you clarify that again?

MR. KORNETT: In order to properly fund this program, you would have to limit the number of people that actually -- people, organizations, that are receiving funds. It would be very difficult to open up an Uncompensated Care Trust Fund arrangement with thousands of organizations which are going to

provide primary care. An association with a health care institution which would in turn affiliate with those programs and be a paymaster, if you will, to them, would probably be a lot more effective than trying to deal with several thousand organizations at the same time.

The accountability would be there. I think hospitals have demonstrated over the years their accountability with respect to finances. They've also demonstrated their acceptance of regulation. We're a highly regulated industry, and I think we have the wherewithal to deal with that. If the State mandated that there are populations out there that require health care attention, particularly on the preventive side, then it's up to the hospitals, I believe, to align themselves with those organizations that could potentially provide those services and be a funding source through the hospitals to them.

ASSEMBLYMAN McGREEVEY: My last question, Michael, focuses again on the labor component and the employer component, mindful of the fact of your State fiscal picture. What mechanism would you use to raise those revenues? I mean, you talked about requiring a threshold level of coverage for certain particular procedures, the acute care; say, for example, looking at maternity, etc., a certain amount of preventative-- How would you raise those moneys, and would you call for these particular procedures to be required? Would that just be a flat mandate on the employer or would you create a pool? How would that be dealt with?

MR. KORNETT: Well again, Chairman, two ways. If the employers currently providing health care insurance-- There's two ways to look at it. I don't want to say good guy/bad guy here in this situation, but people may complain to you that the cost of doing business in the State of New Jersey just increased because you imposed this assessment on me: Either I provide health care insurance, or I pay an assessment.

But look at the other side of the equation. All of the people who are currently complying and do supply health care insurance to their people-- What incentive do they have over a period of time, but to continue the deductibles and coinsurances and eventually try to get out of providing health care insurance because they see that the other side of the equation is being picked up by the Uncompensated Care Trust Fund? So as an incentive to the good guys, you have to do something to assess the others that aren't complying.

ASSEMBLYMAN McGREEVEY: And that would be what?

MR. KORNETT: And that would be to create a fund, if they didn't comply with basic health care insurance coverage for their employees.

ASSEMBLYMAN McGREEVEY: Thank you. The other point that I just want to touch on is, you mentioned the Canadian system. You disagreed with the concept Governor Cuomo discussed in his former State of the State Address of the possibility in New York of having a universal government-sponsored health insurance program as in Canada, where each province acts as a single payer. I would just like you to touch on your philosophical concerns with that type of system.

MR. KORNETT: I could probably guess if I had an insurance company hat on that I'd be developing a product today which would supplement whatever socialized medicine you put into place, such as in Canada and Sweden, and you can go to all of the countries that do this. Sixty percent to 70% of the people may get involved with socialized medicine. The rest are outside of socialized medicine either paying for a better grade of medicine themselves or they have a supplementary insurance to pick up the difference.

ASSEMBLYMAN McGREEVEY: Sounds like supplemental insurance here. Mr. Felice?

ASSEMBLYMAN FELICE: Yes. Just briefly, Michael, would you say a great percentage of your people receiving uncompensated care are people that are not employed?

MR. KORNETT: No, on the contrary I believe most of them are employed.

ASSEMBLYMAN FELICE: Okay.

MR. KORNETT: They just don't have the ability to pay.

ASSEMBLYMAN FELICE: Okay. But of those, a certain percentage are not employed. Correct?

MR. KORNETT: A certain percentage, a small percentage.

ASSEMBLYMAN FELICE: Some of the states have considered and there has been legislation where those people who for a period of time are unemployed -- they may have lost their job, relocated or whatever, or the company may have moved out -- to consider that those people who are receiving unemployment insurance, that a very small percentage of it be utilized for minimum care for that person while they are unemployed. Do you think this has merit? Some of the states have certainly done that or considered it. This is a forced payment of the weekly allowance they are getting for unemployment. It may be for six months; it may be longer for certain people. Wouldn't this help those people to at least feel they were contributing in a small way to a certain health plan which would give them minimum coverage? That is what we're looking for.

MR. KORNETT: I think that would be a excellent way to handle the unemployed.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Assemblyman Kelly?

ASSEMBLYMAN KELLY: I want to get something straight in my mind: Do you mean to tell me I can go to a hospital and have my three chins removed, these bags under my eyes, and not pay for it, and it be picked up by uncompensated care?

MR. KORNETT: That's right, if we don't catch up-- You might have a lien on your house in the process.

ASSEMBLYMAN KELLY: Say I don't own a house?

MR. KORNETT: If you manage to get in through an admission of some sort and it wound up as a bad debt, there's no other place for it to go but into the Uncompensated Care Trust Fund.

ASSEMBLYMAN KELLY: I'd like to ask one other question: Are there procedures being performed by both the hospitals and the doctors where they do -- or are performing because they are concerned more about suits than taking care of the patient? Is that true or untrue, or is it just a small inconsequential amount?

MR. KORNETT: No, I wouldn't say there are procedures. I think it's well-known that there are some defensive testing that's being done throughout all hospitals because of the potential liabilities, to cover all bases. But I don't think procedures are being done -- no major procedures.

ASSEMBLYMAN KELLY: That's all I have.

ASSEMBLYMAN McGREEVEY: Thank you very much, Michael.

MR. KORNETT: Thank you.

ASSEMBLYMAN McGREEVEY: The next person who will be testifying is the President of the New Jersey Hospital Association, Mr. Louis Scibetta.

L O U I S P. S C I B E T T A: Good morning, Mr. Chairman, members of the Committee. I'm Louis Scibetta. I'm President of the New Jersey Hospital Association. With me is Don Camisi, who serves as Group Senior Vice President of the New Jersey Hospital Association. I'm going to try to be relatively brief with my comments, and perhaps our time could be more productive in questions and answers, if you have any when I finish.

I want to express a personal comment of appreciation to you, Mr. Chairman, for the invitation to be here to address this very important subject to the citizens of New Jersey, as well as to the hospitals which are serving these citizens.

Our Association, as you know, represents all 119 hospitals in the State and I'd like to share with you today some of our views, and hopefully encourage dialogue on this issue that's so important to us collectively. At the start, let me try to make a focal point for all my remarks regarding access to health care which I think is really the basis for this subject. I feel very proud of the fact that there is virtually no other state in this country that's shown the foresight and the ingenuity that New Jersey has shown in dealing with hospital cost containment, while guaranteeing hospital care for all of its population.

The dual reality that New Jersey hospitals' costs per admission are $855 below the average costs of hospitals in the Northeast; and that no one is ever denied care because of the inability to pay is often overlooked in the greater debate of increasing health care costs. Those facts shouldn't get lost in the shuffle. They should be benchmarks for what we consider to be efficiency and effectiveness of our hospital operations.

As you well know, in 1987 the State Legislature -- endorsing a concept and commitment created by the New Jersey Hospital Association -- saw fit to create a Uncompensated Care Trust Fund. Prior to the establishment of the Fund as was pointed out to you by Mr. Kornett, individual hospitals placed surcharges on their patients' bills.

The Trust Fund, currently financed by a uniform markup of hospital rates as opposed to an individual hospital markup system which existed before, simply serves as a bank account which some hospitals put money into, and others draw money from. The Fund has been successful in spreading the cost of indigent care among all general hospitals in this State, while simultaneously helping assure access and equal hospital care to the poor, and that is an important point. Although it has had its growing pains and now may be in need of financing from sources other than a markup of all hospital bills, the basic

premise which drives the Fund is sound and fair. Its administration by the State, frankly, has been effective, and it has been professional.

Hospitals that provide a significant amount of uncompensated care are not penalized because of geographic location or the economic status of their patients. No person in this State is denied necessary hospital care due to an inability to pay. The Fund also protects hospitals with high uncompensated care caseloads from the financial insolvency that you heard about, and the patients served by those hospitals from having to pay exorbitant, further bill markups.

One thing our diverse hospital industry knows for sure: No hospital -- whether it be an acute care hospital, psychiatric, rehabilitation, long-term care, or other specialty hospital -- is immune from the demands placed on them to survive financially while maintaining their most important bottom line, which is quality care to our patients. People now speak as if these two goals should be mutually exclusive; frankly, that bothers me.

We really have no room in this State for a system that discriminates between those who will get and those who will not. Perhaps the deeper question which begs an answer in the form of public policy is, "What should everyone have access to?" This should precede payment decisions, so that hospitals are not left with the responsibility for providing comprehensive care for everybody with insufficient funding levels.

We know we cannot be naive. The demands of caring for an increasing AIDS and aging population while juggling questions of how to secure added and new funding dollars for a yearly uncompensated care price tag now expected to exceed about $600 million are, many times, overshadowed by a regulatory system that I believe everybody currently admits is, at best, overly complex and slow to respond, and that concerns

me. But we are not here today to debate regulatory reform. That's an issue for another commission, another testimony, another discussion.

We are here today to discuss solution strategies for a very particular dilemma. That dilemma has philosophical, and some ethical underpinnings, but it cries, however, for practical and workable solutions.

Simply put, health care providers find themselves on the horns of a tremendous challenge. Never has society demanded "more" in the way of medical care. Never has the public argued so loudly that more hospital care be provided for less cost.

Despite these opposing currents, the New Jersey Hospital Association first and foremost believes that the State must continue to guarantee access to care for all individuals, and that an effective and equitable mechanism for paying for that care must be maintained. To assure continued access, government must accept an expanded role of its social responsibility by addressing these needs. When one considers that 11% of our population receives care through the Trust Fund, it's not unreasonable that 11% of hospital costs go toward covering uncompensated care. If 11% is considered to be too high a number by certain parties, then we should perhaps get to the heart of the problem. Let's reduce those numbers of uninsured who, in fact, rely on the Uncompensated Care Fund.

In an effort to ensure that moneys are available to cover costs for the people who cannot pay for hospital care, and to guarantee that access to care is not compromised, the Hospital Association not only supports, but would actively participate in various initiatives that it hopes that this Commission will consider. Let me share a couple of them with you:

1) The hospital industry supports the premise that the broader the base of financial support to the Trust Fund,

the more equitable it will be. Hence, we believe it is now time to stop unfairly burdening the hospitalized patient with the price of caring for others. To that end, we feel that the Uncompensated Care Trust Fund revenues should be augmented, or perhaps and ideally replaced with other moneys. These funds could come from a sin tax on liquor and cigarettes, which you've heard about from other testimony; an expanded State lottery; increased fines on environmental polluters; or any other broad-based tax.

2) The uncompensated care problem is not a hospital-based problem, but a society-based problem, and it must be solved where it originates. Hence, the State and the private sector both must make every initiative to expand the number of insured New Jerseyans. The State should broaden Medicaid eligibility requirements so that the maximum number of people in the State can qualify for Federal health care dollars -- 50 cents on the dollar through Medicaid. The fact that more than 800,000 New Jerseyans have either no, or not enough health insurance is really unacceptable.

As I said, the private sector also has a role in the process of reducing the number of uninsured. Since the Uncompensated Care Trust Fund relates only to hospitals, and since too many people are uninsured, why not encourage the private sector to provide hospital insurance?

In an ideal world, it would be welcomed if employers, particularly those small businesses that currently offer no health care coverage, would voluntarily offer basic health coverage. These employers could be provided with tax incentives, proper incentives -- either tax on the State level, or more comprehensive tax benefits from the Federal government -- to encourage basic health care coverage.

But, not seeing voluntary initiatives to prompt employer participation in providing benefits, the industry would support a mandated minimum insurance requirement for

hospital care that would include both inpatient and outpatient coverage. Such a program should be affordable enough for all employers to buy into, and it, too, could be funded with a broad-based tax or a payer differential or discount.

3) Finally, there are other things that society can do to promote the preventive and wellness aspects of health care that simply will keep people healthier and out of hospital settings. Health care not utilized is not an expense. Virtually every hospital in the State now offers a variety of free or low-cost wellness programs ranging from smoking cessation and weigh-reduction to prenatal care, diabetes, cardiac awareness seminars, and so forth. Hospitals clearly will continue to create, subsidize, and promote these programs for the betterment of communities for the people that they serve.

Other hospitals, particularly in urban areas, have expanded cooperative efforts with community clinics, offering staff and technical expertise to help in providing frontline care where care is needed most, at less cost to the system. More of this "joint venturing" between hospitals and existing community resources should be encouraged.

With these types of changes in mind, I can certainly assure you that this Association and the hospitals that we represent share a goal of commitment and vision; commitment to affordable and accessible health care for all New Jerseyans, and a vision for a regulatory environment that allows us the flexibility to respond to what's truly best for the eight million people who walk through our hospitals' doors each year.

Finally, I want to make a comment about the uncompensated care and its application throughout the State. Contrary to popular opinion in some circles, it is not an urban problem. It is a statewide problem. It is a problem of some significant magnitude for society at large; in the City of Newark; in the City of Camden. It is a problem in suburban

areas such as Long Branch and others. It is a problem in very rural areas such as in Bridgeton and Sussex. So this is a statewide problem. We commend you and your efforts to assist us in continuing the services to the public through our hospitals for uncompensated care. I thank you for your time. We look forward to assisting in any way we can and responding to any questions.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. Scibetta. One of the things you talked about is after we-- It's going to be impressive how much tax on alcohol, lottery, and environmental polluters-- So far they're paying for everything in the State. No matter what Commission you go to--

MR. SCIBETTA: I'm not sure if there are any taxes left.

ASSEMBLYMAN McGREEVEY: --including our State deficit. You mentioned mandator minimum insurance requirements for hospital care that would include both inpatient and outpatient coverage. And one of the things, frankly-- It's good that people are stepping forward to the plate to come up with specific requirements, but the next step is, what would you specifically require to be covered?

MR. SCIBETTA: Well I think basic health care services that are essential.

ASSEMBLYMAN McGREEVEY: What does that mean?

MR. SCIBETTA: That means those that are considered medically necessary services for admission. Your patient that comes to a hospital for emergency services must be covered. Hospital care that is considered a requirement for medical necessity as an inpatient must be covered. You can't make a decision when a patient enters the hospital as to whether or not the patient's care should be covered. It needs to be clearly spelled out in any insurance agreement that is provided, as long as it is medically necessary and considered so by the physician admitting the patient.

ASSEMBLYMAN McGREEVEY: So you would cover everything going into a hospital?

MR. SCIBETTA: That is medically necessary.

ASSEMBLYMAN McGREEVEY: Well, we haven't yet defined what is "medically necessary."

MR. SCIBETTA: Well, I heard Assemblyman Kelly talk about taking care of chins and baggy eyes, and I hardly think--

ASSEMBLYMAN McGREEVEY: Except for Assemblyman Kelly's chins.

MR. SCIBETTA: Most of us could benefit from that, Assemblyman. I think that's really not what we would consider medically necessary.

ASSEMBLYMAN McGREEVEY: Aside from cosmetic surgery, what specifically-- Put it this way: What would you exclude?

MR. SCIBETTA: I think some limits on psychiatric services probably could be considered an eligible area to look at. And I think that what we really should do in terms of the specifics of this is sit down with the insurers and determine from them the recommendations that seem to fit in best with the areas of possible consideration for exclusion as inpatient services. But I think that if you go through our hospitals today, Mr. Chairman, this is one of the problems we have in addressing this question.

Our hospitals are filled with intensive care patients, practically throughout the entire State of New Jersey, so to try to pick and choose who should or shouldn't be able to access that, is a question. Now, when you get into some of the questions they are dealing with, for example, in the State of Oregon, such as rationing of services-- That is a question that I think has so many ethical implications to it that I don't believe a forum such as this is one that can provide any real intelligence to kinds of conclusions you might want to arrive at.

At this point in time, we are assuming as hospital providers that if patients present themselves, and the physician says, "This care is medically necessary," that hospital care is considered a right of the public in this State, and as such, we have a responsibility to admit them and to take care of them.

ASSEMBLYMAN McGREEVEY: We recognize those concepts. I guess what I'm looking for, and if I would ask the Hospital Association-- Maybe this isn't the forum, but that's precisely what we're looking for. We're looking to grapple with a very difficult issue; not to say that we are going to abolish the Uncompensated Health Care Trust Fund, because maybe that always ought to be there as a backup. But we're looking to answer that hard, difficult question of what should be covered?

I'd like to touch on the question of the acute care setting, recognizing that indigent services could perhaps be offered in less costly settings, such as primary care services. What is your comment, recognizing that you represent obviously the acute care facilities-- What is your comment regarding offering coverage for--

MR. SCIBETTA: I suggest that when you look at a hospital, you have to recognize that hospitals provide ambulatory services, acute care services, long-term care services, psychiatric services, and rehabilitation services, comprehensively across-the-board, obviously in conjunction with the position. So our interests are with the patient and the comprehensive element of care to that patient. I think that there's little doubt in my mind that we have been very shortsighted over the past five decades, perhaps, in not providing adequate coverage for ambulatory services and requiring in the past, prior to things like PROs and PRGs and so forth, where you simply couldn't admit a person anyway who should be taken care of on an ambulatory basis.

But I believe if we are not farsighted now in making certain that ambulatory services are adequately covered, that clinic services are not in any way diminished -- particularly in areas where there simply is no other health care coverage -- that hospitals be given the opportunity to take space when they might have, to provide frontline health care services, particularly in very highly urbanized settings where during the late hours at night and early in the morning there's just no other health care providers available to take care of our public; and that they be given the opportunity to convert space into different ways of taking care of people on an ambulatory basis. This would serve the public at large quite well. Get rid of some of the regulations that stand in the way of that and make sure the coverage is provided.

ASSEMBLYMAN McGREEVEY: Just to assure you that at some later point in time we will be looking at the question of nonhospital care, and whether it's considered under the private practice in a medicine -- and the legitimate concerns the industry has from their exemptions from regulations under the Health Care Facilities Planning Act, such as ambulatory, surgery centers, etc. So they will be addressing the second phase, which is a legitimate concern.

MR. SCIBETTA: Mr. Chairman, may I just say one other thing?

ASSEMBLYMAN McGREEVEY: Sure.

MR. SCIBETTA: The issue of home care has not really been addressed and that's very critical -- I mean to prevent a patient from having to go into the hospital for a few days, weeks, months if adequate home care is provided, and to make certain that there is a place for the person to go. This is a serious problem nationally.

ASSEMBLYMAN McGREEVEY: Now, would you ensure home health care?

MR. SCIBETTA: Yes.

ASSEMBLYMAN McGREEVEY: Okay.

ASSEMBLYMAN FELICE: Thank you, Mr. Chairman, if I may. Mr. Scibetta? I think one of the questions that the Chairman brought up is who does the doctor admit as a patient? Sure, with malpractice, they are going to try to admit anyone who looks like a serious case. Maybe a standard they could go by is their DRGs? That's basically a lot of your basic billing programs that have been set by the State Department of Health. That's certainly one direction as a basis to start saying, "We can use that as a basis for those that really need care."

The other thing that you touched on that was important, was the use of hospital space. One of the things I know as a former Mayor and having to get up in the middle of the night to get a magistrate so that they could take someone to an acute hospital for psychiatric reasons, is that that 24/48-hour period-- A lot of these hospitals could be utilized for that type of 48-hour coverage for those patients from municipalities. That's a thought for some of the space that could be utilized under some of these programs. I wonder if different hospitals are considering it?

MR. SCIBETTA: Are you talking about involuntary confinement or a mental illness--

ASSEMBLYMAN FELICE: Yes.

MR. SCIBETTA: --or are you talking about police type confinement?

ASSEMBLYMAN FELICE: Well, it actually was a combination. Is it involuntary without having to get a magistrate?

MR. SCIBETTA: If it's a medical problem and they have facilities for them, it's certainly an appropriate function for a hospital. Many times they are not necessarily considered violent and don't necessarily need to be in locked facilities. I think that's the gray area. I know you have some hospital folks behind us. They may be able to shed even better light on that subject.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much. I appreciate it, Mr. Scibetta, not only on this issue but in issues to come.

MR. SCIBETTA: Yes sir. We'll be working with you, and we look forward to that. And thank you very much for the opportunity.

ASSEMBLYMAN McGREEVEY: Thank you both. In recognizing that for future witnesses-- We recognize the dilemma. I think we'd appreciate it if the witnesses focus on the specific question regarding identifying those personal levels of health care that ought to be addressed. I'd like to call upon Mr. Keith McLaughlin from the Raritan Bay Medical Center.

K E I T H H. M c L A U G H L I N: Thank you, Mr. Chairman and Committee members. I am, for the record, Keith McLaughlin, President of the Raritan Bay Medical Center with divisions in Perth Amboy and Old Bridge. I have been affiliated with the Raritan Bay Medical Center for the past 18 years. Thank you for the opportunity to address you this morning regarding an issue which affects all New Jerseyans. These days health care and hospital costs seem uppermost in people's minds.

I would like to begin by clarifying what I think is an important point -- the difference between health care costs and hospital costs.

Hospital costs are the day-to-day expenses involved in providing specific clinical and medical care. These costs include salaries, medicines, equipment costs, electric bills, and other basic items to maintain our buildings and medical facilities. Health care costs include the maintenance of a whole system layered onto medical/surgical and outpatient care, including uncompensated care and insurance premiums.

In relationship to the GNP, hospital costs have remained at 4.3% for the last several years. In comparison,

health care costs have risen to over 11% annually of GNP. Clearly, there is a problem in the health care area, but I feel it is a societal problem rather than a management issue. However, it's not a new problem.

In New Jersey, we've long recognized that those unable to afford health care services should be taken care of. Historically, New Jersey counties provided funds to cover the cost of services to the medically indigent. When the DRG system of reimbursement was instituted in 1980, costs for indigent care were included within the payment mechanism. Finally, in 1987, the Uncompensated Care Trust Fund was established, and all hospitals dealt with the problem through an evenly spread surcharge.

The issue of medically indigent patients did not go away, however, and we find ourselves addressing funding issues as economic conditions in the country create even larger numbers of uninsured and underinsured.

While hospitals seek to carry out the mandate from the State to provide quality care for all, regardless of the ability to pay -- which I personally believe is our hospitals' responsibility -- the burden on hospitals as providers increases.

People tend to think that we're part of the problem instead of part of the solution. In my over 20 years experience in health care, I've learned that creative thinking can lead to workable solutions. There are two areas to consider and deal with. I suggest that this Committee give thought to two avenues of approach -- one financial, one programmatic.

Financially, the Trust Fund covers two types of patients: those who are medically indigent with no or slight insurance coverage, and those who can't or don't pay and become "bad debts." Currently the $650 million spent on uncompensated care is disproportionately weighted to bad debt.

Now it is very important to clarify these terms. The system is proportionately funding a greater degree of bad debt verses medically indigent, through the Trust Fund. What happens is that the rule requires patients to provide all sorts of personal documentation such as bank balances and proof of income to show they are indigent. In practical terms, people just don't comply. They refuse to provide the information or promise to do so at a later date and never do. As a result they wind up in the bad debt pool.

The regulations create a nightmare of paperwork for hospitals as we are forced to determine an individual's ability to pay. Frankly, that is beyond our scope. The endless questions of the verification process add overhead, slow services often at a crucial time, and burden hospitals with a regulatory responsibility not legitimately ours. And I might add, since 1989, with the new Uncompensated Care Trust Fund, it is costing the health care system approximately $25 million to $30 million a year to comply with these new regulations. The requirements and qualifications for classification as medically indigent should be reviewed and managed elsewhere so that an accurate picture of the problem is charted.

Unfortunately, however, bad debt is a part of doing business in America today. Perhaps we could address that portion of the Trust Fund by adding a bad debt factor into DRG rates and then separately addressing the medically indigent. Personally, I have long advocated a broad-based tax to fund coverage of the medically indigent. It seems inappropriate that only those individuals who are hospitalized -- and their insurance carriers -- bear the burden of a larger societal problem. Our current funding mechanism places an unfair financial burden on the hospitalized. One portion of the issue can be addressed through corrective and creative funding.

The programmatic portion of the issue also cries out for some different thinking. We could consider using the Trust

to fund an affordable, preventative health care package focusing on education, screenings, and certain basic services such as prenatal care, blood pressure screenings and treatment, diabetes testing and referral, and cholesterol screenings with nutritional counseling. Pool coverages could work to provide an affordable package which would save moneys later on when patients are often hospitalized for treatment of advanced stages of various diseases. Medical experts should determine the specific components of such care, but Ben Franklin was right: "An ounce of prevention is worth a pound of cure."

I hope I have given the Committee some key issues to consider. We must remember that health care costs and hospital costs are two different issues; that the definition and qualification of the medically indigent needs review so that we can adequately and accurately measure our bad debt and that preventive coverage can obviate the need for greater expenses later on.

New Jersey has been in the forefront of addressing the needs of the indigent. It's an idea whose time is coming in other states across the country. We now have an opportunity to refine our efforts and should use this investigation to dissect the components involved in uncompensated care and put them back together in a more accurate and fair fashion. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you. Mr. McLaughlin, if you will, just a few questions: Would you support the concept of a mandated minimum threshold of health care coverage for all New Jerseyans through requiring that of employers?

MR. McLAUGHLIN: I think in terms of preventative health care, that's a must, in order to, down the road, avoid the increasing cost of health care.

ASSEMBLYMAN McGREEVEY: For preventative as well as acute care?

MR. McLAUGHLIN: Yes.

ASSEMBLYMAN McGREEVEY: The second question-- You talked about bad debt. Assuming that we were able to cover a significant percentage of those who were presently withdrawing from the Uncompensated Health Care Trust Fund and provide for some type of mandatory threshold level of health care insurance-- You talked about bad debt. Would it be more appropriate that this bad debt be taken outside or moved from the Uncompensated Health Care Trust Fund, and that bad debt be dealt with as part of doing business and, say, be factored into the Hospital Rate Setting Commission's approved revenue or application of schedule of rates?

MR. McLAUGHLIN: I would agree with that, but only on the assumption that we redefine "medical indigence" and not follow the definition in the current law. If you go back, and I checked in our particular hospital and I think this is pretty much around the State-- Back in 1987 before the current laws took effect, 50% of uncompensated care was indigent, 50% was bad debt. My estimate is that 90% of the uncompensated care is now bad debt and 10% indigent, only because of the rules.

ASSEMBLYMAN McGREEVEY: Yeah, but bad debt also constitutes those who don't have any health care.

MR. McLAUGHLIN: That's true, but we need to redefine what a medical indigent person is, in terms of financial wherewithal. It's all gotten kind of mixed together and all bad debts, like Mike explained before, for the cosmetic surgery-- It all gets thrown in, and the perception is that it's all uncompensated care.

ASSEMBLYMAN McGREEVEY: I think Assemblyman Kelly went to enroll for his chin. Assemblyman Felice?

ASSEMBLYMAN FELICE: I think some of the issues we're just reiterating. It's a problem that a lot of the hospitals which have bad debt situations-- How much of it can be recovered with proper personnel or business practices of collecting bad debts? I know an acute hospital in our area--

There's quite a few millions that when an effort was really made to go out-- I think that every hospital has that potential, but it's another separate division just to go out on a percentage basis. How much of it are you allowed to, or can you force, to collect some of that bad debt? I think that's one of the problems.

Hospitals are there to give care for patients, and they are not really the accountants and CPAs nor do they have the administrative means, in many cases, to go out and collect some of those bad debts. As you said, providing there's a standard of what is an indigent person, what factors could be put into collecting some of that money? Maybe the State-- Maybe there should be some type of law enforcement procedure to help the hospital collect that portion of the uncompensated care that is strictly a bad debt, that the moneys might be there financially for us. I don't know. It's a good question for us to answer.

MR. McLAUGHLIN: I would suggest that maybe some arm of the State government be the one to determine financial eligibility for uncompensated care. As I mentioned $25 million to $30 million of the health care dollars are now being spent -- approximately $300,000 per hospital -- just to comply with the new law to determine who qualifies for the Uncompensated Care Trust Fund.

ASSEMBLYMAN FELICE: It was interesting a few years back, when we had amnesty for those people who had to pay their taxes -- not only in New Jersey; it took the lead from other states -- the amount of millions of dollars that was collected by the State when those people were given amnesty other than prison terms or heavier penalties. So maybe that kind of system through State legislation or regulation might help that problem in a backdoor type of an approach. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much. Mr. McLaughlin?

MR. McLAUGHLIN: I would just like to respond to your one comment about unbundling into the private sector, primary care. I think therein lies part of our problem. I'm aware of a freestanding diagnostic center not too far from here, not affiliated with JFK, which puts out a very fancy brochure in which they deal with many, many insurance companies. I didn't notice in the brochure that they deal with Medicaid or the Uncompensated Care Trust Fund. So they are skimming profitable business off of hospitals, which effectively raises the unit costs of the patients we are still taking care of in the hospital, because obviously, the higher the volume, the lower the cost.

And a lot of us-- I know, for example, that we have a clinic which is the last source for health care where we provide 24,000 clinic visits per year. That's the last resource of those people to get medical care.

ASSEMBLYMAN McGREEVEY: And also with Raritan Bay's TAP -- Treatment Assessment Program -- for AIDS, they are doing an exemplary job.

MR. McLAUGHLIN: I might add, drugs -- in the outpatient -- brought 54,000 visits, and the predominance of those are bad debts or indigent care.

ASSEMBLYMAN McGREEVEY: Thank you very much, Mr. McLaughlin. At this time we'd like to call upon Mr. Richard Lloyd of Blue Cross and Blue Shield of New Jersey.

R I C H A R D W. L L O Y D: Thank you, Mr. Chairman. Blue Cross and Blue Shield of New Jersey appreciates the opportunity to testify before the Assembly Health Care Policy Study Commission as you continue to come to grips with the many issues associated with health care policy.

At your previous meeting on April 16, 1990, Blue Cross testimony focused on identifying those factors which were contributing to the rapid growth of health care costs. Among the major elements identified in that testimony was the growth

of uncompensated care as a portion of hospital revenues. It is the opinion of Blue Cross and Blue Shield of New Jersey that it would not be possible to stabilize the costs of health insurance in New Jersey without coming to grips with the problem of uncompensated care and government cost shifts.

To a significant extent, the problem of uncompensated care is related to the many New Jerseyans who do not have health insurance and are unable to qualify for Medicaid coverage. Blue Cross believes that reducing the number of New Jerseyans who do not have access to insurance, be it through the private sector or through the Medicaid program, would help ease the explosive growth of uncompensated care and cost shifting. Controlling that rate of growth, or in the best-case scenario, actually reducing these factors as a percentage of overall hospital revenues, would be beneficial to those groups and individuals who currently purchase health insurance.

Since some of this is a reiteration of testimony previously given, and knowing there's a shortage of time, I'm going to just move on to a couple of points. Blue Cross estimates that nearly 30 cents of every dollar of hospital premium that we collect pays for the care of someone other than our customers. As the last statement illustrates, uncompensated care and government cost shifting most clearly impact the amount of premium which needs to be collected to cover hospital costs.

In reconsidering the problem of the uninsured, it's therefore prudent to focus on ways in which there can be access to hospital insurance coverage. Blue Cross recognizes that coverage of medical expenses associated with hospitalization is only one element of health care. However, it is this particular component of the health care system which is directly affected by uncompensated care and government cost shifting.

There is also, in the opinion of Blue Cross, the area of health insurance where the uninsured most need and perhaps want health insurance coverage. When Blue Cross was initially established 50 years ago, it was designed only to provide hospitalization insurance. Over time, the health insurance marketplace expanded to include coverage for physician services and a wide range of other health care benefits. The growth of the health insurance industry into these areas is clearly a by-product of customer demand.

Today the overwhelming majority of the insured population have coverage which is significantly more expensive than hospitalization insurance. Blue Cross clearly believes that for most purchasers, health insurance which goes beyond the benefit for services rendered in a hospital setting is not only appropriate, but it's what the customer wants.

However, as health insurance costs increase, it's becoming more difficult for certain employers, as well as individuals, to purchase or maintain health insurance. This fact increases the number of people who are uninsured, resulting in an increase in uncompensated care. More uncompensated care results in even higher insurance premiums and the cycle continues.

Blue Cross is currently involved in examining various benefits designs which would allow us to have the ability to put forward a product which would cause a significant number of small businesses to purchase health insurance for their employees. In researching these products, Blue Cross is evaluating the way to achieve a product design which is not only affordable, but provides levels of coverage which are sufficiently broad to cause customers to wish to purchase that coverage.

In designing products of this type, it seems critical to include reasonable levels of cost sharing as well as the ability of the insurer to manage care. Cost sharing can best

be defined as deductibles and copayments. Requiring the insured customer to pay for a portion of their health insurance care before insurance reimbursement begins to take effect, or begins to reimburse services at a 100% level, will cause the insurance consumer to be a more prudent utilizer of health insurance benefits. The concept of managed care allows the insurer to determine that the health care services are being rendered in the most cost-effective manner possible.

Blue Cross believes that it is the private insurance marketplace which provides the best mechanism by which to solve the problems of the uninsured. There are, however, several things which would enable the insurance industry in general, and Blue Cross in particular, to meet this challenge.

A basic health insurance product could be made more affordable if it did not have to include mandated benefits. Currently, there are numerous bills pending which would mandate additional benefits in insurance contracts. There are also several mandated benefits laws currently in place in New Jersey. It would require action by the New Jersey Legislature to allow Blue Cross and other insurers to offer insurance products for sale which do not include these mandated benefits. Removal of these benefits would reduce health insurance costs while at the same time offer the basic protection that the public wants and needs.

The Legislature should also consider enacting legislation which would provide tax credits and other incentives to small businesses which provide health insurance coverage to employees.

In previous testimony, Blue Cross recommended expansion of the Medicaid program, as well as additional efforts to improve collection efforts under the existing hospital finance system.

This Commission has correctly focused its attention on how to go about reducing the number of uninsured in this

State. Reducing the number of uninsured will not only improve that group's access to health care, but it will reduce the pressure on the insured population to finance the costs of hospital expenses for the uninsured.

The task of developing insurance products which will provide necessary levels of care and still remain affordable is a challenge for all insurers, including Blue Cross. It is, however, an important part of finding a solution to the health care cost crisis in New Jersey. Blue Cross recognizes its role as a key player in finding a solution to this problem. Working with this Commission, Governor Florio's Commission, and other interested parties, it is our belief that it will be possible to develop health insurance products which will reduce the number of uninsured in New Jersey.

ASSEMBLYMAN McGREEVEY: Thank you, Richard. Just two concerns: You talked about the fact that the Legislature has historically mandated certain benefits, and you call for the removal of those mandated benefits as a way of reducing health insurance costs. But you also talk about offering basic protection that the public wants and needs. Could you define what constitutes that basic protection that the public's wants and needs?

MR. LLOYD: I think in our product design that we're talking about-- We're talking about coverage for basic hospitalization -- the medical/surgical component that is associated with that hospitalization. We're also considering elements of managed care, and when we include managed care, one definition of that might be preventive care, such as well baby care and things of that nature.

ASSEMBLYMAN McGREEVEY: And the second item on page four of your testimony-- You referred to various benefit designs which, "Have the ability to put forward a product which could cause a significant number of small businesses to purchase health insurance for their employees." Could you elaborate on what some of those designs are?

MR. LLOYD: Well I think to be honest with you, some of that is a little proprietary information -- what we're considering. But I think what you are looking to do is one, you are doing a great deal of market research to find out what it is-- At what level do those who are currently not providing insurance for their employees-- At what level would they be willing to purchase that insurance, and what type of benefits do they consider appropriate for that level of purchase?

I think it's our basic belief that the majority of people are looking for coverage which protects them from the catastrophic illness, the hospitalization which can destroy one's personal income. We think that to a great extent medical care with-- Those who are uninsured are able to handle that problem themselves, potentially, with a great deal of difficulty. But it's the hospitalization costs, a major hospitalization that people are concerned with. Also in terms of the impact of the uninsured on the uncompensated care system, it's clearly a hospital driven situation. Basic hospitalization is the building block by which the product designs are all being constructed.

ASSEMBLYMAN McGREEVEY: If at some later point, it would be appreciated -- I think it would be very helpful as we ask the Hospital Association to come back with the specific recommendations of those variety of procedures that ought to be covered. One of the concerns -- and I think we are going to be addressing this at the next hearing -- which is focusing in on business and labor is also the question of affordability for the small employer for both Blue Cross and other commercial payers, especially considering if they have a particularly at-risk population within their insurance pool.

MR. LLOYD: That's correct.

ASSEMBLYMAN McGREEVEY: But that's for the next hearing. Assemblyman Felice?

ASSEMBLYMAN FELICE: Briefly, I agree that one of the directions we have to go is to put more people into some kind of health care coverage. In fact, Dr. Colburn and I are the prime co-sponsors of a bill that's already been drafted and ready to go to Committee. And exactly what you are composing there as far as incentive for small businesses-- I'm sure when the proper session comes up, that will be one of the things that will be considered. I would hope that the rest of the Committee would join with me on that legislation.

MR. LLOYD: We look forward to taking a look at it. It sounds like an excellent idea.

ASSEMBLYMAN FELICE: Well, we'll be glad to supply you with a copy.

ASSEMBLYMAN McGREEVEY: And the last thing, talking about the percentage or those elements in the non-elderly population who lack insurance-- You talked about the private sector, but recognizing the fact that not all businesses-- We've heard ad nauseam about the problems of the Fund. Would you recommend that controlling the rate of the Uncompensated Health Care Trust Fund and to reduce the cost, one of the ways would be to require of employers a requisite level of health care coverage necessary?

MR. LLOYD: I think today, we're not ready to make that statement. I think that--

ASSEMBLYMAN McGREEVEY: Will you be ready to make that statement when you ask for your next rate increase?

MR. LLOYD: Well, hopefully that won't be in the near future.

ASSEMBLYMAN McGREEVEY: We all hope that.

MR. LLOYD: I think that what we would like to see is to first try the carrot approach. It's not something that we are saying should not be considered and evaluated when we look at the whole puzzle, but today I'm not ready to say that word; I'm not going to endorse that concept.

ASSEMBLYMAN McGREEVEY: Just in addressing this problem, it all requires a certain amount of courage and fortitude--

MR. LLOYD: Right.

ASSEMBLYMAN McGREEVEY: --to say the things necessary to seriously address the ongoing problems that we're all very much aware of. And we look for that leadership on behalf of Blue Cross and Blue Shield. Nothing else. Thank you very much.

MR. LLOYD: Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you. Our next individual to testify will be Dr. John Baker. Dr. Baker is with the Medical Society of the State of New Jersey.

J O H N C. B A K E R, M.D.: Thank you very much. I appreciate the opportunity to address the distinguished panel members regarding health care in the State of New Jersey. I am a practicing orthopedic surgeon at Atlantic City Medical Center. I'm surprised to hear that no one has yet mentioned that the casinos should fund this. In Atlantic City, everyone else wants the casinos to fund everything.

Secondly, just when you've heard all of the bad news, there's more to come. Unfortunately, the physicians have, to my knowledge anyway, not been represented adequately in any of these discussions that have gone on previously. It's wonderful that every citizen in the State of New Jersey has access to health care within the hospitals. That's not true within the doctor's office. It also should be mentioned that since 1980, the millions and millions of dollars that the hospitals have provided in indigent care have also been provided by the physicians with one big exception; the hospitals get paid, the physicians do not.

That's nothing. That means when I get up in the middle of the night, at 3:00 in the morning, go in and take care of a stabbing victim, or a drug addict with an abscess that needs to be attended to promptly-- That is totally my

obligation, which I except, as does every other physician who does this. But we do this with the knowledge that we are not getting reimbursed for that care, and that the hospital gets reimbursed fully.

Everyone should know that, and I don't think everyone does. I think it's one of the biggest kept secrets in the State of New Jersey; that millions of dollars have been donated to the State by physicians. In the past, the issue and the problem perhaps was not as severe. We've heard testimony on how the Uncompensated Care Trust Fund has doubled. That means that the level of care given by the physicians has equally doubled.

A young physician trying to practice at an inner city hospital has a great deal of difficulty when 30% of his admissions through any emergency room in that setting will be for free. He still has to pay all of his debts from medical school. He still has to pay his malpractice insurance. He still has to pay his office staff. If he has a Medicaid population, he gets reimbursed $14 for a visit to the office. That does not go to cover the cost of his office. It's not an easy task in today's environment, and I don't expect it to become easier in the future for physicians to practice in this environment.

Yet these people, these patients of ours need care. They don't need the emergency care that occurs at 3:00 in the morning, when they could have gotten preventive care prior to getting to the hospital. But there is no funding to provide that, and they can't afford it, so they don't get it.

I think it's a big problem. I would like to see the Medical Society participate more than it ever has in the past to try and solve this. When the Hospital Association wants to get together with the insurance industry to determine what programs are medically necessary, don't you think that maybe doctors should have some input into that?

I would just like to briefly summarize a white paper from the Task Force which I Chaired for the State Medical Society. I'll try and make it brief. The problem of the medically uninsured patient is one of the major health care issues facing the State of New Jersey, as well as the nation. As we've heard, in the Chapter 83 law, hospitals in New Jersey have been given financial security when providing care for the uninsured, or the bad debt cases, through what is know as the "Uncompensated Care Trust Fund."

However, this Fund has seen expenditures nearly double in four years, going from $230 million to $500 million, and now to $600 million. This will sunset in 1990. At the present time, only hospitals are compensated for care to the uninsured through this Fund. Physicians who in actuality direct and provide the care, along with the nurses-- The nurses are paid; the physicians are not. They receive no compensation for such patients.

One cannot begin to address this issue of the uninsured patient without also taking into perspective the AIDS caseload. New Jersey has 4% of the nation's population and 7% of the AIDS population. At the present time -- this was in 1989 -- there were 7590 identified cases of AIDS in the State which is projected to go to 25,000 in 1992. I, personally, being in the orthopedic community, risk my life every time I operate on someone who comes through an emergency room in the State of New Jersey. There is no mechanism to test that patient, involuntarily. Those patients come in in emergency situations, and we take them into the O.R. It is well documented that this disease can be transmitted through direct contact, needle sticks from the serum to the surgeon.

There were -- last year, I understand -- 19 physicians with AIDS. More conservative than that are assumptions that 40% of all those now carrying HIV will develop full-blown AIDS, which would result in estimates of individual costs of $60,000

per patient, and a total inpatient hospital care of approximately $840 million. Because New Jersey has such a high percentage of AIDS cases who are IV drug users and usually indigent, the majority of the cost of their care will be borne by the public payers.

Thus ensure, the total amount of care required in all potentially uninsured patients from physicians in every category of illness is enormous and should be recognized. Therefore, a system for providing some measure of compensation to the physician in an effort to ensure access and appropriate quality of care for all patients in New Jersey should be implemented.

Physicians' role in charity care: Well, figures are not available for New Jersey specifically. Data collected by the AMA indicate that physicians are providing an increased amount of care free of charge or at a reduced charge for those patients without adequate insurance. The amount of uncompensated care provided by physicians has been estimated to be $23,900 reduction in billings, or a total of $10.8 billion in 1987.

State and net loss: The average loss of income was $16,900 per physician, or a total of $6.3 billion in 1987. I realize this is a difficult task for me, because many people perceive physicians coming to the table with two loaves of bread under their arm asking for more income, and I'm not suggesting that. What I'm saying is that there are certain areas in the State, Indigent care and uncompensated care is an issue statewide, but there are certain concentrated areas where you cannot attract physicians to practice medicine -- quality care medicine -- because of the high load that they would have to bear of uncompensated care.

Atlantic City Medical Center, it's true, took this issue on in 1988 when I was president of the staff there. It was the number one issue addressing the staff; the high

caseload of indigent care that they are required to do and have been doing. We've seen the abandonment of the inner city hospital by the physicians, by the oral surgeons, by the OB department, etc., and I don't understand how it's going to change unless we grasp this problem and deal with it also from a physician's perspective.

Several proposals have been made expanding health benefit coverage to the uninsured, and have been set forth by the Legislature as well as the AMA and various health care professionals.

Medicaid: The major drawback in New Jersey is its lack of a medical indigents law, leaving many persons in the working poor category. We've heard all of this before. The Federal and State governments have a necessary role in assuring access to medical care to persons with incomes that preclude the cost of medical coverage. Under any condition, in New Jersey the Medicaid system needs revamping. More people need to be on their rolls, and the reimbursement level is ridiculous.

Employer/business requirement: This would require small businesses with a certain base minimum number of employees to purchase health care insurance. There are many variations to this system which are beyond my scope to really discuss, but also another area that needs to be discussed is risk pool. For those people that cannot achieve health insurance because of their medical condition, we need to help these people out as well.

ASSEMBLYMAN McGREEVEY: What would you cover, Doctor?

DR. BAKER: I can't answer that question today. Obviously it would have to be discussed in detail. There are certain things such as perhaps cosmetic surgery, that would not be covered. However, as a physician, and as a prospective patient at any time, I want to have coverage for everything that I need that threatens me medically, as does everyone in this room. If any one of us gets sick tomorrow, we don't want

to hear, "I'm sorry, you cannot have that procedure. You cannot get treated because you don't meet these particular qualifications."

If you want systems of socialized medicine as in other countries, fine. Be willing to accept the fact that if you reach a certain age, you are not going to be qualified for heart surgery or dialysis any longer. Tough luck, it's over. Are we willing to say that to ourselves as patients and to every other person who lives in this State? As a physician, I'd like to treat everyone who's sick. That's my job. That's the oath I took and that's what I would like to do. And I do it, as do many, many other physicians in this State irrespective of whether or not the patient can pay us. Look at the record. You'll see that we've been doing it for years, and we'll continue to do so.

The other comment that I would like to make is that it was mentioned earlier whether or not defensive medicine makes a difference? I think it was said that it does not. I would say that it does.

Case in point: A patient came into my office three weeks ago with back pain that had persisted for three to four months. He had previously been seen and had been given an exercise program since his physical examination was obviously negative and he was in otherwise good health. The back pain persisted. Plain X rays were negative. I ordered a MRI, which is a sophisticated test that shows the inside of the body, and it picked up a spinal cord tumor, very rare in a 32-year-old.

I can't order MRIs on every person who comes into my office with back pain at $800 a shot, but that just gives you a little idea of the predicament a physician finds himself in when we say, "Let's cut health care costs, but not on me. I want every test that it takes to find out why I feel the way I do." It's the physician's responsibility to do that, but obviously there are certain parameters. We've all experienced

PROs. We've all experienced DRGs. We are a regulated industry to a large extent. We no longer have the high volume of patients in the hospital. We dealt with that effectively in keeping people out of the hospital.

Many more people are treated as same day surgery. Surgery centers happen because they're less expensive. So I appreciate the task that you have before you. I don't have the answers to solve all of the problems. I'm just saying that if we do not look at the physician component of uncompensated care, the problem will get worse before it gets better.

ASSEMBLYMAN McGREEVEY: Thank you. Assemblyman Felice?

ASSEMBLYMAN FELICE: No, go ahead.

ASSEMBLYMAN McGREEVEY: Thank you very much, Doctor. We appreciate your testimony.

DR. BAKER: Thank you.

ASSEMBLYMAN McGREEVEY: Next is Mr. Daniel Marcantuono, President, Chief Executive Officer of the General Hospital Center at Passaic.

**D A N I E L L. M A R C A N T U O N O:** Good morning. Mr. Chairman, Commission members, my name is Daniel L. Marcantuono. I'm President and Chief Executive Officer of the General Hospital Center in Passaic, New Jersey. We are the community hospital that brought to New Jersey one of the first regional cardiac programs more than 35 years ago. We are a facility that provides a broad range of primary, secondary, and selected tertiary services in a community hospital setting. The General was started by the Passaic City Medical Society in 1891 as a free dispensary for accident victims, and over the years it has grown into a 303-bed hospital.

The General has never in its 99-year history turned anyone away because they could not pay. However, our concern today more than ever is the continued solvency of my hospital and the rest of the hospitals in the State which in part is being made possible through the Uncompensated Care Trust Fund.

This Trust Fund has provided a mechanism whereby the hospital has a source of payment for New Jerseyans unable to pay. Prior to the creation of that Fund, the hospital had no other source of payment for these patients.

The General has experienced over the last three years an average increase in our uncompensated care component of approximately 2% per year. In 1989, the General experienced an overall 12% uncompensated care rate, and we have no reason to believe that our uncompensated care rate will be going down in the future. These increases are occurring despite our best efforts to collect these moneys. May I note here that the hospital is subject to very stringent State mandated credit and collection regulations to ensure each and every hospital does its best to collect before it is declared a bad debt.

But we have observed at least one factor contributing to this increase, and I think you've heard it before: Not all Medicaid eligible patients are, in fact, being enrolled in Medicaid. Once the patient leaves the hospital, we physically lose control over moving that patient through the Medicaid maze, and since we can't force anyone to go to their nearest Medicaid office to complete the necessary paperwork, that person is lost to the system.

We would suggest a mechanism be established whereby each and every hospital in the State be empowered to complete the Medicaid process on site, while the patient is still in the hospital. In this way, we can assure the system that all Medicaid eligible patients become fully enrolled.

We also note that by broadening the eligibility requirements, more people can qualify and, coupled with our suggestion of having more New Jerseyans eligible to take full advantage of Federal dollars, they do so.

We, at the General, support the New Jersey Hospital Association's position that the State must continue to guarantee access to care for all individuals and that some

mechanism for paying for that care be maintained, and that government accept and play a large role in addressing these needs.

It seems clear that to devise a way for other moneys to augment the Uncompensated Care Fund could eventually make health care more affordable and accessible to all, and, as Mr. Scibetta noted, "Stop unfairly burdening the hospitalized patient with the price of caring for others."

My hospital will continue its wellness programs designed to help our communities stay healthy, since this is a basic tenet of why the General exists. But ultimately, we, together, must ensure affordable and accessible care for all New Jerseyans.

I thank you and the Commission for allowing me the time to present these comments.

ASSEMBLYMAN McGREEVEY: Mr. Marcantuono, I just want to let you know that we are going to hear and focus in on Medicaid. I appreciate the comment that you made regarding the hospitals, especially-- Well, you speak on behalf of your hospital being willing to enroll people in the Medicaid application process while the patient is still in the hospital. I just wonder if you can comment succinctly on the question of mandated minimum benefits. Your thoughts?

MR. MARCANTUONO: From the perspective of the hospitals, whatever is deemed to be necessary hospitalization-- The hospitals are there to provide the care for that, and what's deemed by the physician is what should be included in that hospitalization.

ASSEMBLYMAN McGREEVEY: Okay, thank you. Mr. Felice?

ASSEMBLYMAN FELICE: I would just like to comment that I was born in the Passaic General Hospital. It's a great city, and I know the extra burden that you had through the years because the surrounding cities and communities had no hospitals in between St. Mary's and the General. Beth Israel took the

load off of many of the people that could not afford to pay. I know the reputation that you have, but there's some other factors we'll discuss at another time. Thank you.

ASSEMBLYMAN McGREEVEY: Again, I'd just like to echo Assemblyman Felice's comments. Your suggestion regarding the Medicaid enrollment is a very valuable one and something we will take up at a specific hearing. I just want to thank you again.

MR. MARCANTUONO: Thank you all.

ASSEMBLYMAN McGREEVEY: Thank you very much. At this time I'd like to call upon Dr. Adewale Troutman from the Newark Department of Health. Dr. Troutman?

A D E W A L E T R O U T M A N, M.D.: Good afternoon.

ASSEMBLYMAN McGREEVEY: Thank you for rejoining us. Thank you.

DR. TROUTMAN: I will be brief, in the interest of time. I do want to focus specifically on the issue of prevention, which I see as being the answer to a major part of this problem. If you take a look at the major diseases and illnesses that we're talking about-- When you look at the large segment of the population that is uninsured or underinsured, an analysis from a preventive standpoint -- which has been done on a Federal and a State level -- identifies six, and now seven specific disease entities: cancer, cardiovascular, and cerebrovascular disease, chemical dependency, diabetes, lower birth rate, infant mortality, homicide, suicide, unintentional injury, and now AIDS. They account nationally for 60,000 excess deaths in a specific population that we are talking about across the country.

ASSEMBLYMAN McGREEVEY: Doctor, you get the "specific of the year award." Thank you.

DR. TROUTMAN: I'm not finished. Last year at our State conference on the state of black minority health in New Jersey, the State published its own findings on the health

status of blacks, Latinos, and other minorities in the State of New Jersey and found similar to the State's statistics; that black babies die at two-and-one-half times the rate of whites, with a gap even larger than the national norm.

AIDS deaths among black babies are 14 times that of whites. Homicide rates amongst black people are four times greater than among whites. African-Americans in New Jersey make up 53% of AIDS cases, with Latinos representing 13%. The life expectancy for black males is 64 years, as compared to 71 years for whites. Almost 25% of black families are below poverty, compared to 6.3% of whites. Black men die from esophageal cancer at a rate of three times that of white men. Chemical poisoning amongst employed black people occurs at a rate three times that of whites. The black men show a steady increase in the rate of lung and prostate cancer, and the mortality rate from cancer was highest amongst black women -- very similar to national statistics.

Now my point in giving you this information is that if you do a risk factor analysis of the things that are killing people in excess and consequently putting them in a tertiary care system in excess which is causing a tremendous drain on the system -- because of the disproportionate cost of preventive care versus tertiary care -- you come up with some very interesting phenomena, things like cigarette smoking, which nationally accounts for over 360,000 deaths a year, is a major cause -- risk factor, a preventable risk factor in the things that are killing people in excess. Obesity is a major risk factor in diabetes, which kills and impairs in excess and which is the number one cause of blindness, for instance, in the black community and the number one cause of amputation. You find that chemical dependency, alcoholism as well as cigarette abuse, as well as hard drug abuse, is another major preventable risk factor to all of these diseases that we're talking about.

Something that hasn't been mentioned-- Negative stress, excessive, negative, uncontrolled stress is a major co-component of just about all the things that are putting people in hospitals in excess. Now these are all things that can be approached from a preventive standpoint.

If you look at the health care delivery system as the client or the patient, it's one thing to focus on the hospitalization of that client or putting that patient in the hospital -- the system itself -- but that's the more expensive way to go; when you should be looking at the health care delivery system as a client and looking at prevention as the mechanism to keep the health care delivery system out of the hospital.

I think that preventive services can better be provided in a nonhospital setting: physicians' offices, primary care clinics, and creative uses of community-based organizations like affiliation with church organizations acrossed the State; the training of laypersons in blood pressure screening; the training of laypersons in teaching self breast examination; and the stationing of mammography units at churches at periodic settings to do mammographies on a regular basis to get women involved.

We must also look at that fact that the communities we are concerned about have a different outlook on the health care institution that is based upon a crisis orientation of health care, a learned behavior of avoidance of a health care delivery system, and an orientation that says, "Enter the system at the last possible moment." It does not foster wellness. It does not foster prevention. We have a system that does not--

By the way, I should say that in addition to being Medical Director for the City of Newark, I also direct the Emergency Department in Newark at the United Hospital Medical Center, so I see both sides and my boys are in family practice.

ASSEMBLYMAN McGREEVEY: How's your stress level?

DR. TROUTMAN: I'm sorry?

ASSEMBLYMAN McGREEVEY: How's your stress level?

DR. TROUTMAN: It could be better. I do self hypnosis, too. I teach hypnosis. Let me take a minute and go into that with you.

All too frequently when our clients come into the Emergency Department what they get is absolutely what they do not need. Which is, continuity of care, comprehensiveness of care, and preventive care that's family based. We're talking about problems that, to a significant degree, are influenced by family instability, which is growing in our communities. What we get in the emergency room is just the opposite. It's not designed to do that.

I heard you ask several people, "What things would you cover?" Before I give you some specifics, the American Academy of Preventive Medicine, the American Academy of Family Physicians, the American Academy of Pediatricians, or/and others of the National Medical Association represent the interests of minority communities and the Office of Minority Health in Washington, D.C. and Atlanta, at the Centers for Disease Control. All have looked at what preventive measures need to be involved to keep someone healthy. So there are a number of models that exist across the country. The only problem with them is that they have used middle-class, healthy -- otherwise healthy white America as the standard. They have not looked at the needs of the black and the poor and the Latino population.

For instance, if one researcher says a Pap smear every three years in a 20-year-old or a 30-year-old woman is all that's necessary, that does not take into account that that woman is living in a high-risk environment, where there is a higher risk in sexually transmitted diseases. Consequently, she may need that Pap smear every year, even at age 20 as opposed to age 40 or 45 when it is going to be recommended on

an annual basis. So all of the studies that have been done, have to be modified with other influences who have expertise in the areas of minority health, to adapt them to the needs of the communities that are most at risk that we're talking about.

So, mammography should be universally covered. It is one thing that kills black woman in excess. There is no reason that that should not be a part of a preventive maintenance examination that should be covered for that woman. Routine health maintenance examinations on an annual basis, under many circumstances are not covered, and consequently, the private physicians in their offices are not going to be inclined to do them.

A related factor here-- The question of access to care is a very complex one. It's not simply a question of, is there a hospital or clinic in my community? Things such as, you know, hours of operation or transportation to and from, loss of time, waiting, as well as attitudes of the providers, have to be considered. What is the reason people are not going to the health care delivery system? Is it just that they can't get in the door, or is it their concern that the attitude of the providers is not going to be conducive to their using the system, either because of questions of sexism, racism, classicism, or just someone who just had a bad day and doesn't want to deal with somebody walking through the door?

In addition, the question of physician patient ratio is a key here. The GMENAC Report was published several years ago, said "There are going to be too many physicians in the United States by 1990." So the system started cutting back on seats, cutting back on access to subspecialty training, etc., etc. No one ever looked at the fact that the GMENAC Report only dealt with the total number of physicians in the country. It did not separate out primary care physicians; did not separate out physicians who traditionally worked in black and

Latino neighborhoods, meaning black and Latino physicians, and then took the total population and said, "This is the ratio of doctors to patients." By 1990 there are going to be too many."

Well in fact, if you look at the profile -- the disease profile -- of the typical African-American Latino poor population that goes to a clinic or hospital setting, there are multiple diseases. It's not a simple question of a blood pressure check. It's someone who has arthritis and diabetes and is obese and has negative stress, as well as having their blood pressure out of control. So a typical 15-minute visit, which is what physician patient ratios are usually based on, is irrelevant. That patient may need a 45-minute visit on a routine basis just to keep him going. That means the number of clients that can be seen in the course of a day is much less than we have assumed. Therefore, the need for additional physicians or other types of practitioners is much higher. That has to be analyzed and -- to my knowledge -- to this date, that has not been done.

I said I was going to be brief. I'm going to try and stop. Perhaps there will be some questions? Chemical dependency is a major factor. We've talked about that. Therefore, drug detoxification treatment to get individuals off drugs, inpatient and outpatient, should be covered. Support group work for family members, adult children of alcoholics, etc., should be covered. Those things are major preventive components that can keep somebody in a tertiary care system.

I don't see a full range of mental health services being provided in our communities with regular coverage. That should be taken care of. The private practitioner as well as the clinic should be available to provide services -- mental health services -- to individual clients and families, and know that he or she is going to be adequately reimbursed.

I could go on, but I know there are other speakers. I should stop and give you a chance for questions, but the one

thing I want to say is: There is a focus in the State, and nationally, on what is being called minority health; which is a term I don't particularly care for, but that's what is being bandied about, and that's okay for the time being.

The focus on minority health nationally, I think, is going to revolutionize the entire health care delivery system, because by definition it mandates that you have to look at the correlated factors of un-empowerment, underemployment, undereducation, housing, etc., and their impact on the health -- preventive health of any individual. The Office of Minority Health that is currently being debated just passed the Senate Committee on Monday. What is going to be talked about is the need for a greater cooperation of all agencies. and all statewide departments and commissions to address the issues of minority health, with prevention as its foundation.

Now, what that is going to do is spillover into all of our concepts of health care for the entire State and the entire nation, and we're going to finally recognize what people have been saying for all of these years; that prevention is the way and is, in fact, the answer. I'll stop here and take questions.

ASSEMBLYMAN McGREEVEY: Thank you for those very elegant words, Doctor. Mr. Felice?

ASSEMBLYMAN FELICE: I just would like to say, Doctor, that I think what you said -- what you categorized -- that if there's going to be a certain standard of medical treatment then it has to be for children, males and females, and also by geographic locations, and also by the type of people that you're treating. There can't be just one standard for all of the hospitals in New Jersey or anywhere else, because each area has certain specific problems with children, male and female. What you're saying is that it has to be a broad outlook. I agree with you that a lot of it has to be the support and preventative programs that other doctors have also spoken about. I think that is certainly going to be one of the factors when we consider what the standard should be.

DR. TROUTMAN: Well certainly the standard of care with quality as the ultimate objective has to be maintained across-the-broad for everyone, regardless of who they are, or what they look like, or what their pocketbooks look like. It distresses me to no end to hear the number one question out of the mouths of administrators and in some physicians' offices or in emergency rooms or clinics, when someone walks through the door: "Do you have insurance?" and, "What kind of insurance do you have?"

I have seen too frequently in my own emergency room, when the answer is: "The person has 'X' insurance or 'Y' insurance," and the respondent says, "Put the patient on medical service," as opposed to, "okay, what's the patient's problem?" and, "Let's deal with the insurance later on." That disturbs me to no end.

ASSEMBLYMAN McGREEVEY: All right, I just appreciate the concerns that you raised as does, I think, Assemblyman Felice regarding the scope of services that would best meet and address the needs of the uninsured. Thank you very much, Doctor. We hope to see you in the future.

DR. TROUTMAN: I hope you will.

ASSEMBLYMAN McGREEVEY: Thank you. At this time I'd like to call upon Dr. Paul Larson, Senior Vice President of Academic Affairs for UMDNJ. Dr. Larson?

P A U L L A R S O N, M.D.: Thank you. Coming to the table with me is Dr. Eric Munoz, who will be the speaker in place of Mr. Mark Lory, whose mother, I'm sorry to tell you, died early this morning. So Eric--

ASSEMBLYMAN McGREEVEY: Sorry to hear that.

DR. LARSON: --will be speaking in his place. Thank you for allowing us to come and make a presentation to you. I am representing Dr. Stanley Bergen, who happens to be in Chicago today Chairing a panel which is discussing many of the same issues that we are discussing here today.

Although many of you well know some units within the University of Medicine and Dentistry, I wish to briefly outline for you each of our component units that make up the University. We have three medical schools. The first medical school I want to talk about is in Newark. It is the New Jersey Medical School.

ASSEMBLYMAN McGREEVEY: Doctor, could you please just focus on the issue that's on the table today?

DR. LARSON: Okay.

ASSEMBLYMAN McGREEVEY: We'd appreciate it, considering the time restraints.

DR. LARSON: Okay. Well, I will have to come back and refer to them because part of the reason that I want to bring them up-- The solution to the health care cost is not a simple one. It's multifaceted; many issues, and part of the issue is education of the health professionals.

The University of Medicine is unique in that we are the only health science university within the State. We have three missions: education, research, and patient care. One of our goals is to make certain that New Jersey citizens can enter the health professions through affordable education programs, but we also see some other things that we need to do in the educational field. There are things that we can emphasize that can drive health care costs one way or another.

For example, the British system some years ago -- and I'm not advocating the British system -- found that if they used primary care physicians as their gatekeepers to entering into the more complex health care systems, they could lower the health care costs.

Managed care, HMOs now realize that also. At Robert Wood Johnson, one of our medical schools that I did not speak about, but which is located in Piscataway and New Brunswick and also has a clinical program in Camden at the Cooper Hospital--

Two-thirds of their graduates are entering into the primary care programs. This is important for you to realize that not only is this an unusual number, but--

ASSEMBLYMAN McGREEVEY: Doctor, with all due-- We will focus on the question of health care education and specifically physician training, but not at this session. We're focusing very stringently, and it's important that I keep this scope on the question of the Uncompensated Health Care Trust Fund, specifically what requisite threshold of benefits or what delivery system should be provided.

DR. LARSON: Then let me turn this over to my colleague, Dr. Eric Munoz.

ASSEMBLY McGREEVEY: Thank you, but we will-- I want to assure you that we are having an entire second phase of hearing that is focusing in--

DR. LARSON: Thank you.

ASSEMBLY McGREEVEY: --on the question not only of DRGs, but the appropriate question affecting greater reimbursement to provide for a quality university education in the health care system. It's something that I've spoken to Dr. Bergen about.

DR. LARSON: Okay.

ASSEMBLYMAN McGREEVEY: Thank you.

E R I C M U N O Z, M.D.: Thank you, Mr. McGreevey. I'm Eric Munoz. I'm the Medical Director of University Hospital and Associate Dean of the New Jersey Medical School. To focus on the issues you've just mentioned, as you know, University Hospital is the State's major teaching hospital and provides some 20% of the uncompensated days. So it is an institution that's heavily involved in the uncompensated care question. Also as former testimony has suggested, it's in the middle of a number of urban health delivery issues: AIDS, trauma, medical education, etc.

I think the first issue you raised about the thresholds and how do you finance a system of uncompensated care is a difficult kind of problem. I think that the situation in New Jersey and the current level of funding have aided us in avoiding what other states have in tremendous disarray in their health systems, their emergency care delivery systems, and in their hospitals' inpatient populations.

I believe that University Hospital and other hospitals like that would be well-served by a uncompensated care mechanism. The funding, either the current mechanism or funding through employer-based funding mechanism, which I think has been proposed-- In some way that funding must be maintained.

Number two: I think the issue of physician payment for uncompensated care must be addressed. Just last night I saw a gentleman in our emergency room who had advanced rectal carcinoma that was easily detectable for the last several years by a visit to a physician. When I asked him, "Why haven't you been to a physician?" he said, "Doctor, I don't have a doctor. I don't have any insurance." And this is a disease that's far advanced. That's something that I think you are going to need to address.

When it comes to the laundry list of what we provide-- There's been work both in certain states and at the Federal level to suggest that you can make a laundry list, and we can rank from 1 to 9999. That can be done. There are various mechanics to try to do that: What we rank higher than others, and is it a subject of discussion? The Oregon list is public, for example, and the Federal reimbursement methodology that looks at relative values is starting to do that same type of thing.

Whether that has an affect and what incremental effect that will have on health expenditures is yet to be seen, because there's quite a question about whether there will be an

aggregate impact on that, and whether that's just not a lot of rhetoric and a change to the system that adds up to more bureaucracy.

At any rate, I can say that the University Hospital, being a large urban hospital and the State's major teaching hospital, feels that to maintain some mechanism is of the utmost importance if, in fact, the mechanism is shifted to employer-based, and the residual of the patients that are still left and don't have employer coverage-- This needs to be addressed. The mechanics of addressing various kinds of procedures can be done, although I question the aggregate impact of that. Certainly that can be done, but I'd like you to think, as legislators, about whether, in fact, that will have an effect four years from now. It may or it may not.

I thank you for the ability to testify.

ASSEMBLYMAN McGREEVEY: Thank you very much, Doctor. I appreciate it, and I want to assure you that we will get back to the position question. Thank you very much for your testimony.

Our next two witnesses will be Sister Margaret Straney, President & CEO of Cathedral Health Care System, and then Mr. David Wagner of Saint Barnabas Medical Center. Sister? You spoke eloquently at the Governor's Commission not too long ago--

S I S T E R M A R G A R E T J. S T R A N E Y, R.S.M.: Thank you.

ASSEMBLYMAN McGREEVEY: --and forcefully.

SISTER MARGARET: I am Sister Margaret Straney. I am the President of Cathedral Health Care System. I believe you have a copy of my testimony, so I would like to just stress a few aspects of that in the interest of time.

ASSEMBLYMAN McGREEVEY: Thank you, Sister.

SISTER MARGARET: I think it's important to address the issue that access to quality medical care too often is

dependent upon economic status. I would like to echo support for Dr. Troutman's remarks relative to populations and the needs of different populations. We have a very, very cosmopolitan State. We need not develop a laundry list that's supposedly applicable to the entire population, but rather we have to look at people within the State of New Jersey and address the issue of specific need.

If we take a look, for instance, at infant mortality, a critical indicator of health status-- According to recent Department of Health statistics, the infant mortality rate for New Jersey is 10.6, but in places like Atlantic City, Camden, and East Orange, the rate is double that.

Those same statistics show that the percentage of women receiving inadequate prenatal care in New Jersey is 17%. But again, in Atlantic City that number is 60%; in Camden, 59%; in East Orange, 43%.

Exacerbating the problem of inadequate care and lack of accessibility to care is certainly the issue of the uninsured and the underinsured, and the statistics relative to the 37 million constitute, in many cases, the working poor. There are an additional 30-plus million who have inadequate insurance. About 11 million Americans with incomes below the Federal poverty level are not eligible for Medicaid, so the issue of addressing eligibility for Medicaid within the State of New Jersey is of paramount importance.

Moreover, employment is certainly no guarantee of health insurance coverage, so the idea of either assessing employers or requiring that minimum benefits be provided, I believe, is absolutely essential.

ASSEMBLYMAN McGREEVEY: Could you say that again, Sister?

SISTER MARGARET: I believe that it is absolutely essential to either mandate that employers provide minimum benefits or develop a tax assessment, if they choose not to do that.

In 1986, a Robert Wood Johnson Foundation survey found that at least one million Americans were denied access to necessary services because they couldn't pay. And in addition, 14 million who required health care did not seek it because they knew they could not afford it. It's this dynamic which, in part, has fueled the growth of the Uncompensated Care Trust Fund in New Jersey.

What we have today is a system of health care that affords people with private insurance, access to comprehensive and sophisticated health care services. But there are other individuals who work for companies that either can not or do not provide adequate health insurance, and these individuals often lack the personal resources to purchase health insurance on their own. There are still others, the truly indigent, who are totally dependent on health care coverage provided by government programs, and that coverage is often minimal. At the very least, we must strive for the establishment of an appropriate level of care for all, regardless of economic status, race, age, or geographic location. And yet, all of those factors need to be considered when, in fact, we decide what we are going to cover; what is going to be required in terms of coverage.

The best way to accomplish this goal is through the development of managed care systems which define a threshold level of benefits, provide direct linkages to existing providers, and properly reimburse providers for the care they deliver. As noted in a recent report from Bernstein Research, titled, "The Future of Health Care Delivery in America," networks of HMOs and PPOs with providers exist in other parts of the country that have become the basis of a managed care system. We in New Jersey must design and implement our own managed care system; one with a strong emphasis on primary care and prevention. Only by emphasizing wellness, health promotion, education, early diagnosis, and preventive care, can we achieve a system that is more equitable and cost-effective.

I mentioned in the next paragraph some things that I think are important, focusing on preventive care. I agree with Dr. Baker that unless we, in fact, compensate physicians, we are going to have an increasing number of physicians who absolutely refuse to care for Medicaid patients, to say nothing of those who are indigent and totally uninsured.

And if we have, in fact, a large group of quality physicians who will take care of these patients, down the road we will make a significant impact on the cost of health care, because if any person can choose a physician and that physician can be adequately compensated for the care of that patient, the patient will not avoid routine physicals. Appropriate diagnostic X rays and other laboratory testing, outpatient surgery when it's needed, well baby care, and routine physicals are of paramount importance, as well as immunizations, some physical therapy, prescriptions, home health visits, routine hearing and eye exams -- those kinds of things that allow a person to remain a productive individual in society.

We need to define what a healthy New Jerseyan is, and then we need to cover those things that are going to allow the healthy New Jerseyan to emerge. I did state in my recent testimony before the Governor's Commission that the emphasis today, unfortunately, remains on acute care rather than preventive care. And as I noted then, we must begin to move from a sickness model to a wellness model, which requires a true commitment to the concepts of wellness and disease prevention: That means providing adequate insurance coverage for individuals in need of maternal/child health care; this also means paying for the cost of mammographies and other preventive diagnostic tests that not only save lives, but also save millions of dollars on the other end.

That places us, however, on the horns of a dilemma, because if we begin to develop a health care system that's going to deal with a continuum of care, and we start by

allocating a significant portion of our resources to prenatal care -- to the young, then, in fact, we are going to neglect those who have already passed that segment of life. So initially, whatever managed care system we develop, I believe, has to concentrate certainly very heavily on the early years of life and on prevention -- early diagnosis -- but at the same time, must maintain the level of quality of life for those who have already moved along that continuum.

So, in the beginning, whatever we develop has to be phased in because it's going to take us a few years to experience the benefits of what we've applied in terms of prenatal care and postnatal care, well baby care, and so on. We, therefore, have to allocate our resources very, very carefully.

Through this Commission, and through the Governor's Task Force on Health, we have a unique opportunity to explore the development of a progressive managed care system. Such a program could serve as a model for the rest of the nation. New Jersey has already demonstrated its strong commitment to promoting adequate access to health care services with the establishment of the Uncompensated Care Trust Fund. A decade ago we developed a DRG program that served as a model for the nation, and we have 10 years worth of experience with that; some of it good, some of it bad. But we know that we need to evaluate that as we develop other systems.

A program that would emphasize prevention and primary care could ultimately save significant dollars by reducing the great need for costly acute care services that we experience today. This alone would relieve pressure on the Uncompensated Care Trust Fund.

But this goal cannot be accomplished unless payers, providers, and purchasers are all willing to take risks and set aside their own individual interests, which leave a just and equitable health care system. Only by focusing on the primary

and preventive needs of the consumer rather than the individual needs of disparate interest groups, can a cost-effective managed care system become a reality. Only then can a healthy New Jerseyan emerge, regardless of his or her race, color, creed, or more importantly, economic status.

ASSEMBLYMAN McGREEVEY: Thank you, Sister. Sister, I appreciate your comments. They seemed to echo what Dr. Troutman said regarding -- the points -- preventative care. Simultaneously, I also sense that you echo the comments to a certain degree of Dr. Baker; that you would not limit specific coverage. Then the question becomes that we, as a society, I would imagine, have to much more forcefully educate our population as to the availability -- if it is to be -- of preventative care, and also the utilization of that preventative care.

SISTER MARGARET: Yes. And we have to concentrate our resources and provide that preventive care.

ASSEMBLYMAN McGREEVEY: It's a tall order, Sister.

SISTER MARGARET: I know. I know.

ASSEMBLYMAN FELICE: Sister Margaret, just briefly: You mentioned something which is, I think, very important, and that is the fact that doctors be adequately compensated. I think this is something that is very important for the overall preventive picture, especially for those being compensated for uncompensated care type of preventative medicine, because the mandatory Medicare assignment certainly leaves a lot to be desired in watching some of the results of Massachusetts and so forth.

That's the one thing I'm concerned about. If there's mandatory assignment, what type of a program the very people that need that help the most -- and we're talking about those receiving uncompensated care, or Medicare -- would not have the services available of the medical profession, or those doctors who would completely get out of the program. So I think either there's a--

SISTER MARGARET: Many of them already have.

ASSEMBLYMAN FELICE: Yes, I know. And a lot of new ones are not coming into the State. That's a big concern of mine; that throughout, especially New Jersey, the very people that need the help-- There will not be enough professionals to take care of them. So that's a concern that I do have. I think the hospitals and medical profession and the health care organizations realize that, but I think that's the key. What you are saying is that they be adequately compensated.

SISTER MARGARET: If you want to keep patients out of acute care facilities with extensive illnesses that consume significant resources, there are going to have to be available to them physicians who will do the routine physicals and monitor their health over a extended period of time.

ASSEMBLYMAN McGREEVEY: Thank you, Sister.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you. I think Assemblyman Felice echoes the point. Mr. David Wagner from the Saint Barnabas Medical Center. Mr. Wagner.

D A V I D A. W A G N E R: I apologize. I was about to say "Good morning," but it is, "Good afternoon." Are you hearing me all right?

ASSEMBLYMAN McGREEVEY: The last person testifying will be saying, "Good night."

MR. WAGNER: I'm going to skip the preliminaries in my testimony, and if you would, turn to page 2 where I will continue from, because I know you want to get to the heart of the matter.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. WAGNER: In my opinion, we have to do five things:

1) We have to require virtually all companies in New Jersey to provide a basic health insurance program.

2) We have to expand Medicaid to its maximum potential.

3) We'll have to create a state-sponsored health insurance program to fill the gaps.

4) We'll have to invest in and encourage programs of prevention and early intervention.

5) And we will have to provide regulatory relief to encourage hospitals to expand ambulatory services.

Fortunately--

ASSEMBLYMAN McGREEVEY: Mr. Wagner, could you repeat those five, please?

MR. WAGNER: Sure.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. WAGNER: Require all companies in New Jersey to provide a basic health insurance program;

2) expand Medicaid to its maximum potential;

3) create a state-sponsored health insurance program to fill the gaps;

4) invest in and encourage programs of prevention and early intervention;

5) provide regulatory relief to encourage hospitals to expand ambulatory services.

Fortunately, we do not have to reinvent the wheel. At least two states, Washington and Hawaii, have gone through this process, and we can benefit from their experience. In 1974, Hawaii passed the Prepaid Health Care Act which mandates, with certain limitations, that all employers in the State provide health insurance to their workers.

Prepaid health care does not cover the unemployed, dependents, persons working less than 19 hours a week, seasonal workers, students, and low-income/self-employed persons. Now here comes the unfortunately thing, and it certainly relates to some of the testimony you've gotten today about having a law which requires all to provide:

Standard Oil successfully challenged Hawaii's Prepaid Health Care Act on the basis that ERISA preempted the states in

this area. Subsequently, Hawaii successfully gained an exemption from Congress.

ASSEMBLYMAN McGREEVEY: You have to admire Standard Oil's sense of conscience.

MR. WAGNER: Yes -- right. Specifically, the issue incidentally was alcoholism and drug abuse. They didn't want to provide that service, that coverage.

Given the fact that action by the Federal executive and legislative branches seems frozen by the deficit, maybe the Congress would be willing to amend ERISA to allow state experimentation. Short of that, New Jersey may have to follow a course similar to Rhode Island's, in which the state established a state administered fund.

With the exemption in hand, Hawaii has moved to fill the gaps by passing the State Health Insurance Program Act, referred to as SHIP. The creators and administrators of SHIP have, in turn, borrowed heavily from Washington State's Basic Health Plan.

The emphasis of SHIP is on prevention and primary care; health insurance instead of sickness insurance. It, thus, focuses heavily on services such as health appraisals -- well baby and well child care, AIDS screening programs, etc. -- and basic primary care -- 12 physician visits a year, laboratory and X ray, immunizations, and other preventive procedures. Heavy cost items, the secondary and tertiary care which drive up the cost of health insurance, are de-emphasized in SHIP, and some big ticket items such as transplantation and experimental treatments are clearly excluded. Clearly we're talking about some rationing here--

ASSEMBLYMAN McGREEVEY: Yes.

MR. WAGNER: --at least in their program. To carry out the program, SHIP contracts with major health insurers that do not try to run this as a State program per se. The average State subsidy per enrollee is expected to be $500. Each

enrollee must contribute on a sliding scale basis consistent with his or her income. Average monthly contributions are $20, with some enrollees paying nothing. A small copay of $5 is required at the time of the visit.

ASSEMBLYMAN McGREEVEY: May I interrupt you, Mr. Wagner?

MR. WAGNER: Yes.

ASSEMBLYMAN McGREEVEY: Who is eligible for the SHIP program?

MR. WAGNER: All of those who fall outside of existing systems, including the Medicaid program. There are usually people who are unemployed, who may be self-employed--

ASSEMBLYMAN McGREEVEY: Is there a income eligibility limit?

MR. WAGNER: Yes, there is.

ASSEMBLYMAN McGREEVEY: Okay.

MR. WAGNER: It's on a sliding scale basis.

ASSEMBLYMAN McGREEVEY: So they have been--

MR. WAGNER: It's based on the Federal Poverty Index.

ASSEMBLYMAN McGREEVEY: So, I understand the sliding is regarding the copayment. But can anybody enroll in the SHIP program, or do you have to fall within those?

MR. WAGNER: You have to fall within certain poverty guidelines, yes.

ASSEMBLYMAN McGREEVEY: Okay. Thank you.

MR. WAGNER: There's also a test concerning your income and your assets before you can be entered into the program.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. WAGNER: There's no discrimination between public and private providers. A public health department offering screening programs is as much a part of the service network as our major hospitals. I have brought along a copy of the Act and the regulations, and so on, and so forth. Your staff may

have already obtained it. If not, then it's here for you. There are just two other items that I would like to touch on briefly, I know the time is short.

We have talked about intervention. We have had a gentlemen here who is a fine public health officer and is running a fine public health department. His public health department is the exception in New Jersey, not the rule. We have one of the weakest, most archaic health systems in the United States. It needs to be fixed. It's based historically on home rule, and it provides us with a series of small, underfunded, public health departments whose major contributions are well inspections and free rabies shots. I'm not saying that that's necessarily bad, but there's a lot--

ASSEMBLYMAN McGREEVEY: You don't pull any punches do you, Mr. Wagner?

MR. WAGNER: No. You asked me to come here and tell you what I thought, so I'm going to do that.

You must encourage the creation of regional health departments, offering screening and prevention services and even personal health services.

Finally, we must demand regulatory reform so that major providers like hospitals are encouraged to provide ambulatory care outside the hospital setting in cooperation with local health departments, without suffering the adverse effects of a rate-setting system which discourages this course of action. Further, we should exempt hospitals willing to offer these programs as a nonprofit service from the certificate of need process.

And I might add, finally, a good example of hospital-public health cooperation could be found in the City of Philadelphia, which has 10 public health centers. They are the primary care source for thousands of Philadelphians. They are linked to hospitals in Philadelphia by contract. Many physicians from those hospitals man the public health centers.

Unfortunately, we don't have public health centers in New Jersey because we don't have the kinds of laws that encourage that sort of development.

I thank you very much for allowing me to testify here today, and I hope that this has been of some benefit. I'm ready for questions.

ASSEMBLYMAN McGREEVEY: Thank you. It's been of significant benefit. We've heard a couple of these suggestions before, but I just want to touch on your thoughts on-- You said, "Virtually all companies in New Jersey ought to provide a basic health insurance program." What would be constituted within that program?

MR. WAGNER: I think the major emphasis has to be on primary care, to make sure that people get to see the doctor; sort of the HMO concept of seeing a doctor early, being cared for early, with secondary emphasis on inpatient services. It may be because of our-- There's obviously a budget crunch in New Jersey like everywhere else. It may be -- and I would certainly echo what the Sister said -- that we have to phase us in, and we may not be able to provide the kinds of benefits that we should provide as we go through this process.

ASSEMBLYMAN McGREEVEY: What would be the differential between the coverage -- between what you mandate for all companies in New Jersey, in terms of their basic health insurance, and the state-sponsored health insurance program that you referenced, namely Hawaii? Would there be a variation in requisite level of mandated coverage?

MR. WAGNER: I would hope not, but again I think we have to be realistic about our financial resources and it may have to be so. I would hope that the basic program that's provided by the State would meet the same standard as the basic program provided by our industries. I think it's from a standpoint of meeting the need. That needs to be done, but again we have to go through a phase process and we may not be able to do all we would like to do.

ASSEMBLYMAN McGREEVEY: And you would recommend the adoption, I suspect, of the Hawaii Self Health Insurance Program Act as a stopgap measure?

MR. WAGNER: Well, I would recommend it as a concept. I would not say that I recommend the kind of rationing that Hawaii is going through. Now, they are doing that for a very practical reason. They do not know what their exposure is going to be and they don't want to jump into it with both feet and arms. So they want to phase through it and see what happens. You might say, however, interesting enough, that in the State of Hawaii there are only 5% of the population that does not have health insurance.

ASSEMBLYMAN McGREEVEY: Only five?

MR. WAGNER: Only five, which we can see is the benefit of requiring all companies to provide that kind of coverage.

ASSEMBLYMAN McGREEVEY: And basically the SHIP Program is insuring those individuals who are not employed?

MR. WAGNER: That 5% that is not.

ASSEMBLYMAN McGREEVEY: That 5%--

MR. WAGNER: Yes.

ASSEMBLYMAN McGREEVEY: --who are not Medicaid eligible?

MR. WAGNER: That is correct.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. Wagner. Assemblyman Felice?

ASSEMBLYMAN FELICE: I was just going to ask a similar question. The health care program -- the unemployed dependents, and those people working less than 19 hours a week-- They would not be covered under SHIP then?

MR. WAGNER: They would be covered under SHIP.

ASSEMBLYMAN FELICE: They would be covered? Well, just the opposite then?

MR. WAGNER: That's the group that you are picking up.

ASSEMBLYMAN FELICE: Okay. Thank you.

MR. WAGNER: You're quite welcome.

ASSEMBLYMAN McGREEVEY: Thank you, Assemblyman. I had the same question -- thought that Assemblyman Felice did. Thank you very much, Mr. Wagner.

MR. WAGNER: Thank you.

ASSEMBLYMAN McGREEVEY: I'd like to call upon Dr. Salvatore Liguori from Robert Wood Johnson Hospital. Thank you, Mr. Wagner.

**S A L V A T O R E L I G U O R I, Ph.D.:** Thank you, Mr. Chairman and members of the Assembly Health Care Policy Study Commission. Good afternoon. Thank you for allowing Robert Wood Johnson Hospital to come before you and offer testimony on how New Jersey should deal with the problems of providing access to high quality care for those 850,000 of our residents who don't have health insurance, and how to accomplish that worthy goal fairly and equitably.

My name is Dr. Salvatore Liguori, and I am a Vice President in the Corporate Services Division of our hospital. With me today is Anthony J. Schinella, Vice President and Controller in our Finance Division.

I'm also going to deposit my comments with you and try to get right to the saliant points. As a mater of fact, I think that everyone here knows that Robert Wood Johnson is a 106-year-old hospital. We've been providing services for all those years, primarily primary care services until such time as 1977 -- recent history -- when we affiliated with the University of Medicine and Dentistry of New Jersey. Robert Wood Johnson Medical School became their primary teaching hospital, and over the years between 1977 and 1990 we've been providing a whole bunch of tertiary care services. In fact, our hospital has turned into a tertiary referral center. As you read through my comments -- and I hope you will -- you'll see statistic and data that support that.

ASSEMBLYMAN McGREEVEY: Could we have copies of your statement?

DR. LIGUORI: I will provide them for you.

ASSEMBLYMAN McGREEVEY: Okay. Thank you. Thanks, Robert.

DR. LIGUORI: There are also comments in there that I think show the responsibility of our hospital and, indeed, other hospitals to provide for new technology and new equipment and advances in health care in as cost-effective a way as possible. We've been doing that by regionalizing through agreements with other hospitals, mainly St. Peter's Medical Center, under the banner of New Brunswick Affiliated Hospitals, and also a 10-hospital consortium, including ours, to provide lithotripsy services in the region. Those kinds of cooperative arrangements can, in fact, reduce the costs of health care because the costs are obviously spread over a greater number of hospitals, and there's no need for those hospitals cooperating in those kinds of joint efforts to duplicate the technology at the competitive sites. I think that's a very important consideration.

The hospital provides tertiary care on a regional basis as well as to the inner-city residents of New Brunswick, for whom it's provided primary care services for more than a century. The provision of services at Robert Wood Johnson has always been based on the principle of universal access. We hold firmly to the belief, as others have expressed here this morning, that it is completely inappropriate to discriminate among patients on the basis of race, sex, national origin, religion, handicap, ability to pay for needed services, or whether patients have health insurance or not.

Last year our uncompensated care burden went over $11 million for the first time. But part of that cost was for the care of some pediatric AIDS patients, some pediatric oncology patients, and for some patients suffering the ravages of

chronic disease. Except for the fact that the cost burden should be more equitably distributed, we consider that the $11 million was well spent. Our poor and needy deserve the best care we can give.

In this regard, the hospital opposes any regulation mechanism that results in the creation of a two-tiered system of health care that would qualify any segment of the population for less than our total healing efforts.

We suggest that the Commission retain the current universal access to hospital care in New Jersey, simplify the hospital reimbursement system we currently have, and reform its financing. Undeniably, the present reimbursement system provides equal access to hospital care for the poor and medically needy. Mechanisms need to be devised for establishing equitable, stable, and broad-based alternatives to funding the Uncompensated Care Trust Fund. An approach patterned on the State Unemployment Insurance and Disability Fund as will be outlined later in the presentation of the University Health System of New Jersey by its Executive Director, Dr. Tom Terrill, appears to meet these criteria and is very attractive. Certainly, other approaches have been suggested to you. Others still exist and deserve your attention.

For our part, we stand ready to provide our best efforts to help you, Mr. Chairman, and your Commission, to work through these alternatives and to help you devise legislation that is fair and equitable, not only to payers and not only to hospitals, but also to all of New Jersey citizens including those 850,000 residents we mentioned earlier who don't have health insurance but currently have access to hospital care.

ASSEMBLYMAN McGREEVEY: Thank you, Dr. Liguori, and we look forward to Dr. Terrill's remarks. Assemblyman Felice?

ASSEMBLYMAN FELICE: I think that was very informative.

ASSEMBLYMAN McGREEVEY: Thank you very much.

DR. LIGUORI: You are welcome, thank you.

ASSEMBLYMAN McGREEVEY: In that light, I'd like to call upon Dr. Thomas Terrill, Executive Vice President of University Health System. You may want to give a copy of this to any of the press in the back who want a copy.

T H O M A S T E R R I L L, Ph.D.: Good afternoon. Thank you very much for allowing the University Health System of New Jersey to present testimony today. I'm going to dispense with formal testimony. The people you heard from today, especially Mr. Kornett, Mr. Lloyd, Dr. Baker, Dr. Troutman, and Sister Margaret Straney, as well as Dave Wagner and Sal Liguori, have really said it all.

The Uncompensated Care Trust Fund has to be preserved. New Jersey is a State that provides the best access to hospital care in the nation. What's missing? It doesn't provide for physician payment, which is necessary to keep physicians working to provide those services because if we don't, it's not fair. Secondly, there is a mechanism that already exist within the State funding system that's called the SUIDIS Program. Some employers pick up the costs for their employees; other employers do not. Last year that fund cost me $86, and most taxpayers who paid it, that's what it cost them. It generates $600 million a year -- $600 million a year.

If you extended that fund for two more months--

ASSEMBLYMAN McGREEVEY: You are referring to the State Unemployment--

DR. TERRILL: Yes. If you extended that fund for two more months you would have -- and expanded your Medicaid definitions and used those dollars to support your Medicaid program, in addition to the dollars your are already spending, you would generate in excess of $1 billion a year to provide the dollars to fund not only the uncompensated care program, but to expand the definition of what uncompensated care could provide.

ASSEMBLYMAN McGREEVEY: I'm sorry I--

DR. TERRILL: Those remarks are not specifically--

ASSEMBLYMAN McGREEVEY: No, it wasn't-- Your saying to utilize the State-- How much are you saying the State Unemployment Insurance and Disability Fund has?

DR. TERRILL: Well, right now it has in excess of $2 billion sitting in it. I'm not asking you to use those funds. Those are restricted legally.

ASSEMBLYMAN McGREEVEY: That's what I thought.

DR. TERRILL: That's the economic model we're suggesting. The economic model is that if you take that approach--

ASSEMBLYMAN McGREEVEY: The SUIDIS approach?

DR. TERRILL: Yes, and extend it for--

ASSEMBLYMAN McGREEVEY: Health care coverage.

DR. TERRILL: --health care coverage. Don't attack the present SUIDIS, but use that economic model.

ASSEMBLYMAN McGREEVEY: I understand.

DR. TERRILL: Then expand your Medicaid base. You will generate in excess of $1 billion a year, if you do it for two months. Make it $160 for every employer and every employee in the State. Then if you expand your Medicaid definitions, you pick up 50% of the cost from the Federal government.

The last major point we'd like to make is Blue Cross/Blue Shield is the insurer of last resort; no question about it. But give them a level playing field. If you're going to do business as a insurance industry in the State of New Jersey, why are you allowed to do experience rating? Think about taking a look at the impact of telling all health insurers, "You can't have experience rating. You have to go to community rating." All of a sudden it spreads the economic base.

As a quick example of that, General Motors has used ERISA to cover its own employees. That was wonderful 10 years

ago when they had a young working population. Now they're very sorry they did that. As their employee population ages, their costs are going up dramatically. And what do they want to do? They want to point the finger at the industry that says, "Oh the hospital costs are too high. Doctors are charging too much." Sorry, that's not where the problem is.

ASSEMBLYMAN McGREEVEY: So, Dr. Terrill, would you utilize the-- Say if you had by analogy an analogous financial solution to SUIDIS and you would provide-- I've got two questions: Would that be utilized-- Say, for example, you taxed, in a sense, all employers. That would be utilized to cover your recommending just those who are working, or would that be used -- all of those who are working?

DR. TERRILL: Those funds would provide the alternate source of funding, or the Uncompensated Care Fund, number one.

ASSEMBLYMAN McGREEVEY: Ok, but when we talk about uncompensated care--

DR. TERRILL: Right.

ASSEMBLYMAN McGREEVEY: --you're not suggesting an analogous, fiscal mechanism such as SUIDIS, which we use to cover Medicaid obviously?

DR. TERRILL: Correct. I am not.

ASSEMBLYMAN McGREEVEY: Okay. But are you suggesting -- and it's a interesting concept-- Are you suggesting that it cover all those who are employed?

DR. TERRILL: Correct.

ASSEMBLYMAN McGREEVEY: Solely those who are employed?

DR. TERRILL: Correct.

ASSEMBLYMAN McGREEVEY: So wouldn't that be used--

DR. TERRILL: Regardless of if you're a single person. I'm a new Ph.D. I'm out there doing consulting. I'm in business. I'm a subchapter s. I'm sorry, you've got to pay.

ASSEMBLYMAN McGREEVEY: But it would not be used to pay for those who are indigent?

DR. TERRILL: I think with the kinds of dollars you'll generate from that fund, you can take those dollars because there will be money left over. You can support some of the Medicaid programs that you want, and expand its definition.

ASSEMBLYMAN McGREEVEY: This is very much what Governor Cuomo-- I don't know if you--

DR. TERRILL: Yes.

ASSEMBLYMAN McGREEVEY: --procured a copy of his State of the State Address. Basically he's saying, "What you do is reduce insurance premiums, in a sense, because you create a tax structure that basically broadens the risk pool among the broadest aspect of the population and you enable small businessmen, in a sense, to participate and alleviate some burden from the insurance pool."

DR. TERRILL: Absolutely. But what we're simply saying is, that is a very effective mechanism. It's also not nearly as expensive as some of the other programs that have been suggested in other states. I have been fortunate enough in my 30-year career to work in Washington; to work in the Pacific Northwest; to work in Pennsylvania; and now I have enjoyed the benefits of living for five years in New Jersey. And I can assure you that this is the best program that you have going right now.

ASSEMBLYMAN McGREEVEY: Now, in terms of benefit design--

DR. TERRILL: Yes?

ASSEMBLYMAN McGREEVEY: --would you specifically mandate certain benefits in areas? Or, how would you encourage utilization of medicine? I guess the first question is, would you mandate? If you kept an open book, how would you increase utilization of specific benefits such as preventative care?

DR. TERRILL: Mandated benefits are extremely dangerous because what happens is, you get a series of interested groups coming forward saying, "Expand the benefit

package, too." And that will drive your costs up over time. Our suggestion would be to work with your staff to define "medically necessary benefits." The medically necessary benefits should have physician input to provide for both outpatient services and inpatient services.

There is a little glitch in the system that can be changed. Hospitals, right now, function under a very unfair reimbursement rule. They have to assign costs to their operations, their outpatient departments, based on their inpatient overhead, which really makes it a very unfair cost allocation.

ASSEMBLYMAN McGREEVEY: We will address that in the second set of hearings.

DR. TERRILL: I know you will, but I just-- It's that kind of a mechanism. I think there are hospitals which would be willing--

ASSEMBLYMAN McGREEVEY: But when you come up with what you determine to be medically necessary, then you are basically what Dr. Baker suggested and what Sister suggested: You are narrowing the scope of what constitutes reimbursable procedures.

DR. TERRILL: I would not recommend narrowing the scope of reimbursable procedures.

ASSEMBLYMAN McGREEVEY: Well, when you say medically necessary--

DR. TERRILL: Oh, I'm sorry, yes. From the point of view of elective gallbladders, fine. They are not paid for under the uncompensated care program. And for the plastic surgery intervention -- that all of us need, who are going to be 50 and more -- yes, I think those can be controlled and eliminated. I don't think you should be misled by saying that we don't ration care. Of course we do. We ration care everyday. Those who are extremely wealthy are getting augmentation procedures done all the time that their regular benefits do not cover. We're not focusing on that.

ASSEMBLYMAN McGREEVEY: The last question that I have is: When you create this, if you will, insurance mechanism that would significantly address the problem of the working uninsured, and say, for example, you were for the universal health care coverage policy--

DR. TERRILL: Yes?

ASSEMBLYMAN McGREEVEY: --would you-- You would do nothing, though, to prohibit obviously an employer from having increased insurance coverage?

DR. TERRILL: Correct. I think the issue of creating incentives for the employer--

ASSEMBLYMAN McGREEVEY: To go beyond--

DR. TERRILL: To go beyond should be maintained in your legislative package, absolutely.

ASSEMBLYMAN McGREEVEY: Thank you. Assemblyman Felice?

ASSEMBLYMAN FELICE: The question that was in my mind with this program that you have is the proceeds of this $86. You know, we're going to get $500 million. If it's $100, we're going to get $1 billion, in the course -- as the needs--

DR. TERRILL: Grow?

ASSEMBLYMAN FELICE: --increase. So let's say, "Well, gee, maybe we'll start with $200 a person." Aren't we, in a sense, starting with a basic package? You started Blue Cross/Blue Shield, and they just repackage A, B, C, D, or extended coverage. So isn't it similar to starting a similar type of a package?

DR. TERRILL: I think people will eventually opt for programs that they'll want protection for. I'll give you a quick example: A young family with young children is going to need and require a broader scope of benefits. They should have access through your system to purchasing those benefits.

Interestingly enough, when you get to be my age you have a need for only one kind of health insurance program. That's high-risk catastrophic illness. My last visit to a

physician was about five years ago. Why: I'm lucky? I'm a Caucasian? I have a good gene pool? I'm pretty healthy, except for the high stress job that we have. I don't need a bucket of health insurance. Furthermore, I've got a wife who's twice as smart as I am. She works for AT&T. She's got the best benefits package you've ever seen. So my company doesn't need to provide me with any insurance at all. That's another issue that can be addressed, and private business is going to go after it. You watch. They are going to start to eliminate the double coverages that do exist.

But that's not the focus of our concern. The focus of our concern is, how do we get the underinsured and the uninsured covered and protected, so that they'll want to get out there and provide the care? What incentives do we provide for the employer, and also the institutions and physicians to go out there and seek those patients? Let's stop practicing come-and-get-it medicine, and let's go out there and get the people in here. I think that's where we're trying to come from.

Our document has a big huge "draft" stamped on it. Why? Because we don't think we have all of the answers. Some of us think we have some pretty good questions, and we would like to work with you as you move forward, and with your staff, to try and, one, run the numbers, see what the issues are, and see if we can't come up with an effective package. Our whole message is "Look, I represent eight teaching hospitals within the State of New Jersey. We think we have the brightest and best executives in our operations, both CEOs, Chief Financial Officers, and Clinicians. We'd like to have a chance to work with you."

ASSEMBLYMAN McGREEVEY: I especially also appreciate your note that Medicaid has arbitrarily shifted their health care costs to local payers in recent years and how this is impacting an otherwise unfortunate, not level, playing field.

DR. TERRILL: The Feds have done it to us in two ways. They've done it with the Medicare cost shift and with ERISA.

ASSEMBLYMAN McGREEVEY: ERISA, sure.

DR. TERRILL: So, they are really dumping all the responsibility on the State. The nice thing about New Jersey is, New Jersey has taken the lead in the past and it can take the lead again. No question about it.

ASSEMBLYMAN McGREEVEY: Thank you very much, Dr. Terrill. I appreciate it and I look forward to reading the draft in its entirety.

DR. TERRILL: Thank you.

ASSEMBLYMAN McGREEVEY: At this time Beverly Roberts, Director of the Mainstreaming Association for Retarded Citizens.

B E V E R L Y R O B E R T S: Good afternoon. I'm going to be giving you an abbreviated version of my testimony in the interest of time. I am the Director of the Mainstreaming Medical Care Project, a project of the Association for Retarded Citizens of New Jersey.

Mainstreaming Medical Care was developed as a means of identifying barriers to community-based medical care for persons with developmental disabilities, and to recommend ways to overcome those barriers. The project works in cooperation with physicians, nurses, and other health care professionals to provide increased access and a coordinated approach to medical care. I'm here today to talk to you about the barriers blocking access to health care.

These barriers extend from developmental disabilities in an unborn infant to servicing adults with very complex medical conditions. In talking about prevention -- and we've heard a lot about prevention this morning; prevention in general -- I want to briefly discuss prevention of mental retardation and developmental disabilities.

I'd like to call your attention to an extremely important statistic: Over 50% of all developmental disabilities can be prevented by providing good health care to pregnant women and young children. We need to focus attention on health care problems that can be prevented prior to the woman becoming pregnant.

Here is one illustration: If a woman is not immunized against German measles or rubella prior to her pregnancy and she contracts the disease during pregnancy, the devastating result may be a child who is mentally retarded, deaf, and blind. You cannot give an injection to this woman after she becomes pregnant, so it does no good to go to a clinic, find out she's pregnant, and then test her to see if she has immunization against rubella.

This type of thing must be administered before pregnancy. If you think of the relatively small expense of these immunizations before a woman becomes pregnant, versus the lifelong headache and enormous expense that results when nonimmunized women give birth to multiple handicapped babies, it just becomes critical that this type of thing be considered. This is a form of mental retardation that is so easily preventable.

The next area that I'd like to address is the financing of medical care. People with developmental disabilities often have other complicating medical conditions. Finding the financial resources to pay for needed health care services is often difficult or impossible. For people who are Medicaid recipients, doctors -- many doctors -- no longer accept Medicaid as a form of payment for services. We're seeing this over and over again. A person will call and describe that they have a person with a developmental disability on Medicaid and they'd like to have service, and the nurse says, "I'm sorry, we're not accepting Medicaid."

New Jersey, as you've heard earlier, has one of the lowest Medicaid reimbursement rates in the nation. Doctors get only $14 from an office visit. Now, in the population of people who are developmentally disabled, this low reimbursement rate is further complicated because it usually takes longer to examine a patient who is developmentally disabled than it does a nondisabled patient. This is due in part to their inability to describe their symtoms. It's hard for them to explain their medical history, and they also have fear about medical procedures. So it takes time to work with them and help them to understand. You can't just go in and do a procedure that on another person might take two minutes. It might take a half an hour of talking and calming them down and working through what this whole procedure is about.

What we need is a Medicaid fee structure that recognizes that physicians are going to take more time with some patients who are developmentally disabled, and they need to be reimbursed for that extra time.

Another problem is the long period of time for Medicaid approval for certain types of care. For example: In dental work, long delays typically occur when an individual who is Medicaid eligible needs to have a dental appliance redone. The approval process can be extremely slow, sometimes taking many months before approval is given. During that time, the individual must function with no teeth, or with a partial dental plate. Eating is a major burden at that point and malnourishment is possible.

Now, one side of this, of course, would be with good preventive dental care; then you are not going to have as much of this. But in years past, people with developmental disabilities never saw the dentist. So now when they are in adulthood, and for years and years they never got dental care, you are seeing a lot more than you would have in the general population of people who have dental plates, and the real severe dental needs have to be addressed.

An additional concern is that Medicaid does not pay for maintenance of physical therapy. That would be therapy to maintain the level of ambulation that a person has already achieved. This can lead to devastating and expensive results. I'm going to give you a brief case example:

The Jones family consists of Mrs. Jones, who's in her 70s and her two daughters who are in their 40s. Both daughters have cerebral palsy and mental retardation. The daughters are living at home with their aging mother. Both of the daughters walked at one time, but they lost that ability. Because of Mrs. Jones' advancing age, she's not able to lift the adult daughters and put them in a wheelchair. The family now requires a home health aide to help out around the house. That's about four hours a day, five days a week, every week, of home health aide services. Medicaid also had to provide two wheelchairs and a very costly hydraulic lift to get the daughters out of bed in the morning and into the wheelchair. Medicaid had covered all of these expenses. These expenses could very well have been avoided if ongoing physical therapy had been available so that the daughters would be able to continue to walk.

Medicaid recipients are not the only ones to suffer from inadequate coverage. There are an increasing number of medically fragile infants and children from middle-class families whose parents do have private health insurance, but that insurance is inadequate to meet the child's health care expenses which sometimes can be extremely costly.

One example of this is the Barnes family which is comprised of a mother, a father, a six-year-old boy, an 18-month-old girl, and an infant boy. The husband has private insurance through his place of business. Two of the children are quite healthy. But there is an 18-month-old -- who I'm going to refer to as "Katie" -- who was born with multiple congenital anomalies, including mental retardation, a cleft lip

and palate, and congenital heart disease. The only way that little Katie can receive any nutrition is through a nasogastric tube that is passed through her nose into her stomach. She needs to be tube fed every hour around the clock, meaning that she gets 24 feedings per day, everyday. With other types of feeding, Katie would choke and vomit and would not be able to get any nourishment. So this is the only thing that will work for her.

Because the family did have insurance coverage, they were able to have nurses from 11:00 p.m. to 7:00 a.m., and also from 9:00 a.m. to 5:00 p.m. five days a week to provide the feedings and also other care that Katie needs including oxygen from time to time. However, the Barnes family has just used up all of its home nursing coverage. The standard rate paid to visiting nurses is about $35 per hour. The family is not going to be able to afford to pay for this nursing care that they so desperately need to keep their daughter at home. The father's job requires a two-hour daily commute each way, everyday. So most of the burden for caring for Katie and the other two children is on the mother. The family is close to the breaking point now that private insurance will no longer pay for Katie's nursing care at home.

Finally, there is also a tremendous financial burden on middle-class families who are self-employed, and are therefore, not eligible for the group health insurance rates. An example of this is the family of five in which the father owns a small welding business. They have a six-year-old son who has Down's syndrome, and because of this child's disability -- and this child at this point is really very, very healthy, but purely because he's been diagnosed as having Down's syndrome -- the family is required to pay $5600 per year for health insurance. This is a policy that is just hospitalization; no major medical coverage, no prescriptions.

This is just for the hospitalization, which they haven't needed, but of course that's something that they need to have, just in the event of an emergency.

ASSEMBLYMAN McGREEVEY: Beverly?

MS. ROBERTS: Yes?

ASSEMBLYMAN McGREEVEY: In the interest of time, one of the critical questions that I'm concerned with -- especially as it impacts -- is the barriers. I wonder, in the interest of time, if you could focus on-- Because I hear what you are saying in terms of reimbursement levels, and I fully appreciate it-- We will read especially the unique circumstances in terms of families' insurance coverage, but one of the things that doesn't get discussed often enough, unfortunately, is the barriers. I wonder if you could focus on that?

MS. ROBERTS: Okay, You are now talking about the barriers in getting insurance?

ASSEMBLYMAN McGREEVEY: The barriers -- exactly who needs health care -- to people with developmental disabilities.

MS. ROBERTS: Okay. If people are on Medicaid there are barriers and things that aren't covered, like the physical therapy that I just mentioned, long delays in paperwork, the very low Medicaid rates and the fact that physicians don't want to have to take the extra time. Sometimes they won't take a patient all together because they know that a DD person is going to require extra time and a tremendous amount of paperwork will have to be done. Some physicians have said that they prefer not using Medicaid at all, and they provide donated care. I mean some physicians are doing that, but it means that only a small portion of the people who need the medical care are getting it.

For instance, you have in a community one physician who's very caring and willing to work with this population. But what happens is, once people find out that this physician has this caring and this interest, everybody in the whole

community who has a developmentally disabled person wants that physician to treat them. That's an unfair burden on that one physician, and then he ends up starting to turn people away.

There's another real problem in that there are sometimes real complex cases that develop. The community physician never got the education in medical school and has to deal with some of these real complex cases. So either he's not treating the patient or he's mistreating the patient, sometimes with psychotropic medications or in other ways. There's a problem with thyroid disease that often occurs with people with Down's syndrome and physicians who happen to know about this, know that you want to monitor regularly people with Down's syndrome to see if they're developing a thyroid abnormality.

A lot of physicians just don't know this at all, and you can have a person going to the doctor in the community thinking that they're getting good care, and all of a sudden you have a serious problem because something like thyroidism or heart disease is not picked up. So we need to have specialties where this kind of care can be provided, and communicated to the physicians who never got the training.

ASSEMBLYMAN McGREEVEY: These specialty care centers-- You would be recommending them for those who have developmental disabilities?

MS. ROBERTS: What the ideal is, in the community-- We want people to be seen by the physician in the community for those cases where it can be done that way. But sometimes there are real complex cases. Sometimes there are very extremely challenging behaviors that just can't be accommodated in the regular doctor's office. I want to see a continuum, where you have the kinds of service available from the physician at the corner who can take some cases, down to a highly specialized center for real involved cases.

ASSEMBLYMAN McGREEVEY: Thank you. Assembly Felice?

ASSEMBLYMAN FELICE: Yes, thank you, Mr. Chairman. I've been very much involved the last 25 to 30 years with the developmentally disabled, and the facts that you bring up are so important. Few people realize that over 50% of the mentally disabled people can be prevented. A very simple thing like rubella-- I mean in certain countries like Australia and New Zealand, it's mandatory when a young lady reaches a certain age that she gets that shot. These are just some of the things people don't even consider. There is a preventative type of medication or vaccination that could prevent a large number of these cases.

And I agree, having been involved in a community and mental health program, that it's most important that there be some kind of process put into effect to give that community care, that help. If you don't initiate that help in the community, when the parents do pass away, now we have an institutionalized client that has to be taken care of with the proper treatment where there is therapy or assistance. Those people could then be part of the process without being a real detrimental financial burden to the community and the State.

And I commend your organization because I know the work that you are doing, and yes, that is something that has to be addressed. As you say, it has to be a separate issue. Because you know, and I know, that the medical programs that we have and the health care -- a lot of these things are not covered at all. And it's true. There are doctors that do dedicate themselves and give up their time. I hear of the problems they have, even a dentist who takes care of these patients. So I commend you, and I'm sure that will be covered in future discussions. Thank you.

ASSEMBLYMAN McGREEVEY: I just want to echo Assemblyman Felice. Assemblyman Felice has been champion in this regard for many, many years as I'm sure ARC is aware. I just always admired the work that you people do in terms of

being concerned with barriers to the developmentally disabled. In a rush to address the larger health care questions, we're sensitive to those unique needs.

MS. ROBERTS: Thank you.

ASSEMBLYMAN McGREEVEY: So thank you very much for taking the time.

MS. ROBERTS: Thank you very much.

ASSEMBLYMAN McGREEVEY: Next will be Carlton Levine, then Ms. Jane Adams and Dr. Gordon Boals. Is Mr. Levine here?

C A R L T O N L E V I N E: Yes.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. LEVINE: Well, my testimony starts out saying, "Good morning," but obviously it's, "Good afternoon." My name is Carlton Levine and I am the Health Care Organizer for New Jersey Citizen Action. I would like to thank the members of this Commission for the opportunity to share New Jersey Citizen Action's views on the problems of access to health care in this State. I will limit my remarks today to the particular issues of this hearing. However, we are eager to speak to many other important issues that are relevant to the work of this Commission, and look forward to an invitation to share those views in the near future.

As many of you know, New Jersey Citizen Action is the State's largest citizen coalition with over 82,500 individual members and more than 65 affiliated organizations. These groups represent community, labor, senior citizen, tenant, environmental, and religious organizations. All of these groups are extremely concerned with the problems of our current health care system.

New Jersey Citizen Action believes that the only fair and cost-effective solution to the current problems of our health care system is the establishment of a truly universal comprehensive system that covers everyone. We believe that we

can provide all medically necessary coverage to every resident of the State, spending the same total dollars -- or less -- that are spent today, through the efficiencies of a single-payer system. And yes, it can be done on the State level, as many states are now in the process of developing or implementing such plans.

ASSEMBLYMAN McGREEVEY: Mr. Levine, would you endorse the concept that was put forward by Dr. Terrill?

MR. LEVINE: Can you refresh my memory as to that?

ASSEMBLYMAN McGREEVEY: The utilizing of a simple physical mechanism to SUIDIS.

MR. LEVINE: We'd look at a broad-based tax, and certainly since a large portion of the medical dollars spent today come through employers and come through employee sharing, that would seem to make sence as a way of shifting the cost burden adequately to the current sources of health care dollars.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. LEVINE: As to the specific question of the requisite level of health coverage necessary for the uninsured or for any New Jersey resident, we believe that it is inappropriate for a legislative body to determine which specific medical and health related procedures should be available to people unfortunate enough to be uninsured. Such decisions cannot be made coldly as a cost issue. All medically needed procedures should, and must, be available to every resident of our State.

Such decisions must be left to the professional judgment of doctors in close consultation with their patients. Doctors and other health professionals must be given the freedom to determine what procedures are medically necessary.

This is not to suggest, however, that there are not ways of reducing medical costs. Firstly, we need to change the emphasis of our health care system. By providing proper primary and preventative care, we can significantly reduce the need for expensive tertiary care.

Secondly, the State can reduce the costs by improving the quality and uniformity of care. We can reduce the use of procedures and tests by disseminating practice guidelines. The State must research the variations in the use of procedures across the State, as the second study that I handed you relates to, and the one Assemblyman McGreevey saw previously estimated of 20% to 30% of procedures are unneeded.

ASSEMBLYMAN McGREEVEY: An estimated what, excuse me?

MR. LEVINE: An estimaed 20% to 30% of procedures are unnecessary.

ASSEMBLYMAN McGREEVEY: What do you mean: that they're unnecessarily performed?

MR. LEVINE: They're performed without medical need.

ASSEMBLYMAN McGREEVEY: Okay, thank you.

MR. LEVINE: And that's documented in the first study that I showed you.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. LEVINE: Once this is done through the use of small area analysis, such practice guidelines can be improved. Once this is done, the State can then educate doctors and other health professionals as to the most effective treatments. Through developing proper guidelines and disseminating this information, the number of procedures can be reduced, yet no one would be denied the procedures necessary in the judgment of their health care professional. Of course, encouraging second opinions aids this effort.

Lastly, we can significantly reduce medical costs by thoroughly assessing new technologies prior to their widespread application. Too often, expensive new technologies are sold to hospitals and other medical institutions only to have it discovered at a later date that these are no more effective, or even less effective, than cheaper alternatives.

Clearly, we can reduce costs without keeping medically needed procedures from the uninsured. New Jersey Citizen

Action believes that it is imperative that the steps outlined above be taken. We further believe that the only way to address the many and far-reaching problems in the health care system is through a universal comprehensive approach. We are currently developing a specific plan, largely based on the experience of other states as well as nations, which we will present to this Commission in the near future. It is imperative that this Commission adopt such an approach. We must ensure all of our State's residents affordable and accessible quality care, beyond that currently being provided through hospitals. Health care is, after all, a right; not a privilege. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. Levine, and I look forward to your specific plan when you develop it. I would appreciate that as expeditiously as possible.

MR. LEVINE: We are currently in the process of going through materials in order to provide a proper program. It's going to take a bit of time yet--

ASSEMBLYMAN McGREEVEY: Sure.

MR. LEVINE: --but we will certainly expedite the procedure.

ASSEMBLYMAN McGREEVEY: Thank you. Assemblyman Felice?

ASSEMBLYMAN FELICE: Thank you very much.

MR. LEVINE: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much for your patience. I'd like to call upon Dr. Gordon Boals -- excuse me, I'm sorry, Ms. Jane Adams, President, New Jersey State Nurses Association. Thank you, and to all of the witnesses who are here. I appreciate your patience and indulgence.

D O R O T H Y D. F L E M M I N G, M.S.N., R.N.: Mr. Chairman, I am Dorothy Flemming, Executive Director, taking Ms. Adams' place. I'm probably being a little hypoglycemic, but-- The New Jersey State Nurses Association appreciates the opportunity to provide testimony today.

Raising the level of health care for the uninsured would certainly relieve the Uncompensated Health Care Fund, accept that much of the care required by the uninsured is inappropriately provided in high cost acute care institutions instead of private providers' offices. The two reasons that I think these have been addressed in other testimony--

ASSEMBLYMAN McGREEVEY: One day we're going to make sure that all of the preventative people listen to what the hospitals say, and all of the hospitals listen to what the preventative people say.

MS. FLEMMING: But they all left.

ASSEMBLYMAN McGREEVEY: Exactly.

MS. FLEMMING: Obviously the rooms are open 24 hours a day, and they are obliged to treat whoever appears. As many of the speakers have addressed, our emphasis, also, is on preventive care. If preventive care was given, that could prevent the emergency room calls.

We urge the Legislature to consider the tally of reimbursement policies that ignore preventive care and licensure policies that prohibit the reimbursement needs and prescriptive needs of advanced practice nurses.

Advanced practice nurses have been developed in the past 20 years to provide the kind of care to all income levels that is now only available to those who can afford physician care. The constraints on nursing practice by the medical establishments has been profound. Physicians within various State departments refuse to allow full practice and reimbursement, and require overzealous monitoring of advanced practice nurses, inappropriate to their education level. The Legislature should consider those bills that have been introduced to expand nursing practice and reimbursement such as Senator Lipman's S-2100 and Senator Orechio's S-2007 and S-2008.

In considering health care procedures that should be covered by health insurance policies -- and obviously this does

not include everything -- NJSNA support things that have been talked about, such as mammography, pap test, well baby assessments, immunization, and obviously coverage for drug and alcohol treatment.

NJSNA is not invested in the present system of health care delivery. We are actively stating a change in emphasis from tertiary care of the acutely ill to preventive care of the well. We are actively seeking a change in keeping all control invested in the physicians and allowing advanced practice nurses to join the health care team as equal partners.

Thank you.

ASSEMBLYMAN McGREEVEY: I just want to say thank you, because I appreciate the role Andrea and yourself and the New Jersey State Nurses Association are playing. I think specifically you have a much more significant role to play as not only a cost-effective provider of health care, but with an understanding that especially will aid in preventative care and, therefore, preserve the well. I appreciate the Nursing Association -- the State Nurses Association -- taking the time to testify, so could you please express our sincere gratitude to Ms. Adams?

MS. FLEMMING: I will.

ASSEMBLYMAN McGREEVEY: Thank you very much.

ASSEMBLYMAN FELICE: And I echo those thoughts.

ASSEMBLYMAN McGREEVEY: Assemblyman Felice, you have--

ASSEMBLYMAN FELICE: No, no, no, no. It was just exactly what I had in mind -- the work they do, and many times they get unfair criticism.

ASSEMBLYMAN McGREEVEY: At this time I'd like to call upon a Brenda Considine -- excuse me, Gordon Boals for the New Jersey Psychological Association.

G O R D O N E. B O A L S, Ph.D.: I am a licensed psychologist in the State of New Jersey. I'm here representing the New Jersey Psychological Association. In the interest of time, I'm

going to just abstract some of my remarks and get to the bottom line. It was a great pleasure today to hear so many able spokespeople, like Dr. Troutman, Sister Straney, and others speaking so eloquently on behalf of prevention, because prevention seems so often to get overlooked in these debates about health care insurance.

Of course, one of the most important elements in prevention which was underlined by Dr. Troutman is mental health. There are many, many studies indicating the importance of mental health treatment reducing dysfunctional families, reducing substance abuse of all kinds, reducing stress levels, and thereby lowering lots of other medical costs. The problem is that increasingly, insurance companies, in attempting to offer low-cost insurance programs and employers trying to find low-cost insurance programs, cut mental health programs.

And so, in addition to the million people who have no health insurance, there are many, many more people in the State who have health insurance but no coverage for mental health. And the question is, how should this problem be handled? There are really two ways you can go: One is to use millions of dollars of tax money to support publicly funded clinics, because the mental health problem isn't going to go away; it has to be addressed. So the question is, do you do it through tax dollars and publicly funded clinics, or do you do it through private health insurance and mandated coverage for mental health? We strongly believe that the latter approach is a better one. I'm aware that there are several bills, including some sponsored by Assemblyman McGreevey, which are attempting to expand substance abuse -- to include drug abuse in addition to alcohol.

I wanted to draw you attention to some bills which specifically attempt to mandate mental health coverage. Those introduced by Senator--

ASSEMBLYMAN McGREEVEY: Senator Codey.

DR. BOALS: --Codey and Assemblywoman Ogden and Assemblyman Otlowski. These bills have been around for awhile. The legislative process has cut the benefit levels very severely, to below the point where we think is really unnecessary or desirable, but they would get the principle instituted, and they would provide some very necessary benefits -- the amounts I've given you in the following paragraph.

An additional option, which I wanted to draw your attention to -- which is under consideration in Pennsylvania and some other states -- would be to provide even more flexibility in mandated mental health coverage by allowing some portion of the inpatient benefit to become available for outpatient use, since judicious use of outpatient would reduce much larger costs for inpatient in many cases. So I wanted to thank you for your consideration in this.

ASSEMBLYMAN McGREEVEY: Thank you very much, Dr. Boals. I appreciate your last suggestion as being very responsible. Assemblyman Felice?

ASSEMBLYMAN FELICE: Yes, I also agree. I think that's an important part of the preventative medicine picture, the psychological approach to outpatients. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much, Dr. Boals. Brenda Considine for the Center of Outreach and Services for the Autism Community. Is Brenda here? (no response) Okay. Thank you. Pat Buckley from MCOSS Nursing Services. Is Pat here?

P A T R I C I A B U C K L E Y: Yes.

ASSEMBLYMAN McGREEVEY: Thank you Pat.

MS. BUCKLEY: You have my testimony--

ASSEMBLYMAN McGREEVEY: Yes.

MS. BUCKLEY: --so I'll try and make this very short. I am Pat Buckley, a Supervisor at MCOSS Foundation. MCOSS is a voluntary, nonprofit home health agency. Let me begin with the problem of access to care for woman, infants, and children. As

you know, the Public Health Priority Funding which supports prenatal and well child clinics in New Jersey will be discontinued as of July 1. With this funding gone, Medicaid becomes the only financial access to care to many of the working poor.

Due to the Federal mandate, the access to Medicaid insurance will increase to 133% of the U.S. poverty level. However, there are many more women, infants, and children above this 133 level of poverty who still cannot afford adequate health care. Many advocacy groups report the necessity to raise the eligibility level to 186% of the poverty level, to meet the health needs of these women and children.

For the underinsured and uninsured, middle-aged adult, preventative health care is an impossibility. Pap smears, mammograms, and colon cancer smears are not available to many. When they are ill, this same population does not have the ability to obtain the necessary sick care services.

Health care services to the homebound mentally ill are available only on a limited basis or not available at all. Clients at the end of their lives who wish to die at home surrounded by their loved ones do not always have the ability to secure hospice benefits. Care for these most vulnerable members of our society should be available universally.

Care in the home versus care in the institution is frequently not an option. Certainly not all health care programs need to be carried out in hospitals. Screenings and health care can be, and is, provided in community-based clinics and in the home. The Uncompensated Care Trust Fund, available to hospitals, should be expanded to include community health care agencies.

Also, not all care need be carried out by physicians. Nurse specialists and nurse practitioners can provide equally comprehensive care in a most cost-effective manner.

We at MCOSS strive to provide services to all clients, regardless of ability to pay. The agency provides much uncompensated care through Fund raised dollars, but financial limitations exist. The State must be responsive to the health care needs of all New Jersey residents. On behalf of MCOSS and the client we serve, thank you.

ASSEMBLYMAN McGREEVEY: Pat, I just want to thank you, not only on behalf of the MCOSS Foundation which has done an extensive amount of work in this region, but also because of the point you raised about home health care services. I'm sure you saw the Pepper Commission report that talked about how we can take care of four individuals in the home health care setting for every one in the nursing home or the acute care facilities settings. Clearly this is a cost-effective and also fundamentally more humane method. So I thank you. Assemblyman Felice?

ASSEMBLYMAN FELICE: I also echo those thoughts because I think what we're trying to say is, an agency such as yours has been very, very instrumental in preventing some of the problems that may develop without that care. I see that that need is actually going to increase, more than decrease as far as financial aid is concerned. But by expanding those services to the health care and community, I think it's a big step in the right direction. I thank you.

MS. BUCKLEY: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you, Pat. I appreciate your waiting.

We just have two more individuals. Robin Zimenoff of the United Cerebral Palsy of the State of New Jersey. Is Robin still here? (no response) And the last person, and we appreciate it very much, is Marian Ross of UMDMJ. Is Marian here? (no response)

I'd just like to thank everyone who remained, for your thoughtfulness. I'd like to thank the press for their

thoughtfulness and patience in waiting -- the staff that's here, the members of OLS, but especially Assemblyman Felice, who for so many years has been a champion in this regard and is consistently a voice for the importance of accessibility to health care. Thank you very much.

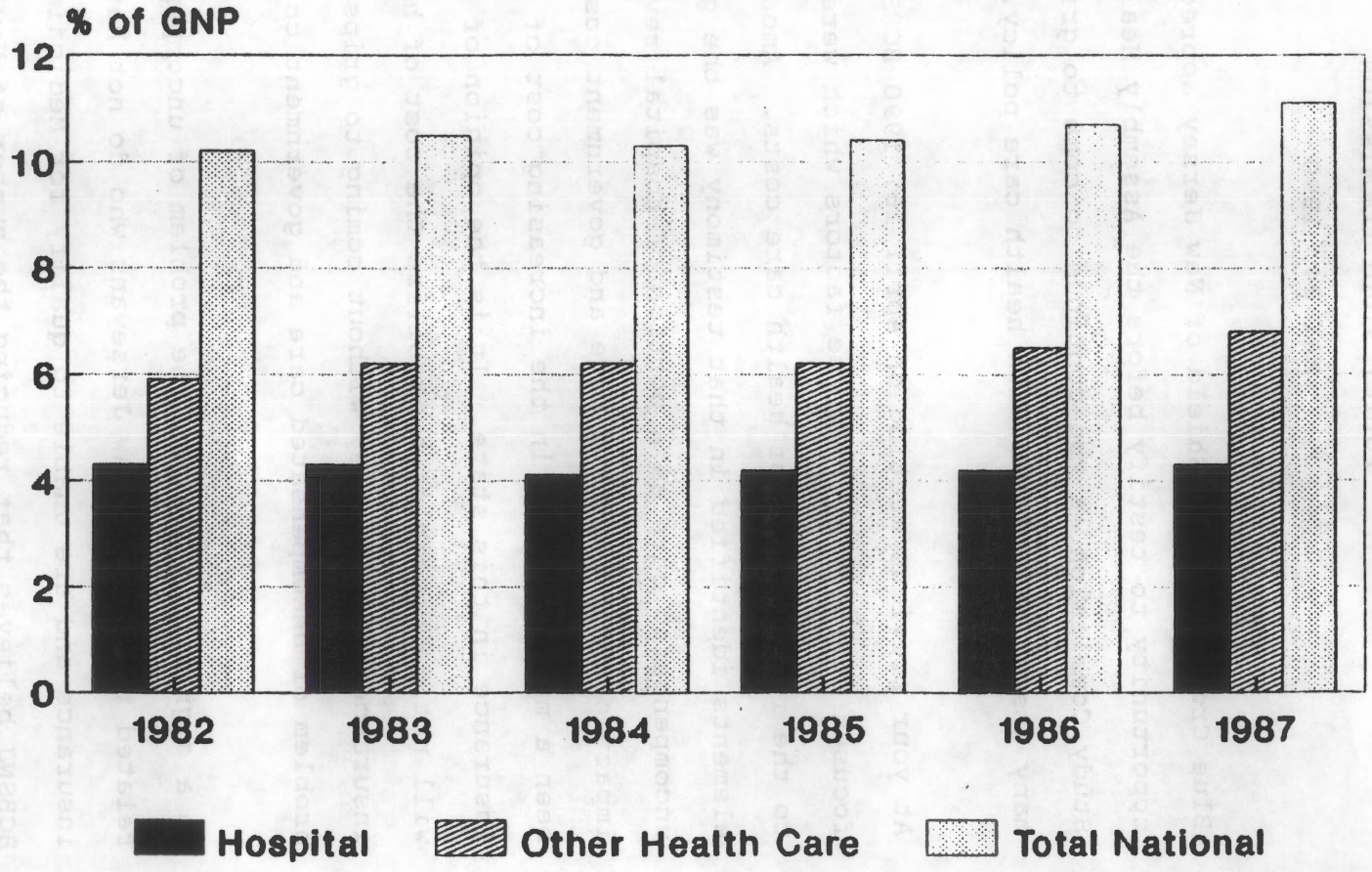
ASSEMBLYMAN FELICE: Mr. Chairman, I thank you for the opportunity to be a part of this. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much. And this has concluded our hearing.

(HEARING CONCLUDED)

# APPENDIX

# NATIONAL HEALTH CARE EXPENDITURES AS A PERCENT OF GNP




Source: HCFA, Office of the Actuary

BLUE CROSS AND BLUE SHIELD OF NEW JERSEY

STATEMENT TO THE ASSEMBLY HEALTH CARE

POLICY STUDY COMMISSION

MAY 24, 1990

Blue Cross and Blue Shield of New Jersey appreciates the opportunity to testify before the Assembly Health Care Policy Study Commission as you continue to come to grips with the many issues associated with health care policy.

At your previous meeting on April 16, 1990 BCBSNJ's testimony focused on identifying those factors which were contributing to the rapid growth of health care costs. Among the major elements identified in that testimony was the growth of uncompensated care as a portion of hospital revenues. The impact of uncompensated care and government cost shifting has been a major element in the increasing cost of health insurance in this state. It is the opinion of BCBSNJ that it will not be possible to stabilize the cost of health insurance in New Jersey without coming to grips with the problem of uncompensated care and government cost shifts.

To a significant extent, the problem of uncompensated care is related to the many New Jerseyans who do not have health insurance and are unable to qualify for Medicaid coverage. BCBSNJ believes that reducing the number of New Jerseyans who do not have access to insurance, be it through the private

sector or through the Medicaid program, would help ease the explosive growth of uncompensated care and cost shifting. Controlling that rate of growth, or in a best case scenario, actually reducing these factors as a percentage of overall hospital revenues would be beneficial to those groups and individuals who currently purchase health insurance.

In your invitation to BCBSNJ to testify at today's hearing you reference an interest in determining the requisite level of health care coverage necessary for the uninsured to offset the need to utilize the Uncompensated Care Trust Fund. In considering this question the first thing which this Commission should recognize is that the Uncompensated Care Trust Fund does not reflect the true cost of uncompensated care. Individual hospitals can apply to the Hospital Rate Setting Commission for adjustments to their reimbursement rates to cover the cost of uncompensated care which is not recoverable through the Trust Fund. BCBSNJ estimates that nearly 30 cents of every $1.00 of hospital premium BCBSNJ collects pays for the care of someone other than our customers.

As the last statement illustrates, uncompensated care and government cost shifting most clearly impact the amount of premium which needs to be collected to cover hospital costs. In reconsidering the problem of the uninsured it is, therefore, prudent to focus on ways in which they could be

given access to hospital insurance coverage. BCBSNJ recognizes that coverage of medical expenses associated with hospitalization is only one element of health care. However, it is this particular component of the health care system which is directly effected by uncompensated care and government cost shifting. It is also, in the opinion of BCBSNJ, that area of health insurance where the uninsured most need, and perhaps want health insurance coverage.

When the Blue Cross system was initially established over fifty years ago, it was designed only to provide hospitalization insurance. Over time the health insurance marketplace expanded to include coverage for physicians services and a wide range of other health care benefits. The growth of the health insurance industry into these areas is clearly a by-product of customer demand. Today the overwhelming majority of the insured population have coverage which is significantly more expansive than hospitalization insurance. BCBSNJ clearly believes that for most purchasers, health insurance coverage which goes beyond benefits for services rendered in a hospital setting, is not only appropriate, but it is what the customer wants.

However, as health care costs increase it is becoming more difficult for certain employers, as well as individuals, to purchase or maintain health insurance. This fact increases

the number of people who are uninsured, resulting in an increase in uncompensated care. More uncompensated care results in even higher insurance premiums and the cycle begins again.

BCBSNJ is currently involved in examining various benefit designs which would allow us to have the ability to put forward a product which would cause a significant number of small businesses to purchase health insurance for their employees. In researching these products, BCBSNJ is evaluating the way to achieve a product design which is not only affordable, but provides levels of coverage which are sufficiently broad to cause customers to wish to purchase that coverage.

In designing products of this type it seems critical to include reasonable levels of cost sharing, as well as the ability of the insurer to manage care. Cost sharing can best be defined as deductibles and copayments. Requiring the insured customer to pay for a portion of their health insurance care before insurance reimbursement begins to take effect, or begins to reimburse eligible services at a 100% level, will cause the insured customer to be a more prudent utilizer of health insurance benefits. The concept of managed care allows the insurer to determine that the health care services are being rendered in the most cost effective manner possible.

BCBSNJ believes that it is the private insurance marketplace which provides the best mechanism by which to solve the problem of the uninsured. There are, however, several things which would enable the insurance industry in general, and BCBSNJ in particular, to meet this challenge.

A basic health insurance product could be made more affordable if it did not have to include mandated benefits. Currently, there are numerous bills pending which would mandate additional benefits in insurance contracts. There are also several mandated benefit laws currently in place in New Jersey. It would require action by the New Jersey Legislature to allow BCBSNJ and other insurers to offer insurance products for sale which do not include these mandated benefits. Removal of these mandated benefits would clearly reduce health insurance costs, while at the same time offer the basic protection that the public wants and needs.

The Legislature should also consider enacting legislation which provides tax credits and other incentives to small businesses which provide health insurance coverage to their employees.

In previous testimony BCBSNJ recommended expansion of the Medicaid program, as well as additional efforts to improve

collection efforts under the existing hospital finance system; we continue to endorse these changes since they should work to stabilize the cost of health insurance.

The Assembly Health Care Policy Commission has correctly focused its attention on how to go about reducing the number of uninsured in this state. Reducing the number of uninsured will not only improve that group's access to health care, but it will also reduce the pressure on the insured population to finance the cost of hospital expenses for the uninsured.

The task of developing insurance products which will provide necessary levels of care and still remain affordable is a challenge for all insurers including BCBSNJ. It is, however, an integral part of finding a solution to the health care cost crisis in New Jersey. BCBSNJ recognizes its role as a key player in finding a solution to this problem; working with this Commission, Governor Florio's Commission and other interested parties, it is our belief that it will be possible to develop health insurance products which will reduce the number of uninsured in New Jersey.

TESTIMONY OF

DANIEL L. MARCANTUONO, PRESIDENT

The General Hospital Center at Passaic

on

ACCESS TO HEALTHCARE IN NEW JERSEY

to

ASSEMBLYMAN JAMES E. McGREEVEY

and

THE STATE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

JFK Medical Center

Edison, NJ

May 24, 1990

8X

MR. CHAIRMAN, COMMISSION MEMBERS, MY NAME IS DANIEL L. MARCANTUONO, PRESIDENT AND CEO OF THE GENERAL HOSPITAL CENTER AT PASSAIC, PASSAIC, NEW JERSEY.

WE ARE THE COMMUNITY HOSPITAL THAT BROUGHT TO NEW JERSEY ONE OF THE FIRST REGIONAL CARDIAC SURGERY CENTERS MORE THAN 35 YEARS AGO. WE ARE A FACILITY WITH A DISTINGUISHED REPUTATION FOR PROVIDING A BROAD RANGE OF PRIMARY, SECONDARY AND SELECTED TERTIARY SERVICES IN A COMMUNITY-HOSPITAL SETTING. THE GENERAL WAS STARTED BY THE PASSAIC CITY MEDICAL SOCIETY IN 1891 AS A FREE DISPENSARY FOR ACCIDENT VICTIMS AND OVER THE YEARS HAS GROWN INTO A PRESTIGIOUS 303 BED HOSPITAL

THE GENERAL HAS NEVER IN ITS 99-YEAR HISTORY EVER TURNED ANYONE AWAY BECAUSE THEY COULD NOT PAY. HOWEVER, OUR CONCERN TODAY MORE THAN EVER IS THE CONTINUED SOLVENCY OF THE HOSPITAL WHICH IN PART IS MADE POSSIBLE THROUGH THE UNCOMPENSATED CARE TRUST FUND.

THIS TRUST FUND HAS PROVIDED A MECHANISM WHEREBY THE HOSPITAL HAS A SOURCE OF PAYMENT FOR NEW JERSEYANS UNABLE TO PAY. PRIOR TO THE CREATION OF THE FUND,THE HOSPITAL HAD NO OTHER SOURCE OF PAYMENT FOR THESE PATIENTS.

THE GENERAL HAS EXPERIENCED OVER THE LAST THREE YEARS AN AVERAGE INCREASE IN OUR UNCOMPENSATED CARE COMPONENT OF APPROXIMATELY 2% PER ANNUM. IN 1989 THE GENERAL EXPERIENCED A 12% UNCOMPENSATED CARE RATE AND WE HAVE NO REASON TO BELIEVE THAT THIS WILL NOT GO UP IN 1990. THESE INCREASES ARE OCCURING DESPITE OUR BEST EFFORTS TO COLLECT THESE MONIES. MAY I NOTE HERE THE HOSPITAL IS SUBJECT TO VERY STRINGENT STATE MANDATED CREDIT AND COLLECTION REGULATIONS TO ASSURE THAT EACH HOSPITAL DOES GIVE ITS BEST EFFORT TO AN ACCOUNT BEFORE IT IS DECLARED A BAD DEBT.

WE HAVE OBSERVED AT LEAST ONE FACTOR CONTRIBUTING TO THIS INCREASE:

- NOT ALL MEDICAID ELIGIBLE PATIENTS ARE IN FACT ENROLLED IN MEDICAID. ONCE THE PATIENT PHYSICALLY LEAVES THE HOSPITAL WE DO LOOSE CONTROL SINCE WE CANNOT FORCE ANYONE TO GO TO THE NEAREST MEDICAID OFFICE TO COMPLETE THE NECESSARY PAPERWORK.

WE WOULD SUGGEST A MECHANISM BE ESTABLISHED WHEREBY EACH HOSPITAL BE EMPOWERED TO COMPLETE THE MEDICAID APPLICATION WHILE THE PATIENT IS STILL IN THE HOSPITAL. IN THIS WAY WE COULD ASSURE THE SYSTEM THAT ALL PATIENT MEDICAID ELIGIBLES ARE FULLY ENROLLED.

WE MAY ALSO NOTE THAT BY BROADENING ELIGIBILITY REQUIREMENTS MORE PEOPLE CAN QUALIFY AND COUPLED WITH OUR SUGGESTION HAVE ALL NEW JERSEYANS ELIGIBLE TO TAKE FULL ADVANTAGE OF FEDERAL DOLLARS DO SO.

WE AT THE GENERAL SUPPORT THE NEW JERSEY HOSPITAL ASSOCIATION'S POSITION THAT THE STATE MUST CONTINUE TO GUARANTEE ACCESS TO CARE FOR ALL INDIVIDUALS AND SOME MECHANISM FOR PAYING FOR THAT CARE MUST BE MAINTAINED AND GOVERNMENT MUST ACCEPT AND PLAY A LARGE ROLE IN ADDRESSING THESE NEEDS. MY EARLIER SUGGESTION RELATIVE TO MEDICAID PROCEDURE MAY HELP IN THIS RESPECT.

IT SEEMS CLEAR THAT TO DEVISE A WAY FOR OTHER MONIES TO AUGMENT THE UNCOMPENSATED CARE FUND COULD EVENTUALLY MAKE HEALTHCARE MORE AFFORDABLE FOR ALL AND AS MR. SCIBETTA HAS NOTED, "STOP UNFAIRLY BURDENING THE HOSPITALIZED PATIENT WITH THE PRICE OF CARING FOR OTHERS."

MY HOSPITAL WILL CONTINUE ITS WELLNESS PROGRAMS DESIGNED TO HELP OUR COMMUNITIES STAY HEALTHY SINCE THIS IS A BASIC TENNET OF WHY THE GENERAL EXISTS BUT ULTIMATELY WE TOGETHER MUST ASSURE AFFORDABLE AND ACCESSIBLE HEALTHCARE FOR ALL NEW JERSEYANS.

I THANK YOU FOR THE TIME YOU HAVE ALLOWED ME TO PRESENT THESE COMMENTS.

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

ACCESS TO HEALTH CARE IN NEW JERSEY

PUBLIC HEARING

THURSDAY, MAY 24, 1990

10:00 A.M.

PRESENTED BY:

MARGARET J. STRANEY, R.S.M.
PRESIDENT AND CHIEF EXECUTIVE OFFICER
CATHEDRAL HEALTHCARE SYSTEM
ONE GATEWAY CENTER, SUITE 2600
NEWARK, NEW JERSEY 07102-5311
(201) 642-5100

12X

MY NAME IS SISTER MARGARET J. STRANEY. I AM PRESIDENT AND CHIEF EXECUTIVE OFFICER OF CATHEDRAL HEALTHCARE SYSTEM, A MULTI-HOSPITAL SYSTEM SPONSORED BY THE ARCHDIOCESE OF NEWARK. I AM GRATEFUL TO HAVE THE OPPORTUNITY TO SPEAK BEFORE THIS COMMISSION.

THE ISSUE OF PROVIDING ACCESS TO AFFORDABLE HEALTH CARE BY ALL SEGMENTS OF THE POPULATION IS PERHAPS THE MOST CRUCIAL HEALTH CARE ISSUE FACING THIS COUNTRY. IN EXPLORING THIS ISSUE WE MUST ANSWER TWO BASIC QUESTIONS: WHAT IS A HEALTHY NEW JERSEYAN? WHAT BASIC SERVICES ARE NEEDED TO CREATE AND MAINTAIN AN ACCEPTABLE LEVEL OF HEALTH IN OUR STATE?

WHILE STRIDES IN TECHNOLOGY HAVE REVOLUTIONIZED MEDICAL TREATMENT, OUR ABILITY TO DELIVER HEALTH CARE IN A COORDINATED, EQUITABLE MANNER HAS NOT KEPT PACE. ACCORDING TO A RECENT REPORT FROM THE CATHOLIC HEALTH ASSOCIATION, ACCESS TO QUALITY MEDICAL CARE TOO OFTEN IS DEPENDENT ON A PERSON'S ECONOMIC STATUS, AGE, PLACE OF RESIDENCE, OR RACE. FACTORS SUCH AS IGNORANCE AND POVERTY ARE EFFECTIVE BARRIERS TO HEALTH CARE, EVEN IN THE MIDST OF ADVANCED TECHNOLOGY AND ADEQUATE RESOURCES. A WHOLE RANGE OF "SOCIETAL DISEASES," SUCH AS AIDS AND SUBSTANCE ABUSE, AFFECT THE HEALTH CARE NEEDS OF INDIVIDUAL SEGMENTS OF THE POPULATION AND MUST BE CONSIDERED AS WE DEFINE A BASIC LEVEL OF HEALTH CARE.

LET'S LOOK FOR A MOMENT AT INFANT MORTALITY, A CRITICAL INDICATOR OF HEALTH STATUS. ACCORDING TO RECENT DEPARTMENT OF



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HEALTH STATISTICS, THE INFANT MORTALITY RATE FOR NEW JERSEY IS 10.6 PERCENT. BUT IN PLACES SUCH AS ATLANTIC CITY, CAMDEN, AND EAST ORANGE, THE RATE IS DOUBLE THE STATE AVERAGE.

THOSE SAME STATISTICS SHOW THAT THE PERCENTAGE OF WOMEN RECEIVING INADEQUATE PRENATAL CARE IN NEW JERSEY IS 17 PERCENT, BUT IN ATLANTIC CITY THAT NUMBER IS 60 PERCENT; IN CAMDEN 59 PERCENT; IN EAST ORANGE 43 PERCENT.

EXACERBATING THE PROBLEM OF ACCESS TO HEALTH CARE IS THE GROWING NUMBER OF UNINSURED AND UNDERINSURED INDIVIDUALS. THERE ARE CURRENTLY IN THE UNITED STATES 37 MILLION UNINSURED INDIVIDUALS; ABOUT 12 MILLION OF THEM ARE CHILDREN. AN ADDITIONAL 20-30 MILLION AMERICANS HAVE INADEQUATE HEALTH INSURANCE. MEDICAID, DESIGNED TO PROVIDE HEALTH INSURANCE TO THE POOR, CURRENTLY COVERS LESS THAN HALF OF THAT POPULATION NATIONALLY. ABOUT 11 MILLION AMERICANS WITH INCOMES BELOW THE FEDERAL POVERTY LEVEL ARE NOT ELIGIBLE FOR MEDICAID. MOREOVER, EMPLOYMENT IS CERTAINLY NO GUARANTEE OF HEALTH INSURANCE COVERAGE. IN FACT, ONE OF THE LARGEST AND MOST RAPIDLY GROWING GROUPS IS THAT OF THE WORKING POOR - - WORKING PEOPLE WHOSE EMPLOYERS PROVIDE INADEQUATE OR NO HEALTH INSURANCE AT ALL.

PEOPLE WHO LACK HEALTH INSURANCE ARE LEAST LIKELY TO SEEK PREVENTIVE AND PRIMARY HEALTH CARE. AS A RESULT, CONDITIONS WHICH COULD BE TREATED EASILY IF DETECTED EARLY OFTEN DEVELOP INTO ACUTE ILLNESSES REQUIRING LENGTHY AND COSTLY TREATMENT.

IN 1986 A ROBERT WOOD JOHNSON FOUNDATION SURVEY FOUND THAT AT LEAST 1 MILLION AMERICANS WERE DENIED ACCESS TO NECESSARY SERVICES BECAUSE THEY COULD NOT PAY. IN ADDITION, 14 MILLION PERSONS WHO



14X

REQUIRED HEALTH CARE DID NOT SEEK IT BECAUSE THEY KNEW THEY COULD NOT AFFORD IT. IT IS THIS DYNAMIC WHICH IN PART HAS FUELED THE GROWTH OF THE UNCOMPENSATED CARE TRUST FUND IN NEW JERSEY.

WHAT WE HAVE TODAY IS A SYSTEM OF HEALTH CARE THAT AFFORDS PEOPLE WITH PRIVATE INSURANCE ACCESS TO COMPREHENSIVE AND SOPHISTICATED HEALTH CARE SERVICES. BUT THERE ARE OTHER INDIVIDUALS WHO WORK FOR COMPANIES THAT EITHER CANNOT OR DO NOT PROVIDE ADEQUATE HEALTH INSURANCE, AND THESE INDIVIDUALS OFTEN LACK THE PERSONAL RESOURCES TO PURCHASE HEALTH INSURANCE ON THEIR OWN. THERE ARE STILL OTHERS, THE TRULY INDIGENT, WHO ARE TOTALLY DEPENDENT ON HEALTH CARE COVERAGE PROVIDED BY GOVERNMENT PROGRAMS, AND THAT COVERAGE IS OFTEN MINIMAL. AT THE VERY LEAST, WE MUST STRIVE FOR THE ESTABLISHMENT OF AN APPROPRIATE LEVEL OF CARE FOR ALL, REGARDLESS OF ECONOMIC STATUS, RACE, AGE, OR GEOGRAPHIC LOCATION. WE MUST ENSURE A MORE EQUITABLE DISTRIBUTION OF HEALTH CARE SERVICES.

THE BEST WAY TO ACCOMPLISH THIS GOAL IS THROUGH THE DEVELOPMENT OF MANAGED CARE SYSTEMS WHICH DEFINE A THRESHOLD LEVEL OF BENEFITS, PROVIDE DIRECT LINKAGES TO EXISTING PROVIDERS, AND PROPERLY REIMBURSE PROVIDERS FOR THE CARE THEY DELIVER. AS NOTED IN A RECENT REPORT FROM BERNSTEIN RESEARCH, TITLED "THE FUTURE OF HEALTHCARE DELIVERY IN AMERICA," NETWORKS OF HMOs AND PPOs, WITH PROVIDERS, EXIST IN OTHER PARTS OF THE COUNTRY THAT HAVE BECOME THE BASIS OF A MANAGED CARE SYSTEM. WE IN NEW JERSEY MUST DESIGN AND IMPLEMENT OUR OWN MANAGED CARE SYSTEM, ONE WITH A STRONG EMPHASIS ON PRIMARY CARE AND PREVENTION. ONLY BY EMPHASIZING WELLNESS,



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HEALTH PROMOTION, EDUCATION, EARLY DIAGNOSIS, AND PREVENTIVE CARE CAN WE ACHIEVE A SYSTEM THAT IS MORE EQUITABLE AND COST-EFFECTIVE.

THAT MANAGED CARE SYSTEM SHOULD PROVIDE ALL NECESSARY MEDICAL SERVICES, FOCUSING ON PREVENTIVE CARE: DOCTORS' OFFICE VISITS, OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY TESTING, OUTPATIENT SURGERY, WELL-BABY CARE, ROUTINE PHYSICALS, IMMUNIZATIONS, PHYSICAL THERAPY, PRESCRIPTIONS, HOME HEALTH VISITS, AND ROUTINE HEARING AND EYE EXAMS.

AS I STATED IN RECENT TESTIMONY BEFORE THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS, THE EMPHASIS TODAY UNFORTUNATELY REMAINS ON ACUTE CARE RATHER THAN PREVENTIVE CARE. AS I NOTED THEN, WE MUST BEGIN TO MOVE FROM A SICKNESS MODEL TO A WELLNESS MODEL, WHICH REQUIRES A TRUE COMMITMENT TO THE CONCEPTS OF WELLNESS AND DISEASE PREVENTION. THAT MEANS PROVIDING ADEQUATE INSURANCE COVERAGE FOR INDIVIDUALS IN NEED OF MATERNAL/CHILD HEALTH CARE. THAT ALSO MEANS PAYING FOR THE COST OF MAMMOGRAPHIES AND OTHER PREVENTIVE DIAGNOSTIC TESTS THAT NOT ONLY SAVE LIVES BUT ALSO SAVE MILLIONS OF DOLLARS FOR THE HEALTH CARE SYSTEM BY PREVENTING LARGER PROBLEMS AND BIGGER COSTS DOWN THE ROAD.

WE ARE FACED WITH SOME VERY TOUGH DECISIONS ABOUT WHERE ALONG THE CONTINUUM OF CARE WE SHOULD INVEST OUR SCARCE HEALTH CARE DOLLARS. AN INVESTMENT IN PRENATAL CARE WILL OBVIOUSLY REAP DIVIDENDS IN A HEALTHIER POPULATION. BUT THAT DOESN'T MEAN WE CAN IGNORE THE PRESSING CURRENT HEALTH CARE NEEDS OF OUR ELDERLY POPULATION. THEREFORE, ANY REALLOCATION OF RESOURCES MUST BE PHASED IN CAREFULLY.



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THROUGH THIS COMMISSION AND THROUGH THE GOVERNOR'S TASK FORCE ON HEALTH, WE HAVE A UNIQUE OPPORTUNITY TO EXPLORE THE DEVELOPMENT OF A PROGRESSIVE MANAGED CARE SYSTEM. SUCH A PROGRAM COULD SERVE AS A MODEL FOR THE REST OF THE NATION. NEW JERSEY HAS ALREADY DEMONSTRATED A STRONG COMMITMENT TO PROMOTING ADEQUATE ACCESS TO HEALTH CARE SERVICES WITH THE ESTABLISHMENT OF THE UNCOMPENSATED CARE TRUST FUND. A DECADE AGO, WE DEVELOPED A DRG PROGRAM THAT SERVED AS A MODEL FOR THE NATION, AND WE HAVE 10 YEARS WORTH OF DATA FROM THAT INITIATIVE.

A PROGRAM THAT WOULD EMPHASIZE PREVENTION AND PRIMARY CARE COULD ULTIMATELY SAVE SIGNIFICANT DOLLARS BY REDUCING THE GREAT NEED FOR COSTLY ACUTE CARE SERVICES THAT WE EXPERIENCE TODAY. THIS ALONE WOULD RELIEVE PRESSURE ON THE UNCOMPENSATED CARE TRUST FUND.

BUT THIS GOAL CANNOT BE ACCOMPLISHED UNLESS PAYERS, PROVIDERS, AND PURCHASERS ARE ALL WILLING TO TAKE RISKS AND SET ASIDE THEIR OWN INDIVIDUAL INTERESTS TO ACHIEVE A JUST AND EQUITABLE HEALTH CARE SYSTEM. ONLY BY FOCUSING ON THE PRIMARY AND PREVENTIVE NEEDS OF THE CONSUMER, RATHER THAN THE INDIVIDUAL NEEDS OF DISPARATE INTEREST GROUPS, CAN A COST-EFFECTIVE MANAGED CARE SYSTEM BECOME A REALITY. ONLY THEN CAN A HEALTHY NEW JERSEYAN EMERGE, REGARDLESS OF HIS OR HER RACE, COLOR, CREED OR, MOST IMPORTANT, ECONOMIC STATUS.

THANK YOU.



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**TESTIMONY OF DAVID A. WAGNER, SENIOR VICE PRESIDENT**

**SAINT BARNABAS MEDICAL CENTER**

**BEFORE THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION**

**May 24, 1990**

My name is David Wagner. I am a Senior Vice President at Saint Barnabas Medical Center and a former Deputy Commissioner of Health for planning and regulatory activities.

Prior to the passage of Chapter 83, New Jersey hospitals, like most hospitals in the United States "cost shifted" to the commercial payors to cover the costs for caring for the indigent or those who created bad debt.

Chapter 83 declared the promotion of "the financial solvency of hospitals" as a public policy and the costs of indigency and bad debt became legitimate "elements of costs" that were to be covered by the rate system.

Since the federal government had invested in developing the DRG system in New Jersey and was interested in observing that system as a possible model for the United States, a waiver was granted which allowed New Jersey to set rates for Medicare patients and to allocate a fair share of indigency and bad debt to Medicare patients.

You have been aware of what has happened since and the problems we now face.

Of course, we could repeal Chapter 83 and let hospitals and patients fend for themselves. To do so, however, would be inconsistent with New Jersey's long standing commitment to assure care to all its citizens. It would recreate the situation that I found when I arrived at the Health Department in 1975: Urban hospitals, with few commercial payors available for cost shifting, were on the verge of bankruptcy; they were unable to improve their plants; they were unable to buy the newest equipment and they had suppliers' payments spread out 180 days and beyond.

I know that it is your intent not to go back to the "bad old days" if at all possible.

In my opinion to achieve this end we must do ~~four~~ five things:

1) Require virtually all companies in New Jersey to provide a basic Health Insurance program;
2) Expand Medicaid to its maximum potential;
3) Create a state sponsored health insurance program to fill the gaps;
4) Invest in and encourage programs of prevention and early intervention;
5) Provide regulatory relief to encourage hospitals to expand ambulatory services.

Fortunately we do not have to reinvent the wheel. At least two states, Washington and Hawaii have gone through this process and we can benefit from their experience. In 1974, Hawaii passed the

Prepaid Health Care Act which mandates, with certain limitations, that all employers in the state provide health insurance to their workers.

Prepaid Health Care does not cover the unemployed, dependents, persons working less than 19 hours a week, seasonal workers, students and low income/self employed persons.

Unfortunately Standard Oil successfully challenged Hawaii's Prepaid Health Care Act on the basis that ERISA preempted the states in this area. Subsequently Hawaii successfully gained an exemption from Congress.

Given the fact that action by the federal executive and legislative branches seem frozen by the deficit, it may be that Congress would be willing to amend ERISA to allow state experimentation. Short of that, New Jersey may have to follow a course similar to Rhode Island's in which the state established a state administered fund.

With the exemption in hand, Hawaii has moved to fill the gaps by passing the State Health Insurance Program Act, referred to as SHIP. The creators and administrators of SHIP have, in turn, borrowed heavily from Washington State's Basic Health Plan.

The emphasis of SHIP is on preventive and primary care, "health" insurance instead of "sickness" insurance. It thus focuses

heavily on services such as health appraisals (well baby and well child care, age appropriate health screening), and basic primary care (12 physician visits a year, laboratory and x-ray, immunizations and other preventive procedures). Heavy cost items, the secondary and tertiary care which drive up the cost of health insurance, are de-emphasized in SHIP and some big ticket items such as transplantation and experimental treatments are clearly excluded.

To carry out the program, SHIP contracts with major health insurers. The average state subsidy per enrollee is expected to be $500. Each enrollee must contribute on a sliding scale basis consistent with his or her income. Average monthly contributions are $20 with some enrollees paying nothing. A small co-pay of $5.00 is required at the time of a visit.

There is no discrimination between public and private providers. A public health department offering screening programs is as much a part of the service network as is a major hospital.

I have brought along a copy of the Act and the Regulations for your review, Mr. Chairman.

Let me touch on two other items on my list: prevention/early intervention and regulatory reform.

We have one of the weakest, most archaic public health systems in the United States. In our modern society with its

serious personal health problems we can ill afford a "home rule" system run rampant which leaves us with a variety of small underfunded public health departments whose major contributions are well inspections and free rabies shots. We must encourage the creation of regional health departments offering screening and prevention services.

Finally, we must demand regulatory reform so that major providers, like hospitals, are encouraged to provide ambulatory care outside the hospital setting, in cooperation with local health departments, without suffering the adverse effects of a rate setting system which discourages this course of action. Further, we should exempt hospitals willing to offer these programs as a non-profit service from the certificate of need process.

ROBERT·WOOD·JOHNSON
UNIVERSITY HOSPITAL

PUBLIC HEARING TESTIMONY BEFORE THE
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
HONORABLE JAMES E. MC GREEVEY, CHAIRMAN

SALVATORE LIGUORI, Ph.D.
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23 X

One Robert Wood Johnson Place
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**PUBLIC HEARING TESTIMONY BEFORE THE**
**ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION**
**HONORABLE JAMES E. MC GREEVEY, CHAIRMAN**

**MAY 24, 1990**

Chairman Mc Greevey, members of the Assembly Health Care Policy Study Commission, good morning. Thank you for allowing Robert Wood Johnson University Hospital to come before you and offer testimony on how New Jersey should deal with the problem of providing access to high quality health care for the 850,000 of our residents who do not have health insurance, and how to accomplish that most worthy goal fairly and equitably.

My name is Dr. Salvatore Liguori, and I am vice president in the Corporate Services Division of our Hospital. I am accompanied this morning by Anthony J. Schinella, Finance Division vice president and controller.

Robert Wood Johnson University Hospital in New Brunswick has a 106 year history of service to the community and dedication to the health care needs of the people we serve. We are organized as a not-for-profit hospital and, though governed by an independent Board of Directors and our own senior management and administrative staffs, the Hospital enjoys a close affiliation with the University of Medicine and Dentistry of New Jersey (UMDNJ) as the core teaching Hospital for the University's Robert Wood Johnson Medical School.

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As a result of two affiliation agreements and over thirteen years of affiliation, the UMDNJ presence on our Board of Directors and on key Board Committees has increased, as has the cooperation between the two institutions in such matters as sharing common facilities and services, capital construction and development of clinical programs.

Robert Wood Johnson University Hospital is a 416-bed academic medical center pursuing a threefold mission in research, education and patient care.

On the research front, Parkinson's disease, Crohn's disease, AIDS, cardiovascular disease, cancer and many other disorders are coming under the investigator's microscope at our Hospital. The results of some of these investigations are considered "breakthroughs" such as the recent finding that the drug deprenyl significantly delays the onset of the more serious symptoms of Parkinson's disease. This year a new 13,000 square foot Clinical Research Center was opened on the third floor of the Hospital's Acute Services Building. The Center has laboratory and patient facilities for conducting clinical trials of new drugs, therapies, and biomedical devices, and is a satellite of the Center for Advanced Biotechnology and Medicine, which is a joint project of UMDNJ and Rutgers, the State University.

In education, our Hospital had 235 resident doctors completing their education in ten specialized fields last year. These residents are physicians who have graduated from leading medical schools and who provide 'round-the-clock care for our patients. In addition, last year 186 third and fourth year medical students received their clinical training at our Hospital.

The evolutionary and continuous changes and improvements in patient care are best explained in terms of a few statistics. For example, today more than half (53%) of our patients come to the Hospital from outside our primary service area compared with 19% when the first affiliation agreement was signed in 1977. Between 1982 and 1989, as the Robert Wood Johnson Medical School faculty transitioned to the Hospital:

* admissions increased by 36%
* Emergency Room visits increased by 21%
* surgeries increased by 24%
* patient days increased by 30%
* admissions from the Emergency Room increased by 23%
* critical care days increased by 111%

These data not only highlight the increasing volume at our Hospital, they also underscore its development as a tertiary referral center for high acuity patients. And this growth and expansion has taken place while other hospitals in New Jersey and across the country were posting decreases in these areas.

As the Hospital matures as a significant academic medical center, new and innovative programs are being added or planned, especially as they relate to the identification and development of key centers of excellence. These include:

* Adult cardiac catheterization, angioplasty and open-heart surgery
* An inpatient and ambulatory oncology program including a pediatric oncology program identified for support as a Valerie Fund Children's Center
* The Comprehensive Breast Center, which is the only one of its kind in New Jersey
* A Lupus Center
* The Parkinson's Disease Information and Referral Center
* An AIDS Program, which includes basic AIDS research and clinical studies for developing and testing new therapies against the disease
* A Scoliosis Program, which is the largest of its kind in the country
* The Children's Center, which includes among its many services a Cystic Fibrosis Program, a Spina Bifida Program and the unique Laurie Neurodevelopmental Institute
* The Melanoma and Pigmented Lesion Center
* Level I Trauma Center
* Pediatric cardiac services
* An Epilepsy Center

The Hospital has used innovative measures to avoid the needless costs of duplicating new and expensive technologies in the Central New Jersey region. The Hospital has joined with St. Peter's Medical Center under the banner of New Brunswick Affiliated Hospitals (NBAH) to offer:

* a three site Mobile Intensive Care Unit Program
* Magnetic Resonance Imaging (MRI) at the Laurie Imaging Center for both clinical and research applications
* a joint blood program to help keep down the cost of blood and blood supplies

In addition the Cancer Institute, a recent NBAH effort with UMDNJ-Robert Wood Johnson Medical School, will eventually be a major cancer research and treatment center in New Jersey.

The Hospital assembled a consortium of nine additional area hospitals and private urologists to bring to the region the revolutionary benefits of lithotripsy as an alternative to surgery for kidney stone disease. The New Jersey Kidney Stone Treatment Center at our Hospital represents a regionalized sharing of facilities and equipment that spreads the high cost of this technology over ten hospitals who now have no need to locate competitive lithotripsy services at their sites.

The Hospital actively participates in the group purchasing plan of the University Health System of New Jersey (UHSNJ) and the New Jersey Hospital Association's contract purchasing plan in an effort to keep down the cost of supplies. In addition, we seek out volume discounts for educational institutions.

The Hospital provides tertiary care on a regional basis as well as to the inner city residents of New Brunswick for whom it has provided primary care services for more than a century. The provision of services at Robert Wood Johnson University Hospital has always been based on the principle of universal access. We hold firmly to the belief that it is completely inappropriate to discriminate among patients on the basis of race, sex, national origin, religion, handicap, or ability to pay for needed services, or whether patients have health insurance. Last year, our uncompensated care burden went over $11 million. But part of that cost was for the care of pediatric AIDS and pediatric oncology patients, and for some of our elderly patients suffering the ravages of chronic disease. Except for the fact that the cost burden should be more equitably distributed, we consider that the $11 million was well spent. Our poor and needy deserve the best care we can give.

In this regard, the Hospital opposes any regulation or mechanism that results in the creation of a two-tiered system of health care that would qualify any segment of the population for less than our total healing efforts.

We suggest that the Commission retain the current universal access to hospital care in New Jersey by simplifying the hospital reimbursement system and reforming its financing. Undeniably, the present reimbursement system provides equal access to hospital care for the poor and medically needy. Mechanisms need to be devised for establishing equitable, stable and broad-based alternatives to funding the Uncompensated Care Trust Fund. An approach patterned on the State Unemployment Insurance and Disability Fund, as outlined in the UHSNJ's position paper, appears to meet the criteria and is very attractive. Certainly, other approaches exist and deserve your attention.

For our part, we stand ready to provide our best efforts to help you, Mr. Chairman, and your Commission to work through these alternatives and to help devise legislation that is fair and equitable not only to payers and to hospitals, but also to all of New Jersey's citizens--including those 850,000 residents who currently do not have health insurance but have access to hospital services.

Thank you.

DRAFT

# UNIVERSITY HEALTH SYSTEM OF NEW JERSEY

## 1990 STATEMENT OF POSITION

## ON

## FINANCING THE NEW JERSEY

## HEALTH CARE SYSTEM

## AND

## RESTRUCTURING THE PRESENT

## HOSPITAL PAYMENT SYSTEM

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## EXECUTIVE SUMMARY

Governor Florio captured the essence of the present health care financing crisis by utilizing a patient bill to identify the problems which must be solved. Appearing as the leadoff witness at the first public hearing of the Governor's Commission on Health Care Costs, the Governor displayed "Exhibit A" for all to see and observed that "complicated formulas" made the bill difficult to understand. In fact, the price per case (Diagnosis Related Group, "DRG") actually formed only a small part of the bill; in addition, there was an "Add on" which can sometimes amount to several times the price per case, and a "Surcharge" to finance the Uncompensated Care Trust Fund which represented an additional charge of almost 20% to the bill which he had selected.

Later witnesses focused on the divergence which sometimes occurs between the amount of the bill and the charges for an individual stay, while virtually all consumer witnesses, including the Governor, drew attention to the rapid increases in health insurance premiums which the system has suffered in recent years. At the same time, however, many witnesses noted with pride that the New Jersey system had been able to protect the solvency of its health care institutions, including the inner city hospitals, and had preserved the principle of universal access to health care for all, including the poor.

Developing solutions to the financing crisis requires a carefully balanced response to the legitimate interests involved in



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three sets of relationships: among consumers, among providers, and between consumers and providers. For example, consumers who purchase health care insurance, and therefore pay into the Trust Fund, are naturally frustrated by those who fail to purchase health care insurance, and therefore end up as beneficiaries of the Trust Fund. Yet, few would alter the priorities of the wage earner who loses his job in a declining economy, and finds new employment sufficient only to put food on the table, pay rent, and keep his family together. As the Governor put it: "Health care is not a question of special interests: It's about creating a solution that is in the interest of our entire state community, that provides all our citizens with full access to quality health care they can afford."

Bold solutions are necessary. Nevertheless, care must be taken to identify the real sources of the crisis, and to develop solutions which will work. This is why the UHSNJ 1990 STATEMENT OF POSITION begins with perspective regarding the history and development of the New Jersey prospective payment system (Chapter 83), and reaches out to various sources, such as Medicare and Maryland, to identify successful ideas which hold the potential to contribute effective solutions.

The STATEMENT OF POSITION organizes fourteen sets of ideas into three major areas for action: STRUCTURE, EQUITY and FINANCING.

(1) <u>STRUCTURAL ISSUES</u> are changes that can be made to the mechanics of the payment system, such as the development of the <u>All-</u>



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Inclusive Rate, which will greatly contribute to the system's simplicity and prospectivity.

(2) EQUITY ISSUES, including recognition of the financial impact on providers which treat a more difficult mix of patients, will result in a fairer allocation of limited resources. The solutions in both of these areas, which have been studied thoroughly for over two years now, hold the potential to reduce costs by eliminating certain categories of appeal, and thereby also reducing the need for bureaucracy.

(3) FINANCING ISSUES, have received the least attention: i.e., Every effort must be made to secure funding from the broadest possible insurance base, rather than having a shrinking insurance base pay increasingly more to cover an expanding population of uninsured. Furthermore, we must maximize the return to our State from Federal sources. Finally, for those individuals for whom health care insurance remains economically out of reach, serious consideration must be given to the creation of a statewide employer/employee tax in order to spread the burden across all of us.

The Governor has provided a helpful tool for understanding how our fourteen sets of ideas can contribute to a resolution of the crisis: Perhaps more than any other single document, the patient bill captures both the failures and the successes of Chapter 83. Thus, for example, he highlighted the Surcharge in his presentation. The section on FINANCING ISSUES in the STATEMENT OF POSITION identifies three sets of ideas which are responsive:

- The Insurance Mechanism

Whenever possible, health care expenditures should be addressed through the Insurance Mechanism. Several areas of current insurance policy hold the potential for converting the uninsured to insured by developing more affordable forms of health insurance: e.g., benefit design, particularly mandated benefits in areas which may encourage over utilization, and conversely, those benefits, such as preventive care, which can demonstrate a documented cost/benefit advantage. Regulatory policies regarding open enrollment, community rating, restrictions on "pre-existing conditions", and premium consideration for subscribers who maintain a "healthy life style", as well as tax incentives designed to encourage appropriate coverage, must be part of any FINANCING reform analysis. Most important from our perspective, UHSNJ, as the State's largest network of tertiary care providers, is prepared to assume a leadership role in the development of any alternative delivery system, such as managed care or the SCOPE program in Colorado, which holds the potential to maintain universal access for needed care in New Jersey, while reducing the Surcharge. (St. of Pos., p.25)

- Uncompensated Care Surcharge

The Surcharge which Governor Florio highlighted is currently funded through insurance premiums - in effect, a user's tax on the people who pay for health insurance. Because refinements to the insurance mechanism do not represent a complete solution to the problem of the working uninsured, UHSNJ proposes that consideration be given to establishing a universal coverage policy to be financed through an employer/employee tax on wages modeled after the successful financing solutions used to fund State Unemployment Insurance and Disability, SUI/DIS. Expanding the Base for Financing Uncompensated Care through the tax structure will eliminate the Surcharge, reduce insurance premiums, and spread the responsibility for what is essentially a social issue. Furthermore, a portion of the funds should be made available to enable State government to shift at least some of the burden from local payors to the Federal government by expanding Medicaid eligibility. (St. of Pos., p.26)

- Federal Revenue Maximization

As the Governor observed, Medicare has arbitrarily shifted the burden of health care costs to local payors in recent years. Since relieving the burden on local payers (both insurance and tax) is in New Jersey 's interest, Medicare Revenue Maximization must receive careful attention: i.e., Individual providers must insure that they are receiving appropriate payment from Medicare for items including graduate medical education, capital, patient care and disproportionate share. Moreover, in addition to expanding Medicaid eligibility, the State government can help by capitalizing on New Jersey's historic leadership role in health care financing: Three

issues, which have received considerable attention in New Jersey recently, are Severity of Illness, payment for ambulatory care, and capital payment policy. Because these issues also represent high priorities for Congress and the Administration (the Health Care Financing Administration) they may represent opportunities to regain our waivered status, particularly given Governor Florio's experience in Congress on health care issues. (St. of Pos. p.27)

Our suggestions related to the Surcharge involve complex issues. Many of these issues concern relationships among different groups of consumers - e.g., rate payors v. taxpayers, insured v. uninsured - properly balancing these often competing interests will require careful study, and implementing some of the major ideas will require legislation. However, the Surcharge was not the only item on the patient bill which the Governor drew attention to; he also highlighted the Add-on which, in certain cases, can amount to several times the price per DRG. The causes of the Add-on problem include the treatment of Indirect Costs (i.e., overhead, such as administration and plant), delayed appeals, prior year final reconciliation, and the treatment of capital. Many of these problems result from the conservative design features built into the nation's first prospective payment system for healthcare. However, in contrast to the Surcharge, the solutions to the Add-on problems have been studied for years. In this particular regard, the six Structural Issues set forth immediately below could be implemented by this time next year, and would have an immediate and significant impact in terms of simplicity, prospectivity and fairness:

- The All-Inclusive Rate

We note in the Statement of Position at p. 5 that three years after New Jersey pioneered prospective payment, Medicare simplified our model by developing an All-Inclusive Rate. Basically, the cost per case determined by Medicare includes

everything except payments for capital and graduate medical education. The more complex New Jersey rate structure, which is largely a product of the fact that our system was the first in the country, is the source of much of the confusion, delay and surprise which we read about daily in the newspapers. Although the concept of the All-Inclusive Rate has gained the support of the majority of the hospitals, the payors and the Department of Health, it has somehow never come to pass.

- Avoiding Arbitrary Penalties

The second issue is the coefficient of variation (CV). Discussed at p. 6 of the document, this statistic was developed to insure that the system operated fairly: i.e., Since some DRGs are better than others, the CV was utilized to insure that the judgments about the relative efficiency of different providers did not exceed the predictive strengths of the regulatory methodology. For a decade now this simple safeguard has worked quietly and effectively. Unfortunately, its application has been limited to Direct Care Costs only (i.e., nursing, ancillary services, etc.). The damage resulting from the failure to apply it to Indirect Costs was observed over the last two years: i.e., The implementation at 100% of a flawed Standard for Indirect Costs led to unjustifiable penalties and, in the end, cost the consumers who were obliged to make the damaged providers whole through the appeal process.

Implementing the All-Inclusive Rate (in which Direct and Indirect Costs are combined) would represent a natural opportunity to apply the CV to all costs. In addition to promoting simplicity and prospectivity, it would restore a natural balance to the system, and eliminate a large category of consumer confusion. Combined with the three suggestions in the next paragraph, it would also eliminate many categories of appeal, reduce interest payments on under-collections, and enable the Administration to streamline the bureaucracy.

- Operating Margin, Appeal Process, Cash Flow Relief

The uncertainty caused by the absence of an adequate Operating Margin (Statement of Position, p. 7) is the direct cause of many appeals. Because the rate structure lacks a reasonable financial cushion, hospital management is obliged to exercise all avenues of appeal. Delayed appeals lead to more uncertainty, and the process feeds on itself. It follows that the quid pro quo for

a reasonable operating margin should be an Appeal Process limited to only major issues, such as a complete overhaul of the rate structure necessitated by the implementation of a major certificate of need. (Statement of Position, p. 8). With respect to outstanding appeals, greater flexibility with respect to Cash Flow Relief will limit the interest payments which the consumer must pay on delayed appeals which are ultimately successful. (Statement of Position, p. 9).

- Simplify the Patient Bill

Finally, particularly with respect to the small number of self-pay patients, the divergence between charges and the total price per case (DRG plus Add-on plus Surcharge) which sometimes appears on the patient bill generates concern and confusion. Another anachronism of the early years of Chapter 83, there are various potential solutions, each with pros and cons. UHSNJ commits itself to work with providers, payors and consumers to develop the solution that best promotes simplicity and fairness. Because the range of possible solutions is well known, there is no reason why reform to Patient Billing cannot be implemented at the same time as the solutions to the other five STRUCTURAL ISSUES (Statement of Position, p. 10). In this regard, we suggest that no more effort be wasted tinkering with incremental changes to the old system. Rather, government energy should be immediately redirected to implementing these six STRUCTURAL changes as soon as possible. If the changes cannot be made in time for January, 1991, a partial economic factor should be utilized to extend the current system until the changes are ready, probably by the first quarter of 1991.

Implementing the STRUCTURAL changes should have an immediate and significant beneficial impact on the payment system. Long term gains, however, cannot be secured without attending to the five EQUITY ISSUES discussed beginning at p. 11 of the STATEMENT OF POSITION: i.e., One would not expect a normal delivery to consume as many resources - labor, supplies and capital - as a patient with AIDS. It follows that in an industry where the patient is the product, one must adjust for the demands put on the hospital by different kinds of patients. From the point of view of both the consumer and provider, this adjustment is particularly crucial at

a time when the Governor is trying to fairly allocate scarce resources. The five EQUITY ISSUES are:

- Indirect Cost, Statement of Position, p. 12;
- Capital, Statement of Position, P. 14;
- Severity of Illness, Statement of Position, p. 17;
- Ambulatory Care, Statement of Position, p. 20;
- Core-Teaching Hospital Support, Statement of Position, p. 22.

Several of these issues have been studied almost as long as the STRUCTURAL ISSUES. Although the solutions may take somewhat longer to implement because the problems are more complex, there is no apparent reason why the EQUITY ISSUES cannot be resolved in time for January, 1992 rates. Moreover, the dividends will be significant. For example:

- Ambulatory Care costs are inflating much more rapidly than costs of inpatient care. Systems analogous to the DRG's which determine standardized prospective payment amounts for ambulatory episodes could be easily added to the New Jersey System.
- The elimination of unneeded bricks and mortar probably represents the most significant savings to the health care system over the long term. Capital policy is the key to closing underutilized facilities. HCFA is currently examining adding capital to the DRG payment. New Jersey is uniquely positioned to implement prospective payment for capital, and to link this financing mechanism to regionalized planning, if desired.
- Severity of Illness represents a dramatic breakthrough in terms of quality of care.

Not unexpectedly, these same three issues appear prominently on the national health care agenda. With Governor Florio's experience in Congress, there is no reason why the years which New



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**Jersey has invested in studying these issues cannot now be utilized to restore our national leadership in the development of innovative health care financing.**

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**UNIVERSITY HEALTH SYSTEM OF NEW JERSEY**

**1990 STATEMENT OF POSITION**

The citizens of our State are entitled to high quality health care at reasonable cost. UHSNJ suggests that progress can be made toward achieving this goal through a carefully balanced response to the legitimate interests involved in three sets of relationships: among consumers, among providers, and between consumers and providers. In order to develop such a response, it is important to understand the lessons of the last decade, a time when New Jersey assumed the national leadership role in the design and implementation of innovative approaches to health care financing. Now New Jersey's health care payment system is in need of a comprehensive overhaul. However, the development of effective solutions will come from understanding the factors which went into the design of the nation's first system of prospective payment by the case, the factors which contributed to a sustained period of success, and the reasons for decline. The experience of New Jersey's prospective payment system can be divided into three distinct phases: Design (1976-1979), Implementation (1980-1986), Adjustment (1986-present).

It has been pointed out by many parties that the current system is too complex and cumbersome. In order to understand the circumstances which led to this problem, it is helpful to return to the Design Phase (1976-1979) during which most of the elements of



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the current system were developed. At that time, two sets of considerations could not be ignored: First, prospective payment, i.e., rates of payment "fixed in advance", represented a radical departure from years of cost and charge based reimbursement. Second, many elements of the methodology used to develop prospective rates were crude. Not unexpectedly, therefore, various "protections" were built in to moderate change in the two components which determine the level of payment to specific providers, as well as to the system as a whole: Price and Volume. Although well intended and useful at the time, these conservative design features have ultimately contributed to delay and complexity. Referred to here as Structural Issues, it is submitted that many of these elements of the methodology have outlived their usefulness.

During the Implementation Phase, which began in 1980, change in the basis of payment, from retrospective to prospective, provided hospital management with a natural incentive to improve operational performance. In New Jersey, significant declines in length of stay and ancillary utilization enabled Chapter 83 to offset unreimbursed increases in the cost of labor and new technology, to pay for increases in uncompensated care out of rates rather than general revenues, and still left surpluses at most institutions. This achievement was all the more remarkable because at the same time these gains were made, the public enjoyed a moderation in the rate of increase of health care premiums. It is generally acknowledged that the Implementation Phase came to an end around the mid-eighties as the opportunities for additional improvement began to diminish.



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Faced now with the reality of limited resources, it was logical that two sets of issues initially obscured by the success of the Implementation Phase should finally come into clearer focus: the appropriate level and distribution of responsibility for funding New Jersey's health care delivery system (Financing), and the allocation of those resources among various kinds of providers (Equity). Thus, the sorting out of Financing and Equity Issues during the Adjustment Phase, which continues to the present, represents a natural progression.

In order to provide a blueprint for a fair and comprehensive set of solutions, the 1990 UHSNJ Statement of Position divides issues into the three categories noted above: six Structural Issues that will contribute simplicity and prospectivity to the payment system and improve financial incentives to the providers to perform efficiently, as well as reducing bureaucratic delay by reducing the number of appeals; five Equity Issues that will result in a fairer allocation of limited resources among providers by improving judgments concerning efficiency, and contribute to further reductions in appeals by converting Rate Commission controversies into methodological solutions, and; three Financing Issues because, perhaps more than any set of issues, the sustained period of success enabled New Jersey, consumers and providers alike, to postpone vital financing decisions.



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## STRUCTURAL ISSUES

New Jersey's system of prospective payment by the case was the first in the nation when implemented in 1980. Being first contributed to many of the conservative design features which were built into the system. Three years later, Medicare was able to take advantage of the New Jersey experience by building a payment system out of the same basic elements that was simpler and more prospective. UHSNJ is suggesting six structural changes to the Payment System in order to enhance its prospectivity and simplicity:

- All-Inclusive Rate;
- Coefficient of Variations/CV;
- Operating Margin;
- Appeals;
- Cash Flow Relief; and
- Patient Billing.

The All-Inclusive Rate is intended to capitalize on the Medicare improvements. The Medicare system is designed, however, for a single payor. In contrast, the NJ System covers all payors and, hence, all sources of patient revenue for NJ institutions. This more comprehensive degree of financial control naturally imposes a higher standard on the regulator to be fair, and to avoid arbitrariness. Accordingly, two issues have been included in order to meet this standard: the C.V. and the Operating Margin. It is expected that in addition to making the system simpler and more prospective, all three issues will greatly contribute to a reduction



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in the volume of Appeals. However, in order to relieve the financial pressure caused by the existing undercollections, UHS also supports short term Cash Flow Relief. Several solutions also exist to make Patient Billing simpler, fairer and more understandable. Taken together, these six regulatory changes to the mechanics of the payment system will restore its natural balance and will immediately redress many, if not most, of the causes of consumer irritation.

All-Inclusive Rate

In the initial design of Chapter 83, in order to cushion institutions against dramatic changes in patient volume, Indirect Costs (overhead such as administration and plant) were separated from Direct Costs (patient care functions such as nursing and ancillary services) and made "fixed": i.e., set and paid at a predetermined amount, regardless of increases or decreases in the number of patients which the provider treated. Although this feature added stability during the Implementation Phase of prospective payment, it later contributed to the system's complexity and compromised its prospectivity. Indeed, this is the source of many current consumer complaints: i.e., Like the Medicare Prospective Payment System (PPS), Diagnosis Related Groups (DRGs) per se have actually functioned well, allocating scarce resources among providers in relation to the differing demands of the mix of patients treated at each institution. Unfortunately, however, the construction and timing of the various add-ons to DRGs for Indirect



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Costs, capital costs, uncompensated care and undercollections from delayed appeals, have left the New Jersey payors uncertain, and the consumer angry and confused.

In 1983, the Medicare PPS was implemented with a rate per DRG which included both Direct and Indirect Costs, an All-Inclusive Rate. This rate is fixed and final (prospective), simple and, because there are no artificial distinctions among kinds of costs, leaves little room for manipulation. The All-Inclusive Rate did receive considerable attention in New Jersey during the Adjustment Phase. Covered more fully under Equity Issues, the solution which was developed, a flat add-on for each admission to cover the Indirect Cost component, unfortunately represented a step backward in terms of fairness. Moreover, for purposes of this section on STRUCTURAL ISSUES, continuing to maintain the artificial distinction between Direct and Indirect Costs assures that the hoped-for benefits of simplicity will not be realized, and that opportunities for "financial creativity," which can disadvantage one provider relative to another, will remain. Accordingly, our suggestion is that a model like Medicare be adopted: i.e., a full step down of all costs to the DRGs based on appropriate statistical information sets.

C.V./Coefficient of Variation

One of the distinguishing features of our payment system is its emphasis on fairness. In contrast to the Medicare system which controls only the rates of a single payor, administrative law in



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both New Jersey and elsewhere requires that local regulated industries not be treated arbitrarily. One such element of this process is the coefficient of variation ("CV"): Put simply, some DRGs are better predictors of experience (costs) than others. The CV is a statistical tool utilized to insure that the judgments made about the relative efficiency of different providers do not exceed the predictive powers of the regulatory methodology. The effect of not utilizing such a safeguard was witnessed last year when payments for Indirect Costs, based on a flawed unit of service, were made at 100% Standard. Consumers and providers alike suffered from dramatic reallocations of resources. Moreover, the public paid first for the rates as determined, and paid again to make whole those institutions that were financially damaged as a result of an unfair rule. It is submitted that particularly with the implementation of an All-Inclusive Rate, the CV should be preserved to protect against an arbitrary result. Keeping the basic statistical safeguard will avoid unnecessary appeals, and keep the system lean.

Operating Margin

No business or industry can function over the long term without an operating margin. Whether to build inflation adjusted capital reserves for future reinvestment, to provide discretionary funds for programs not requiring a certificate of need, to acquire state of the art technology, to improve quality of care, or simply to protect against unforseen circumstance, the rate structure must allow the hospital to generate some amount of surplus. Obviously, the amount



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of the operating margin depends on the adequacy of other elements of the rate structure such as the technology factor, economic factor and capital payment process. The issue of an operating margin received little attention during the Implementation Phase because years of cost based reimbursement had provided numerous opportunities for improved operational performance. With the change in financial incentives caused by the introduction of prospective payment, most providers were able to generate a surplus. With the gradual elimination of these opportunities, the need arose to explicitly identify the operating margin as a financial element of the payment system. Although this step was taken during the Adjustment Phase, it is submitted that the margin, which currently amounts to less than 1%, is inadequate. It is submitted that an appropriate amount be determined by studying experience in both private and regulated industry (including the hospital industry elsewhere), and that the role of the operating margin be carefully defined in relation to other elements of the payment system.

Appeal Process

Adjustments added on to the rate per case to deal with undercollections from prior years have badly distorted the payment system and undermined consumer confidence. The development of the Indirect Cost add-on last year made a significant contribution to the elimination of one major cause of undercollection in the final reconciliation process. This issue should be brought to closure with the implementation of an All-Inclusive Rate which utilizes

appropriate statistics to allocate all costs to the DRG. Application of the C.V. to determine a fair All-Inclusive Rate for each institution will avoid many future appeals, the other major contributor to the undercollection problem. Moreover, the quid pro quo for a reasonable operating margin (or incentive for accepting the rates as proposed) should be elimination of many opportunities for appeal, particularly with respect to small dollar items. Finally, responding to the issues set forth in the section on EQUITY ISSUES should result in the elimination of many of the large dollar appeals currently facing the system. The implementation of these reforms should enable the Commission to totally overhaul and reduce the Appeal Process.

Cash Flow Relief

Along with EQUITY ISSUES, the failure to resolve STRUCTURAL ISSUES has resulted in significant hospital undercollections. Although solving these two sets of issues will provide a prospective solution to this problem, UHS suggests that the current cash flow policy be revised to offer greater flexibility. By more carefully defining the need for Department of Health intervention, a more sensible set of limitations can be defined within which hospitals would be afforded more flexibility to adjust their own markup. The immediate benefit to consumers would be a reduction in the amount of interest which must be paid on undercollections. By the same token, the interest payment policy, combined with more targeted bureaucratic oversight, should also deter hospitals from

overcollecting. Should cash flow needs persist, UHS would favor a long term solution similar to the Uncompensated Care Trust Fund - i.e., a fund established through an across-the-board surcharge on hospital markups.

Patient Billing

It is our understanding that the vast majority of consumer complaints regarding Chapter 83 relate to the add-ons for Indirect Costs, delayed appeals, prior year final reconciliation and the mechanics of the Uncompensated Care Trust Fund. We believe that the solutions discussed in this section, particularly the All-Inclusive Rate, will resolve most of these problems. Nevertheless, some consumer complaints do relate to the process of "paying by-the case", particularly with respect to the small number of "self-pay" patients. Moreover, it is in everyone's interest that patient billing be simple and understandable. In this regard, there are various potential solutions to the problem, each of which has pros and cons. UHS commits itself to working with providers, payors and consumers to define the problem, and to develop the solution that best promotes simplicity and fairness.



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## EQUITY ISSUES

Issues of Equity concern the allocation of resources among groups of different kinds of providers. Such issues may be subdivided into issues of Price and issues of Volume. Although both kinds of issues appeared on the rate reform agenda during the last two years, the overwhelming emphasis was placed on resolving issues of Volume, probably because the solutions were easier to implement. Linking financial performance more closely to patient volume was an important advance supported by UHSNJ; it provided the basic tool to apply pressure to under-utilized providers, and to reward those which are well-utilized. Unfortunately, much of this progress was badly compromised when, with a single exception, issues of Price were left unresolved: i.e., one would not expect a normal delivery to consume as many resources - labor, supplies and capital - as a patient with AIDS. It follows that in an industry where the product is the patient, one must carefully adjust for the demands put on the hospital by different kinds of patients. Thus, failure to adjust prices (payment rates) to recognize the burdens on hospitals which systematically attract, or are referred, more severely ill patients can result in financial harm - a problem which can be exacerbated if patient volume is increasing. The basic lesson of the Adjustment Phase is that a significant misallocation of scarce resources can occur if issues of Price and Volume are not dealt with together, in a balanced way.



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The failure to deal with Price and Volume concurrently can also cause harm to the consumer. In order to avoid being arbitrary, a regulatory system must find a way to deal with all legitimate issues. It follows that when such issues are not dealt with by way of a rule (i.e., the rate setting methodology), they naturally appear as an exception (i.e., an appeal issue). In this regard, virtually all of the items discussed in this Section have appeared in the Adjustment Phase as major appeals. This is undesirable because rules, which operate automatically, are more efficient ways of handling regulatory issues and, hence, more prospective. Assuming they are fair and properly balanced, rules also help to insure that the public does not pay for the same issue twice, and they reduce the need to maintain a large bureaucracy to analyze and "hear appeals".

There are five issues of Equity that UHSNJ presents and supports;

- Indirect Cost;
- Capital;
- Severity of Illness;
- Ambulatory Care; and
- The Core Teaching Hospital Support.

Indirect Cost

Indirect Cost (i.e., overhead such as administration, plant, etc.) was treated as "fixed" in the original system design. That is, the hospital was entitled to a pre-determined sum regardless of

increases or decreases in patient volume. In theory if a hospital admitted only one patient during the year they might be paid for all of their annual Indirect Costs. This treatment of Indirect Cost produced complexity, delay, and had compromised the incentives of the system. Accordingly, UHS supported a more direct linkage between Volume and financial health and, indeed, one of the reforms implemented during the Adjustment Phase was the conversion of this fixed expense to an add-on to each patient case. Although the add-on represented a forward step with respect to Volume, this progress was more than offset by the failure to deal with the Price issues. That is, within a given group of hospitals, the add-on for Indirect Cost is the same whether the patient had a simple appendectomy, or AIDS. Indeed, hospitals are currently paid twice as much for a normal delivery (one add-on for the mother and a second add-on for the baby) as for a patient with cancer or a triple by-pass.

The flat add-on fails to give any recognition whatsoever to factors including case-mix, payor-mix, or the impact of differing programs of Graduate Medical Education (GME). Not unexpectedly, UHS has a particular interest in the fair resolution of the GME issue, already the subject of appeal. UHS would prefer to see these issues handled methodologically, a posture taken throughout this STATEMENT OF POSITION. Two actions are required to solve this problem: First, a fair methodology must be determined for allocating Indirect Cost to the DRGs. UHS favors an approach, like Medicare, which utilizes a full step-down based on appropriate statistics. Second, the "continuous" methodology implemented last year to adjust for the



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impact of GME on Direct Patient Care Costs must be applied to all costs, including Indirect Costs. Although we recognize that some refinement may be needed to the weightings assigned to different kinds of GME programs, the "continuous" methodology was nevertheless developed to apply to all costs, Direct and Indirect.

Capital

The elimination of unneeded bricks and mortar probably represents the most significant savings to the health care system over the long term. Studied for approximately 5 years, prospective payment for capital has now been reprioritized to the top of the agenda by HCFA. By linking capital payments more directly to patient volume, underutilized facilities will be closed or converted, and the system will be left with funds to promote the financial health of well-utilized, well-managed institutions.[1] Basically, this involves eliminating the current pass-through, and treating capital in much the same way as other inputs; i.e., labor and supplies. (It is important to appreciate that the most

[1]Reimbursement for capital should provide appropriately utilized hospitals with, not only adequate dollars to meet current requirements, but also adequate equity for future reinvestment in plant. New Jersey is paying the price of inadequate equity in the rate system: In 1986, approximately 83 cents out of every dollar in fixed assets was financed through debt. This is 34% higher than the national average of 62 cents out of every dollar. This costs the system in at least two ways: First, higher debt means higher interest costs. Second, the high degree of leverage in this State translates into higher investor risk, which results in lower ratings and higher interest rates. So, New Jersey pays a higher relative interest rate on a greater amount of debt. No benefit is derived by underreimbursing all hospitals.



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significant savings to be derived through the closure of underutilized hospitals are not capital costs, since that only amounts to approximately 8% of total costs, but rather the operating costs, especially Indirect Costs which would be totally eliminated.) Although the methodology for allocating capital to the price per case is straightforward, some additional work needs to be done to insure that the impact of teaching is properly accounted for in determining the standard. Moreover, a transition period is needed so that adjustments can be made by both the institutions and the market. Finally, a direct linkage can be developed with regional planning if desired. Accordingly, UHS favors the inclusion of capital in a prospectively determined rate, provided, however, that appropriate recognition is given to the impact of teaching, case-mix intensity, and that existing capital obligations are respected.

Not unlike the issue of Indirect Cost, UHS is particularly concerned that appropriate recognition be given to the impact of teaching on capital: i.e., major movable equipment, new technology, and bricks and mortar. There are many obvious examples: Operating rooms must be sufficient in size to enable a student to observe a surgeon performing a procedure; ancillary services must be sufficient to accommodate the more sophisticated clinical testing which a student must encounter during his/her residency, and so forth. Utilizing the patient bed as a point of focus, it has been estimated that major teaching hospitals require approximately 30% more square feet per bed than non-teaching hospitals, and an equivalent comparison can be made in terms of cost per bed. This

notwithstanding, the immediate issue is that the capital pricing policy under consideration by the Department of Health Task Force Workgroup - Capital Pricing discussed below provides no recognition for the impact of teaching, either in the methodology or the exception process.

The Department of Health Task Force Workgroup - Capital Pricing was asked to develop a methodology for capital reimbursement currently in regulation, not to develop a new capital reimbursement policy. Within that framework, five methodologies were discussed, and the following variable capital price approach was recommended.

CFA = Actual volume x Lower of (the capital cap in effect for that rate year, or the actual CFA eligible expenses ÷ actual volume).

The benefits of this approach were:

- A new cap calculated each year;
- Has the closest relationship to actual costs;
- Eliminates the need for annual appeals for additional capital reimbursement resulting from small additional capital expenditures;
- Provides comfort to the investment community;
- Potentially accommodates old capital;
- Provides payor comfort since there is an upper limit; and
- Exceptions to the capital cap would not be affected.

The Committee also suggested that it be allowed to meet again to formulate and propose recommendations for changes in the methodology that would require a change in the regulations

(legislation). Some of the ideas discussed in the Committee were a standard capital price approach, differentiation between teaching and non-teaching hospitals, recognition that those hospitals that treat a more severe (longer relative LOS) case-mix than other hospitals would be under-reimbursed, whether capital reimbursement should be part of an All-Inclusive rate and other related issues. Unfortunately, resolutions of all of these issues have been postponed.

Severity of Illness - Patient Outcome

DRGs are based on a limited number of readily available medical data elements. This limitation sometimes results in broad and heterogeneous groups of patients.[2] Termed "Severity of Illness," the inability of the present payment system to distinguish and to appropriately pay for subgroups of exceptionally difficult cases poses no financial problem for the typical community hospital. Although such providers certainly care for uniquely sick patients from time to time, the small and constant proportion of the institution's overall case-mix which these admissions represent is offset by a percentage of uncomplicated admissions. In other words, the problem is neutralized under a system of averages. This is not so, however, in the case of institutions which specialize: i.e.,

[2]The evidence for this is the rather high coefficients of variation for certain DRGs. As noted, the "C.V." is the statistic which measures the homogeneity of each DRG: The more homogeneous the group, the lower the CV, the higher the predictive power and, therefore, the likelier that the system will result in rates of payment which are fair and equitable.



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When a provider's delivery system is set up to systematically attract the most difficult kinds of cases, the distribution of severe cases within a given DRG may no longer reflect the typical institutional profile, and the averaging system will begin to cause harm. Under the present system, the more the provider specializes, the greater the financial damage it incurs.

Teaching institutions are set up to systematically attract the most difficult kinds of cases because, as part of their mission, they must provide the clinical challenge required to train new physicians. Not unexpectedly, many of New Jersey's teaching hospitals volunteered for a study designed to test one system for measuring Severity of Illness. Although the study had limited predictive value because the participants self-selected, it tended to suggest results of broader significance:

(1) There is little question that Severity of Illness is important to the financial health of the small segment of providers that treat a more complex case-mix. The adjustment is particularly critical to providers that specialize, as well as to those that are evolving into this role. However, the study also suggests that some community providers may also treat a more severe case-mix.

(2) Perhaps the most interesting revelation is the strong linkage between Severity of Illness and the Standard. 76 DRGs, which accounted for 27% of patients and over 40% of hospital patient care costs, were found to be significantly affected by Severity of Illness. The addition of the Severity adjustment to the 76 DRGs improved the ability of those DRGs to predict cost by 38.2% and,

because of the automatic adjustment built into the system (the C.V.), more of the payment standard was blended into each provider's rates. Moving to Standard has been a shared goal of providers and payors alike, and has been supported by UHSNJ. In summary, the group which may benefit most from the integration of a Severity of Illness adjustment into the payment system are those providers that treat their case-mix, whether simple or complex, efficiently - a point which should be of considerable interest to the payors and consumers.

(3) Finally, the current system lacks any real outcome measures. Perhaps the most significant achievement of the Severity of Illness study was the breakthrough on measuring outcome: i.e., Because patient information is collected at a sufficient level of detail, a framework was created to measure if a patient's health status is improved as result of the hospital episode. It is submitted that this is important to both providers which deliver high quality care and, especially, to consumers.

The last administration often spoke of the importance of the Severity of Illness issue, particularly with respect to patient outcome. Nevertheless, the result of the first study was the commissioning of a second study designed to compare two systems for measuring this issue. UHS submits that it is time to implement a system designed to adjust for Severity of Illness. For those providers and payors concerned about cost and inconvenience, an alternative has now been developed which utilizes centralized data



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processing and sampling to solve both of these problems. Until implemented, hospitals should be allowed a right of appeal.

Ambulatory/Outpatient Services

The current payment system for Ambulatory/Outpatient services needs to be changed in order to encourage increased utilization of ambulatory approaches to care and reduced inpatient use. The decision should be made by the clinician and the resultant payment system should be economically neutral, thus, we need to eliminate present inequities, reduce complexity and create incentives based on clinical decisions as opposed to administrative/financial decisions (i.e. payment system neutral).

- Present Problem in Outpatient Reimbursement

The payment system overallocates costs of Indirects to the outpatient services in the hospital. As a result, these "inflated" Indirect allocations generate artificially higher prices and create negative financial incentives for physicians to use outpatient services. These inflated charges create a price differential that makes hospital outpatient service non-competitive with freestanding Ambulatory Centers.

Present outpatient reimbursement is based on a "cost finding" which is then rebased. If an institution can move more services to outpatient thereby creating a more efficient operation, present economic gains are "carved out". Thus, the payment system should



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move toward payment of a "standard rate" so that efficiencies gained are rewarded and not carved out.

- Emergency Room Revisions

The payment system is now going to have a two tiered payment methodology for Emergency Room Care. Thus, primary care services rendered in the Emergency Room will be paid at a lower rate. True Emergency care will be paid at a higher rate. Regardless of how the new payment system allocates the costs for service, recognition of the total costs of providing the service must be accommodated in the new payment program.

- UHSNJ Recommendations
  - There should be movement toward a Standard Ambulatory Payment Rate
  - Payment for Indirect Costs should be Volume Variable and based upon "Incremental" costs as opposed to the present "allocated" costing formula.
  - Same Day Medical Services should be treated consistently with Same Day Surgery. In other words, treatments should become "Incentive Neutral" thereby eliminating the controversy of:
    - Is this case Inpatient or Outpatient?
    - Is this case Medical or Surgical?
  - An economic analysis leading to a better understanding of the cost of Outpatient Services should be initiated. The present formula for determining total costs includes many

"standby costs" that would not be eliminated if outpatient services were discontinued at the hospital. The present formula should be revised to reflect only incremental costs for personnel, supplies, utilities and capital.

- Services provided in the ambulatory setting should be subject to utilization review.

Core Teaching Hospital Support

There are four core teaching hospitals of the University of Medicine and Dentistry of New Jersey:

* University Hospital
* Cooper Hospital University Medical Center
* Robert Wood Johnson University Hospital
* Kennedy Memorial Hospitals, University Medical Center

The University of Medicine and Dentistry Core hospitals represent the State of New Jersey's most significant clinical commitment to medical education. Among other things, these facilities as a group:

- provide medical education to more that 25% of the total Statewide approved residents;
- provide the broadest base of medical and social services available in the State;
- offer unique specialty programs in transplantation, neonatology, infectious diseases, and general medicine not available in other hospitals;

- are the largest provider of AIDS treatment and care in the State, and provide the only Level I Trauma service in New Jersey.

The New Jersey payment system reimburses for services provided based on a methodology of average costs. Clearly, the tertiary services provided by these Core facilities are not average in program intensity or levels of specialization and sophistication. Equity in reimbursement for these services was supposed to be addressed when reimbursement based on Severity of Illness was implemented and the continuous GME adjustment extended to all costs. Since it now is apparent that these reforms will not be implemented in the near future, we suggest that special financial recognition be provided to these Core teaching hospitals. We recommend that the concept of an Add-On to the rates of this distinct group of academic medical centers be considered. This approach would be the easiest to implement since it is simple, predictable and consistent with the existing reimbursement system.

## FINANCING ISSUES

In 1980, Medicare participated in New Jersey's health care financing system under a waiver which obliged it to pay without limitation Chapter 83 rates, including the costs of uncompensated care. In exchange, New Jersey implemented a prospective payment system for acute care hospitals which later served as the model for the Medicare Prospective Payment System (PPS). The change in basis of payment which occurred during the Implementation Phase, from cost to prospective payment, provided the hospital industry the financial incentives that led to a dramatic improvement in operational performance. Coupled with the waiver that shifted a portion of the total cost from local payors to the Federal Government, the surpluses of the early eighties enabled each provider to deal individually with the problem of insuring universal access, as well as with operational issues such as manpower shortages and new technology. Rather than address the issue through general revenues, the problem of access was solved during this time period with a simple hospital specific "add-on" to the rates of each provider.

The add-on did not represent a sound solution to the issue of financing uncompensated care. Because each provider services a different mix of patients, it led to significant distortions among patients, payors and providers, particularly inner-city versus suburban providers. Although this immediate problem was resolved with the implementation of the Uncompensated Care Trust Fund in 1987, the renegotiation of the Medicare waiver on less favorable



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terms during the Adjustment Phase brought the FINANCING ISSUE into sharp relief: i.e., The State was allowed to continue to reallocate Medicare funds among providers, however, the amount of the funds were limited to PPS levels. This limitation caused a "cost shift" to local payors. Coupled with a deteriorating State economy which caused a net increase in the number of uninsured, the natural result was the filing of successive requests for substantial rate increases by the State's largest local payor, Blue Cross.

Insurance Mechanism

Whenever possible, health care expenditures should be addressed through the insurance mechanism. Developing a state-wide financial mechanism to support more affordable forms of health insurance should reduce the population which directly depends on the Uncompensated Care Trust Fund. Converting the uninsured to insured involves crafting an approach to health care insurance which is attractive to a market of potential subscribers (employers and insureds) with limited resources. In this regard, several areas of current insurance policy should be reexamined: e.g., benefit design, particularly mandated benefits in areas which hold the potential for over-utilization, and conversely, those benefits, such as preventive care, which can demonstrate a documented cost/benefit advantage. Regulatory policies regarding open enrollment, community rating, restrictions on "pre-existing conditions", and premium consideration for subscribers who maintain a "healthy life style", as well as tax

through insurance premiums - in effect, a user's tax on the people who pay for health insurance. UHSNJ suggests that consideration be given to establishing a universal coverage policy to be financed through an employer/employee tax on wages modeled after the successful financing solutions used to fund State Unemployment Insurance and Disability, SUI/DIS. An appropriate reduction should be provided for employers/employees who provide health insurance in order to neutralize any negative incentive to drop coverage. This will expand the base for financing the medically indigent and provide incentives to insure. Financing uncompensated care through the tax structure will also enable State government to shift at least some of the burden from local payors to the Federal government: i.e., To the extent possible, New Jersey should increase Federal participation (matching funds) by expanding Medicaid eligibility. The expansion of this funding base will enable some of these monies to be used to support special program initiatives in targeted populations.

Medicare Revenue Maximization

Relieving the burden on local payors is in everyone's interest. Because the Federal government shares in the cost of the Medicaid program, expanding Medicaid eligibility may be one way to accomplish this. Maximizing the return to New Jersey under the Medicare Prospective Payment System is another way. Thus, individual providers can minimize the impact of the current Medicare cost-shift to local payors by assuring that appropriate levels of Medicare

reimbursement have been secured for items such as GME, capital, patient care and disproportionate share.

State government can help too: Two issues which have received considerable attention in New Jersey during the Adjustment Phase are Severity of Illness and payment for ambulatory care. Not unexpectedly, these same two issues represent high priorities to Congress and the Administration (the Health Care Financing Administration.) It is submitted that we should utilize the experience developed in these two areas to regain New Jersey's leadership role in health care financing. Although success obviously cannot be assured, there would appear to be little reason not to utilize New Jersey's track record and current political strength to attempt to regain the waivered status which we enjoyed until 1986. If the waiver can be regained, however, the cap negotiated by Maryland which determines the contribution from Medicare should be studied. It appears that Maryland has been more successful in maximizing reimbursement from PPS through effective negotiation of the cap. The ultimate outcome of this issue could mean that the nation's biggest payor - Medicare - would be participating/supporting New Jersey's health system at an increased level of financing.



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## CONCLUSION

We have witnessed a burgeoning of the Uncompensated Care Trust Fund followed by successive requests by Blue Cross for substantial increases in rates, an unwelcome phenomenon. Do these events suggest a rekindling of health care inflation, or are other factors at work, such as a deteriorating economy and the loss of the Medicare waiver? Although improvements can certainly be made in the health care delivery system to improve efficiency, it is submitted that more questions must be asked to identify the correct solution, or solutions? Thus, for example, New Jersey Blue Cross points out that despite its recent requests, the absolute level of premium remains low relative to other Northeastern states. Moreover, data recently issued by the NJHA indicates that in 1988, New Jersey hospitals' revenue as a percentage of the average worker's income was the lowest in the country. Although perhaps a function of ten years of prospective payment, it is not clear that New Jersey, one of the richest states in the nation, should take pride in this figure. It may not necessarily project a vision of the kind of health care delivery system which our citizens either want or deserve.

UHS submits that careful consideration should be given to various relationships in order to develop perspective on this issue. For example, consideration might be given to the performance of New Jersey's health care delivery system relative to peer states, such as Maryland, to surrounding states in our region, and to the nation.

cost of medical manpower training, and so forth. Inherent in any approach is a set of policy decisions concerning Price and Volume. These decisions, whether explicit or implicit, will naturally affect other issues such as cost, quality and access. This is why our first contribution to this process of change is an "issues framework". Hopefully it will lead us to understand what has worked, to identify what has failed, and to face the future together by building on a long and proud New Jersey tradition of innovation and national leadership in health care financing.



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**TESTIMONY BEFORE THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION**

GOOD MORNING. MY NAME IS BEVERLY ROBERTS AND I AM THE DIRECTOR OF MAINSTREAMING MEDICAL CARE, A PROJECT OF THE ASSOCIATION FOR RETARDED CITIZENS OF NEW JERSEY. MAINSTREAMING MEDICAL CARE WAS DEVELOPED AS A MEANS OF IDENTIFYING BARRIERS TO COMMUNITY-BASED MEDICAL CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AND TO RECOMMEND WAYS TO OVERCOME THOSE BARRIERS. THE PROJECT WORKS IN COOPERATION WITH PHYSICIANS, NURSES, AND OTHER HEALTH CARE PROFESSIONALS TO PROVIDE INCREASED ACCESS AND A COORDINATED APPROACH TO MEDICAL CARE. I AM HERE TODAY TO TALK TO YOU ABOUT THE BARRIERS BLOCKING ACCESS TO HEALTH CARE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, IN PARTICULAR MENTAL RETARDATION. THE BARRIERS I PLAN TO TALK ABOUT ARE VARIED AND OFTEN COMPLICATED. THEY EXTEND FROM PREVENTING DEVELOPMENTAL DISABILITIES IN AN UNBORN INFANT TO SERVICING ADULTS WITH COMPLEX MEDICAL CONDITIONS. BARRIERS TO QUALITY HEALTH CARE FOR THE DEVELOPMENTALLY DISABLED COME IN THE FORM OF POLICY DILEMMAS, HEALTH CARE DELIVERY SYSTEM LIMITATIONS, AND SOCIOECONOMIC CONDITIONS ASSOCIATED WITH POVERTY.

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THE FIRST ISSUE I WOULD LIKE TO ADDRESS IS PREVENTION. I WOULD LIKE TO CALL YOUR ATTENTION TO AN EXTREMELY IMPORTANT STATISTIC; OVER 50% OF ALL DEVELOPMENTAL DISABILITIES CAN BE PREVENTED BY PROVIDING CARE TO PREGNANT WOMEN AND CHILDREN. THIS FACT IS DOCUMENTED IN CERTAIN UNALIENABLE RIGHTS, THE FINAL REPORT OF THE GOVERNOR'S TASK FORCE ON SERVICES FOR DISABLED PERSONS AS WELL AS PROGRAMS FOR PREVENTING THE CAUSES OF MENTAL RETARDATION, PUBLISHED BY THE GOVERNOR'S COUNCIL ON THE PREVENTION OF MENTAL RETARDATION. SUCH PROGRAMS AS "NEW JERSEY CARE," A SPECIAL MEDICAID PROGRAM FOR LOW-INCOME FAMILIES AND "HEALTHSTART," A STATEWIDE PROGRAM AVAILABLE TO ALL MEDICAID ELIGIBLE PREGNANT WOMEN AND CHILDREN UNDER THE AGE OF TWO ARE A WORTHY BEGINNING BUT THEY ARE NOT ENOUGH.

COVERAGE MUST BE EXPANDED TO DEAL WITH HEALTH CARE PROBLEMS THAT COULD BE PREVENTED PRIOR TO THE WOMAN BECOMING PREGNANT. FOR INSTANCE, IF A WOMAN IS NOT IMMUNIZED AGAINST GERMAN MEASLES (RUBELLA) PRIOR TO HER PREGNANCY AND CONTRACTS THE DISEASE DURING PREGNANCY, DEVASTATING SEVERE PROBLEMS OFTEN CAN OCCUR CAUSING CHILDREN TO BE MENTALLY RETARDED, BLIND & DEAF.

INJECTIONS CANNOT BE GIVEN ONCE THE WOMAN BECOMES PREGNANT. A SECOND AREA NOT COVERED UNDER MEDICAID IS GENETIC COUNSELING. GENETIC DISORDERS RESULT IN SUCH DISEASES AND CONDITIONS AS SICKLE CELL DISEASE, HEARING DISORDERS, AND PHENYLKETONURIA (PKU). PKU IS CAUSED BY A RECESSIVE GENE IN BOTH PARENTS THAT DEPRIVES A CHILD OF AN ENZYME NEEDED TO METABOLIZE CERTAIN COMMON PROTEINS RESULTING IN SEVERE MENTAL RETARDATION. FINALLY, MONITORING TO PREVENT ENVIRONMENTAL CONTAMINANTS, ALCOHOL & DRUG ABUSE, RADIATION, AND INADEQUATE PRENATAL CARE IS ESSENTIAL IN PREVENTING DEVELOPMENTAL DISABILITIES, IN PARTICULAR MENTAL RETARDATION.

THE NEXT AREA I WOULD LIKE TO ADDRESS IS THE FINANCING OF MEDICAL CARE. PEOPLE WITH DEVELOPMENTAL DISABILITIES OFTEN HAVE OTHER COMPLICATING MEDICAL CONDITIONS. FINDING THE FINANCIAL RESOURCES TO PAY FOR NEEDED HEALTH CARE SERVICES IS OFTEN DIFFICULT OR IMPOSSIBLE FOR PARENTS OR GUARDIANS OF PERSONS WITH DEVELOPMENTAL DISABILITIES. TO THIS END, THE ASSOCIATION FOR RETARDED CITIZENS HAS PREPARED A PUBLICATION DESIGNED TO EDUCATE A PARENT OR GUARDIAN OF A DEVELOPMENTALLY DISABLED PERSON AS TO THE DIFFERENT SOURCES OF HEALTH CARE SERVICES AVAILABLE TO THEM AS WELL AS METHODS OF FINANCING THESE SERVICES. I

HAVE BROUGHT COPIES OF THE PUBLICATION WITH ME FOR YOUR REVIEW. THE ARC FOUND THAT SINCE THE STATE AND FEDERAL GOVERNMENT HEALTH ASSISTANCE PROGRAMS USE TECHNICAL TERMS THAT CAN BE CONFUSING AND DIFFICULT TO UNDERSTAND, A RESOURCE HAD TO BE DEVELOPED THAT WOULD PUT THESE SERVICES INTO EVERYDAY LANGUAGE.

FINANCING MEDICAL CARE FOR PERSONS WHO ARE DEVELOPMENTALLY DISABLED IS AT BEST TENUOUS. MANY DOCTORS NO LONGER ACCEPT MEDICAID AS A FORM OF PAYMENT FOR SERVICES. BECAUSE MOST DEVELOPMENTALLY DISABLED ADULTS ARE ON MEDICAID, THEY FACE RESTRICTED ACCESS TO CONSISTENT MEDICAL CARE AS A RESULT. MEDICAID FEE-FOR-SERVICES IN NEW JERSEY IS PRESENTLY ONE OF THE LOWEST REIMBURSEMENTS IN THE NATION, WITH DOCTORS RECEIVING ONLY $12 FOR AN OFFICE VISIT. IN COMPARISON, A HOSPITAL-BASED VISIT IS REIMBURSED AT BETWEEN $40 AND $75 A VISIT. THE LOW REIMBURSEMENT RATE IS FURTHER COMPLICATED BY THE LENGTH OF TIME A VISIT WITH A DEVELOPMENTALLY DISABLED PERSON TAKES IN COMPARISON TO A PERSON WHO IS NOT DEVELOPMENTALLY DISABLED. PERSONS WITH DEVELOPMENTAL DISABILITIES GENERALLY TAKE LONGER DUE TO THEIR INABILITY TO EXPRESS THEIR SYMPTOMS OR TO EXPLAIN THEIR MEDICAL HISTORY. AS A RESULT, A WORKABLE FEE STRUCTURE IS NEEDED TO COMPENSATE THE PHYSICIAN FOR

THE ADDITIONAL TIME IT TAKES TO EXAMINE THE PATIENT.

A SECOND PROBLEM THAT EXISTS IN FINANCING HEALTH CARE IS GENERALLY PRIVATE MEDICAL INSURANCE COVERAGE DOES NOT FOLLOW A DEVELOPMENTALLY DISABLED PERSON ONCE THE PARENT LOSES A JOB OR DIES. NOW WHEN A PARENT LOSES A JOB OR DIES, THE INSURANCE DIES.

A THIRD PROBLEM WORTHY OF COMMENT IS THE LONG PERIOD OF TIME FOR MEDICAID APPROVAL, PARTICULARLY FOR DENTAL WORK. LONG DELAYS TYPICALLY OCCUR WHEN AN INDIVIDUAL WHO IS MEDICAID ELIGIBLE NEEDS TO HAVE A DENTAL APPLIANCE REDONE. THE APPROVAL PROCESS IS EXTREMELY SLOW, SOMETIMES TAKING MONTHS BEFORE APPROVAL IS GIVEN. DURING THAT TIME, THE INDIVIDUAL MUST FUNCTION WITH NO TEETH, OR ONLY A PARTIAL PLATE. EATING BECOMES A MAJOR BURDEN, AND MALNOURISHMENT IS POSSIBLE.

AN ADDITIONAL CONCERN IS THAT MEDICAID WILL NOT PAY FOR MAINTENANCE PHYSICAL THERAPY, I.E., THERAPY TO MAINTAIN THE LEVEL OF AMBULATION THAT A PERSON HAS ALREADY ACHIEVED. THIS CAN LEAD TO DEVASTATING AND EXPENSIVE RESULTS AS IN THE CASE OF THE JONES FAMILY. MRS. JONES,

WHO IS IN HER 70'S, LIVES WITH HER TWO DAUGHTERS, WHO ARE BOTH IN THEIR 40'S, BOTH OF WHOM HAVE CEREBRAL PALSY AND MENTAL RETARDATION. BOTH DAUGHTERS WALKED AT ONE TIME, BUT THEY LOST THEIR ABILITY TO WALK. BECAUSE OF MRS. JONES' ADVANCING AGE AND THE DAUGHTERS' INABILITY TO WALK, THE FAMILY NOW REQUIRES A HOME HEALTH AIDE FOR APPROXIMATELY 4 HOURS PER DAY, 5 DAYS A WEEK. THE FAMILY HAS ALSO BEEN PROVIDED WITH TWO WHEELCHAIRS AND A COSTLY HYDRAULIC LIFT TO GET THE DAUGHTERS OUT OF BED IN THE MORNING. THESE EXPENSES ARE PAID FOR BY MEDICAID -- EXPENSES WHICH COULD VERY WELL HAVE BEEN AVOIDED IF ONGOING THERAPY HAD BEEN PROVIDED.

MEDICAID RECIPIENTS ARE NOT THE ONLY ONES TO SUFFER FROM INADEQUATE COVERAGE. THERE ARE AN INCREASING NUMBER OF MEDICALLY FRAGILE INFANTS AND CHILDREN FROM MIDDLE CLASS FAMILIES WHOSE PARENTS HAVE PRIVATE HEALTH INSURANCE WHICH IS INADEQUATE TO MEET THE HEALTH CARE EXPENSES OF THE FRAGILE INFANT OR CHILD. ONE EXAMPLE IS THE CASE OF THE BARNES FAMILY CONSISTING OF A MOTHER, FATHER, AND THREE CHILDREN, A 6 YEAR OLD BOY, AN 18 MONTH OLD GIRL, AND AN INFANT BOY. THE HUSBAND HAS PRIVATE INSURANCE THROUGH HIS PLACE OF BUSINESS. TWO OF THE CHILDREN ARE HEALTHY, BUT THE 18 MONTH OLD (WHO I WILL REFER TO AS "KATIE") WAS BORN

WITH MULTIPLE CONGENITAL ANOMALIES INCLUDING MENTAL RETARDATION, A CLEFT LIP AND PALATE, AND CONGENITAL HEART DISEASE. THE ONLY WAY THAT KATIE CAN RECEIVE ANY NUTRITION IS THROUGH A NASOGASTRIC TUBE THAT IS PASSED THROUGH HER NOSE INTO HER STOMACH. SHE NEEDS TO BE TUBE FED EVERY HOUR AROUND THE CLOCK, MEANING THAT SHE GETS 24 FEEDINGS PER DAY, EVERY DAY. WITH OTHER TYPES OF FEEDING, KATIE CHOKES AND VOMITS AND IS NOT ABLE TO GET ANY NOURISHMENT. BECAUSE OF THE FAMILY'S INSURANCE COVERAGE, THEY HAVE BEEN ABLE TO HAVE NURSES FROM 11:00 PM TO 7:00 AM AND 9:00 AM TO 5:00 PM FIVE DAYS A WEEK, TO PROVIDE THE FEEDINGS AND OTHER CARE THAT KATIE NEEDS TO REMAIN AT HOME, SUCH AS OXYGEN, WHEN NEEDED. HOWEVER, THE BARNES FAMILY HAS JUST USED UP ALL OF ITS HOME NURSING INSURANCE COVERAGE. THE STANDARD RATE PAID TO VISITING NURSES IS $35 PER HOUR, AND THE FAMILY CANNOT AFFORD TO PAY FOR THE CONTINUING CARE. THE FATHER'S JOB REQUIRES A 2 HOUR DAILY COMMUTE EACH WAY, SO MOST OF THE BURDEN FOR CARING FOR KATIE AND THE OTHER TWO CHILDREN IS ON MRS. BARNES. THE FAMILY IS CLOSE TO THE BREAKING POINT NOW THAT PRIVATE INSURANCE WILL NO LONGER PAY FOR NURSING CARE FOR KATIE.

FINALLY, THERE IS ALSO A TREMENDOUS FINANCIAL BURDEN ON MIDDLE CLASS FAMILIES WHO ARE SELF-EMPLOYED, AND ARE,

THEREFORE, NOT ELIGIBLE FOR GROUP HEALTH CARE INSURANCE. ONE EXAMPLE IS A FAMILY OF FIVE IN WHICH THE FATHER OWNS A SMALL WELDING BUSINESS. THEIR 6 YEAR OLD SON HAS DOWN SYNDROME, AND BECAUSE OF THE DISABILITY, THE FAMILY IS REQUIRED TO PAY $5,600 PER YEAR FOR HEALTH INSURANCE. THEIR POLICY PROVIDES JUST HOSPITALIZATION COVERAGE. THEY ARE NOT REIMBURSED FOR DOCTORS OFFICE VISITS OR PRESCRIPTION COSTS. THE FATHER HAS CHECKED WITH CLOSE TO TWO DOZEN INSURANCE AGENTS AND THIS IS THE LEAST EXPENSIVE INSURANCE COVERAGE AVAILABLE.

THE LAST AREA I WOULD LIKE TO ADDRESS IS THE SYSTEM BARRIERS, CONSUMER BARRIERS AND PROVIDER BARRIERS THAT EXIST IN PROVIDING HEALTH CARE TO PERSONS WITH DEVELOPMENTAL DISABILITIES. AS STATED EARLIER, MANY BARRIERS BLOCK ACCESS TO HEALTH CARE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THESE BARRIERS ARE OFTEN SYSTEMATIC DUE TO THE FRAGMENTED HEALTH CARE DELIVERY SYSTEM THAT ONLY AT BEST INFORMALLY LINKS PRIMARY, SUBSPECIALTY AND SPECIALITY CARE GIVERS OR PHYSICIANS. IN ADDITION, FEDERAL AND STATE REGULATIONS DISCOURAGE HEALTHCARE PROVIDERS FROM SERVICING PERSONS WITH DEVELOPMENTAL DISABILITIES DUE TO THE EXCESS PAPERWORK REQUIRED TO BE COMPLETED BY THE PHYSICIAN AND/OR

HEALTH CARE GIVER.

FINALLY, PROVIDER BARRIERS ARE PERHAPS THE GREATEST OBSTACLE FACING PERSONS WITH DEVELOPMENTAL DISABILITIES WHO NEED HEALTH CARE. ONE OF THE MOST SIGNIFICANT PROBLEMS IN THIS REGARD IS THE LACK OF PHYSICIANS WHO HAVE THE EXPERTISE IN DEVELOPMENTAL DISABILITIES AND THE WILLINGNESS TO PROVIDE QUALITY MEDICAL CARE. PRESENTLY, THERE IS ONLY ONE CLINIC IN NEW JERSEY SPECIALIZING IN HEALTH CARE TREATMENT FOR OUR POPULATION, THE DEVELOPMENTAL DISABILITIES CENTER (DDC) AT MORRISTOWN MEMORIAL HOSPITAL. DR. TED KASTNER, MEDICAL DIRECTOR OF THE DDC, AND HIS STAFF HAVE EXTENSIVE EXPERIENCE IN TREATING DEVELOPMENTALLY DISABLED CLIENTS WHO HAVE COMPLEX MEDICAL NEEDS AND CHALLENGING BEHAVIOR. THE DDC STAFF ARE CALLED UPON TO CONSULT WITH PHYSICIANS AND HOSPITAL PROGRAMS ACROSS THE STATE BECAUSE OF HIS VAST EXPERIENCE WITH VERY COMPLEX CASES. ALTHOUGH THE GOAL OF MAINSTREAMING MEDICAL CARE IS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES TO RECEIVE QUALITY MEDICAL CARE FROM THE PHYSICIANS IN THEIR LOCAL COMMUNITY, WE RECOGNIZE THAT THERE WILL ALWAYS BE SOME INDIVIDUALS WHO WILL REQUIRE CARE FROM A SPECIALIZED PROGRAM. MOST PHYSICIANS PRACTICING IN THE COMMUNITY (WITH THE POSSIBLE EXCEPTION OF SOME PEDIATRICIANS) HAVE RECEIVED LITTLE OR NO

RESIDENCY TRAINING IN TREATING PEOPLE WITH DEVELOPMENTAL DISABILITIES. CLINICAL TRAINING IS NEEDED FOR THOSE IN RESIDENCY PROGRAMS. THERE IS ALSO AN URGENT NEED FOR POST-RESIDENCY FELLOWSHIP TRAINING FOR PRIMARY CARE PROVIDERS, PSYCHIATRISTS, AND NEUROLOGISTS. IN PARTICULAR, PHYSICIANS' LACK OF KNOWLEDGE OF PSYCHOTROPIC MEDICATIONS OFTEN RESULTS IN A PATIENT BEING OVERLY MEDICATED OR BEING PRESCRIBED THE WRONG MEDICATION CAUSING HARM TO THE PATIENT BY DECREASING HIS OR HER FUNCTIONING. IN ADDITION, THIS PREVENTS THE PHYSICIAN FROM LOOKING FOR THE REAL CAUSE OF THE PATIENT'S PROBLEM. THE DDC STAFF HAVE SEEN MANY INDIVIDUALS WHO HAVE BEEN PLACED ON THE WRONG MEDICATION BY PHYSICIANS WHO DID NOT HAVE THE TRAINING OR EXPERIENCE IN SERVING OUR CLIENTS. INCORRECTLY PRESCRIBED MEDICATIONS CAN BE COSTLY IN MANY WAYS. FOR EXAMPLE, ONE DEVELOPMENTALLY DISABLED INDIVIDUAL WAS SENT TO AN OUT-OF-STATE GROUP HOME FOR 15 YEARS BECAUSE HIS BEHAVIOR WAS VIEWED AS SO DIFFICULT THAT NO IN-STATE GROUP HOME WOULD ACCEPT HIM. THE COSTS OF SUCH OUT-OF-STATE PLACEMENTS FAR EXCEED THE IN-STATE FEES. THIS INDIVIDUAL RECENTLY HAD HIS FIRST VISIT TO THE DDC AND WAS DIAGNOSED AS HAVING A MEDICAL PROBLEM THAT WAS THE CAUSE OF HIS BEHAVIORAL DIFFICULTIES. THIS PROBLEM IS TREATABLE WITH AN ANTI-CONVULSANT MEDICATION. HAD THIS

MEDICAL CONDITION BEEN UNCOVERED 15 YEARS AGO, THOUSANDS OF DOLLARS IN OUT-OF-STATE GROUP HOME FEES WOULD HAVE BEEN SAVED. THIS TYPE OF SCENARIO HAS OCCURRED OVER AND OVER AGAIN. IT IS ESTIMATED THAT 60% TO 70% OF THE REFERRALS FOR MALADAPTIVE BEHAVIOR MADE TO THE DDC IN THE PAST YEAR AND A HALF WERE FOR UNDIAGNOSED EPILEPTIC DISORDERS, PSYCHIATRIC DISORDERS, OR LACK OF ADEQUATE BEHAVIORAL PROGRAMMING ALL OF WHICH ARE TREATABLE BY THE EXPERIENCED STAFF AT THE DDC. IT IS THEREFORE CRUCIAL THAT ADDITIONAL REGIONAL RESOURCES SUCH AS THE ONE IN MORRISTOWN ARE ESTABLISHED IN NEW JERSEY.

IT IS THE ARC'S FEELING THAT THE SPECIAL NEEDS OF PEOPLE WITH DEVELOPMENTAL DISABILITIES ARE OFTEN FORGOTTEN OR AT BEST PUSHED ASIDE WHEN DEALING WITH ACCESS TO HEALTH CARE IN NEW JERSEY. THIS MUST BE STOPPED. WE ENCOURAGE YOU TO EXAMINE THE MATERIALS WE HAVE PROVIDED FOR YOU TODAY AND REFLECT UPON OUR TESTIMONY WHEN CONFRONTING THE BROADER ISSUES ASSOCIATED WITH ACCESSING HEALTH CARE IN NEW JERSEY. THANK YOU.

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MAINSTREAMING MEDICAL CARE PROJECT

# RECOMMENDATIONS FOR IMPROVING ACCESS TO MEDICAL CARE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

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## BACKGROUND STATEMENT

Many barriers block access to health care for people with developmental disabilities. In general, the present health care delivery system in New Jersey lacks consistently available quality health care for people with developmental disabilities. This is particularly true for adults.

Expanding access to medical care for people with developmental disabilities involves overcoming policy dilemmas, barriers found in the health care delivery system, barriers in provider care, and consumer barriers.

It should be pointed out that people with developmental disabilities are not alone in lacking dependable medical care. Uninsured people or underinsured people face barriers to health care, as do people living in some rural or urban communities. Many people with developmental disabilities are also among the poor of our nation. They endure poverty and the health care available to people of poverty, but have unique health problems.

Many Americans need adequate health care. The working poor, impoverished children, many handicapped or developmentally disabled people, and some elderly people cannot afford a "medical home." Some have defined a "medical home" as a place where people know and care about the client, where the staff keeps clients' medical records, and where staff takes care of basic health care needs

These are our medically homeless. They may have access to a doctor in a medical crisis, but require the continuity of care to prevent some conditions from becoming serious. Because of the special needs of people with developmental disabilities, society must offer the necessary assistance to make a sustained, stable health care system a dependable reality for our citizens.

## HIGHLIGHTS OF BARRIERS:

### System barriers

Among the system barriers are:

a fragmented health care delivery system with only informal, and thus, capricious links between primary care physicians, subspecialty and specialty physicians (see note page 3);

a lack of systematic planning about a health care delivery system for people with developmental disabilities;

federal and state regulatory requirements discouraging



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healthcare provider involvement with developmentally disabled patients (e.g., excess paperwork to describe minor changes in medication);

low Medicaid reimbursement fees for service; and

no Medicaid reimbursement for duration of office visits. (For people with developmental disabilities such visits can be lengthy.).

Consumer barriers

Among the consumer barriers are:

the difficulty of the patients to describe their symptoms, past medical history or family medical history;

more complex medical problems than the general population (e.g., frequency of seizure disorders);

the difficulty of treating people with behavior problems;

confusion about informed consent (i.e., who is the guardian);
need to consider other aspects of the client's life, such as work obligations, when scheduling routine medical care visits (e.g., employers require adequate notice for employee absence, if appointments could be made in evenings, the client's job would be in less jeopardy); and

a gap between medical treatment and community follow-up.

Provider barriers

Among the health care provider barriers are:

negative attitudes toward working with developmentally disabled people;

lack of barrier free offices for non-ambulatory patients;

lack of consistently available transportation for non-ambulatory patients (e.g., especially those who accept Medicaid);

lack of physicians in particular geographical areas; and

lack of specific medical school training in treating people with developmental disabilities and lack of clinical experience in programs other than pediatric programs.



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Direct care provider barriers

Among the barriers presented by the residential providers staff are:

lack of skilled direct care staff who can carry out the physicians' recommendations on a day to day basis, accurately observe clients' health symptoms, record the clients' symptoms or accurately relate the symptoms and medical history to the physician; and

excessive paperwork created to protect the provider from concerns about violating state rules.

The distribution of the above barriers varies with some problems unique to one portion of the state, while others, are found throughout the state.

*Note: Subspecialist and specialist are words that are occasionally used interchangeably. Specialist usually refers to physicians trained in a particular discipline such as pediatrics, internal medicine or psychiatry. Subspecialist usually refers to a physician who has further training in a subdiscipline of a discipline. For example, a cardiologist is also an internist or a pediatrician could also become a pediatric neurologist. Because access to both specialists and subspecialists are often obtained by referral through a primary care physician, the term specialist will be used here to encompass physicians other than primary care physicians.

The Advisory Board extensively discussed and reviewed recent research studies and literature, and listened to presentations by experts. The Board, with expertise in the area of health care, offered recommendations about ways to provide better access to medical care in the community.

The Advisory Board offers these recommendations, anticipating that they can become a starting point for the discussions of others. Whatever the final form of the health care delivery system, it is necessary to begin such discussions because the current system cannot be relied upon to support the needs of increasing numbers of people who will come to live in New Jersey communities.

## STRUCTURE OF THE STATE WIDE SYSTEM FOR MEDICAL CARE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

### Problems Addressed

Building better access to the health care delivery system in the community will help people with developmental disabilities live in the community. As a part of this effort, it is necessary to plan for their medical needs in a systematic way.

Service fragmentation can hinder development of such a system, because fragmentation can result in an unreliable, unpredictable system. An unpredictable system presents a greater risk of health problems. Because the state has responsibility for many people with developmental disabilities, planning for health care services is a necessary component of building community capacity and developing community resources. Community capacity refers to the number of resources within a community that would be available to people with developmental disabilities. To build capacity requires increasing access to existing resources, or adding resources (e.g., a clinic) to the community.

Contributing to fragmentation or duplication of services, agencies providing health care needs for people with developmental disabilities may plan in isolation from other agencies having interrelated responsibilities (e.g., transportation needs, direct care needs, payment and service needs, child health care, adult health care, institutional care, community care, or dental care may be handled separately). Laws, too, can serve to reinforce fragmentation.

The challenge is to look at the natural interconnections among agencies necessary to develop a successful model. Legal and regulatory rules also might constrain the form of health care delivery system.



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## RECOMMENDATIONS

1. A planning model should be developed. The model should include criteria for setting priorities, methods for gathering information for decision making, procedures for reviewing models of care and comparing them against defined needs, methods for evaluating the success of the model under varying conditions, and mechanisms to revise programs.

2. The planning process should include representatives of all who must carry out the decision and all affected by the decisions: residential providers, state officials, health care providers, parents, and consumers.

3. Current laws should be reviewed and those that constrain the health care delivery system proposed as a result of a state planning process should be changed.

4. The planning model should develop accountability measures to evaluate the quality of care provided for the client. As a part of an on-going evaluation of the system, data must be collected and used to make judgments about the system's effectiveness.

5. The model must include mechanisms to respond to evaluations, identify areas overlooked and gaps in service, and to carry out modifications. Because a comprehensive health care delivery system is not yet designed, many unexpected outcomes are possible. Such events might require changing the model.

## COMPONENTS OF THE HEALTH CARE DELIVERY SYSTEM

1. The health care delivery system for the State of New Jersey should include primary, secondary and tertiary care centers. The Federal Government defines a primary care physician as a doctor with a specialty in pediatrics, general practice, family practice, internal medicine, or gynecology. Morristown Memorial Hospital Developmental Disabilities Clinic is an example of a tertiary care center. The tertiary care personnel offer care, too, but also can act as consultants to secondary and primary care centers. Because it is difficult to provide all primary care half a state away, the primary care physician should have access to the tertiary care center. Moreover, behavioral problems of some clients block access to primary medical care. Physicians trained in behavior management and willing to include disruptive clients in their practices might help. However, such clients will probably continue to receive primary care at a tertiary center where they can receive the needed support.

2. Each client should have a medical home. Some have defined a "medical home" as a place where people know and care about the client, where the staff keeps clients' medical records, and where



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staff takes care of basic health care needs. The criteria is that the facility be close, accessible, and the client known. It is likely that this medical home is a primary care center.

3. The health care delivery system should provide specialist (i.e., cardiologists, radiologists, neurologists, etc.) and developmental disabilities specialist support for the primary physician. One form of support is a network of primary, secondary and tertiary care centers formally connected.

4. Within New Jersey, we need three tertiary care centers. However, the final mix of primary, secondary, and tertiary care centers must be designed to fit with variations in local conditions and available staff. At present, there is one tertiary care center at Morristown Memorial Hospital.

5. Coordination of care should be a component of the health care delivery system.

6. The system must include intradepartmental analysis of ways to remove departmental barriers inadvertently created. For example, reducing redundant and excessive paperwork should be a goal. Redundant paperwork and unnecessary paperwork created by providers of residential services, or the division takes valuable time of doctors and pulls the doctor away from contact time with the patient. Excessive paperwork is cited by doctors as one reason for refusing to see people with developmental disabilities. Accountability must be balanced with efficient record keeping (having a commission of lawyers, DD staff, and doctors to define an efficient record keeping system might help this problem).

7. The health care delivery system must assure adequate capacity to provide the clients living in the community with quality health care. The state should initiate a process for developing and defining standards of care. There should be an interdisciplinary group to work on defining quality of care issues.

A health care coordination system would help increase the quality of health care within the community. Moreover, a monitoring system can assure better quality of care. Who will do the monitoring must be defined.

One possible solution to quality care is to fill the open position of medical director of DDD for New Jersey. The position has been open for years.

The health care coordination role affects the quality of care. In some perspectives case management has come to mean reduced length of hospital stay. This is seen as discharge management, sometimes to reduce costs rather than provide quality of care. For others, case management is a more comprehensive role.

8. A team approach to care for people with developmental disabilities should be developed. The roles within the delivery system must be defined. Among the necessary roles are primary care physicians, subspecialists, specialists, developmental disabilities specialists and support staff.

A critical role to be defined and skills delineated is that of the health care coordinator. This person will coordinate the care between the doctor and the direct care staff and other support staff. Defining and developing this position can free the doctor for more contact time with the patient. This role might be filled by nurse practitioners, or other nurses or social workers with appropriate skills.

The health care coordinator role should be separate from that of a case manager. The health care coordination role affects the quality of care. A quality system needs health care case coordination. There should be a different loci of case management for health care matters. We must identify which agency or health care organization should be responsible for this coordination, and who should bring the information together. The role of health care coordinator should not be subsumed under the role of a DD case manager. The roles are distinct.

An adequate health care delivery system must provide trained direct care workers. They need to record appropriate information about the clients' health, efficiently to explain clients' symptoms to doctors, and to carry out doctors' recommendations for care at home.

The health care delivery system should provide appropriate support for the physician. Aspects of support include:

(1) adequate funding for physician services;
(2) information about Developmental Disabilities and medications;
(3) specialty referral network; and
(4) health care coordination support.

The role of the physician in providing quality care must be defined.

9. Because the system will need some set of policies, people, and facilities as yet undetermined, the planning model must include mechanisms for introducing new information. The planning model should address an understanding of how client and practitioner behaviors affect the system, types of organizations to meet those issues, and alternative cost-effective health care delivery systems.

10. Client health problems should be analyzed and provisions for



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specialty care directed toward those needs. For example, seizures and medications are problems for many clients and may require the services of neurologists. The system needs to link specialty care with primary care.

11. Geographical distribution of doctors, including specialists, varies. This leads to differential availability. The state needs to assess shortages of types of physicians in any geographical area and develop methods of remedying the shortage.

12. Because counties are a source of transportation funding, they might not pay for transportation across county lines for patients who need to visit doctors in another county. Policies and laws regarding transportation for non-ambulatory clients must be reviewed and barriers, if they exist, removed.

13. The health care system should be linked to medical education. Developmental Disabilities fellowships can be linked to the system and they in turn to the medical school faculty. New York State has a developmental disabilities fellowship program providing 36 fellowships annually. In New Jersey privately and publicly funded fellowship programs for nurses and physicians should be developed.

14. However, because clients require continuity of care and physician fellows turn over quickly, the health care delivery system must find a way to stabilize the staff who treat the patients.

15. Direct care workers within the system must be trained to interact with physicians, to make significant observations, and to provide care that supports the health of the client. Behaviors of direct care workers are important in designing a system. The direct care giver is very important in care, because medical history is critical to diagnosis, continuity of medical history is important. The family should also have information about how to interact with physicians and have necessary support to do so. Outreach and follow-up are components of a support system from the physician to the family, group home, or patient.

16. Within the state an institute for research into the causes of mental retardation and developmental disabilities should be developed. The center for research should include a clinical assessment component. The clinic would provide assessment of individuals who present symptoms that are difficult to diagnose. The institute could be a coordinated network of services or be located within a facility.

## FINANCING MEDICAL CARE

Problem statement:

Many doctors no longer accept Medicaid as a form of payment for services. Because most developmentally disabled adults are on



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Medicaid, they face restricted access to consistent primary care.

Because people with developmental disabilities often have difficulty in expressing their symptoms or in explaining their medical history, or fear the procedure, they may take more time per visit than other patients. At present Medicaid fee-for-service does not include length of visit in reimbursement schedules.

Information is unclear about the types of insurance available to people with developmental disabilities. The advantages and disadvantages of each type of insurance--Medicaid, Medicare, Dual Coverage- are not well understood. Insurance from private insurance companies is often prohibitively expensive for people with developmental disabilities, if such policies would be written at all.

At present there is no clear actuarial data on medical use by people with developmental disabilities. Rates are not set on an actuarial basis. (Risk assignment is not included in many forms of payment.) Doctors are reluctant to assume unknown risks.

Recommendations

1. Increase medical assistance and reimbursement for treating people with developmental disabilities. New Jersey continues to provide one of the lowest fee-for-service reimbursements in the nation with doctors receiving $12 for an office visit. In comparison, a hospital-based visit is reimbursed at between $40 to $75 a visit.

2. Medicaid should pay physicians for their time with the patient. To do this it is necessary first to determine the cost of time. People with developmental disabilities require more time to treat than does a patient without disabilities. Codes for reimbursing time exist in the CPT4 books (e.g., for phone time in mental health problems). These codes provide a model for such fee structuring for people with mental retardation.

A special level of care code for MR/DD for each office visit should be developed. Such a code would provide guidelines to physicians for a primary care visit requiring an additional amount of time needed to treat some MR/DD patients.

3. Insurance should follow the person with developmental disabilities. Now when a parent loses a job or dies, the "insurance dies." Moreover, there is potential of a Medicaid loss when at the death of a parent, the developmentally disabled child receives the parent's pension or assets. If a person exceeds the dollar threshold, the state denies them eligibility for Medicaid.

4. Medicare, or other form of purchased private insurance might be developed through state or agency planning. One alternative is



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to purchase such insurance through a lifetime planned assistance network or state agency.

5. Medicaid should help doctors become familiar with codes and ways to be reimbursed for all the services that they provide to patients. It is important to inform doctors of fees for which they could be reimbursed and to pay them more equitably for the service that they provide. This knowledge is likely to increase their fees under existing schedules. Among the information that physicians need to receive is:

1. to know the services needed;
2. to discover if the doctor can be reimbursed in existing systems;
3. to define what the doctor can do within the existing codes;
4. to define what the system needs (gap analysis) "should be's;" and
5. to help doctors act as an advocate for needed changes.

6. Hospitals should know the additional fees that they are entitled to for treating people with developmental disabilities. Hospitals may not collect monies that they are entitled to for treating people with developmental disabilities, especially, MR. Indeed, they may not ask or record that information. An MR code on the form will entitle the hospital to higher reimbursement fees. One problem is that hospitals often do not use the MR code to increase the amount of return. For example, MMH hospital only recognizes 80% of the clients in the MMHDD clinic (from MMHDD Clinic research).

7. We recommend that with support from the state and advocacy organizations, doctors investigate developing a sick fund, or medical "tithing" system.

8. We recommend that the state direct Medicaid system away from providing expensive care in hospitals to a less expensive out-patient care.

9. We recognize that there is a right to basic health care for people with developmental disabilities. We need to define the basic health care and develop a national health care policy and insurance to ensure quality health care for citizens.

10. We recommend ensuring that dual coverage of Medicaid and Medicare be available for all adults with developmental disabilities not covered by private group insurance. The client so covered should continue to receive SSDI without penalty. Because more doctors accept Medicare than they do Medicaid, dual coverage promises to increase access to health care.

11. We also recommend that developmentally disabled people on



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Medicare should have ARC developed insurance picking up additional services. Casino monies could be used to fund such a program.

12. Although there is a legislative mandate for changing the Medicaid fees, the same problem persists: nothing is on an actuarial basis. We recommend determining fees on an actuarial basis and paying for risk factors related to the disability.

13. We need to support research that will help in setting fee structures and define medical needs. We need a research base developed to set rates and to understand risk factors. Such research will help to provide clear information.

14. There is a need for integration of dental and medical insurance policies.

15. The gap between health care and the provider agency should be filled with coordination of health care. Medicaid does not reimburse for the coordination component. We recommend that either DD or Medicaid reimburse health care providers for medical case management, perhaps using a Medicaid waiver.

TRAINING RECOMMENDATIONS:

Statement:
In concert with defining the health care delivery system for people with developmental disabilities, educating and training people for roles must begin. The education and training before employment, as well as continuing education must be a component of the system.

The number of physicians continues to increase, suggesting more physicians could serve the medical needs of the general public. However, few physicians have special training in treating people with developmental disabilities.

1. To help increase access to health care for people with developmental disabilities, the committee recommends that more physicians receive training about developmental disabilities.

2. We recommend that public and private agencies develop fellowship programs for physicians within the State of New Jersey. Fellowship programs should include rotation through a variety of disability programs and include clinical work.

Fellowship programs for nurses and other appropriate personnel should also be explored.

The fellowship year could be integrated with a program leading to a MPH degree as well. This program could attract a mix of students into the graduate program in public health such as physical therapists, nurses, social workers with fitting medical



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training, and developmental psychologists. The Masters of Public Health at Robert Wood Johnson Medical School and Rutgers University has a mix of students from the health care community. This program includes information about developmental disabilities.

3. The special training in developmental disabilities must be recognized in some way. Various ways of recognizing the should be explored. It should be noted that drawbacks have arisen in licensing of specialties and specialties focusing on particular populations.

4. Research should be undertaken to determine the kinds of training that can be integrated into the medical school and nursing school curriculum and when it should be included.

5. There should be multiple models for training. Some of the elements of the training should include:

a. the training should fit into existing programs when possible. Because of its life cycle and humanistic approach, Family Practice should be one of the areas emphasized.

b. experiences in working in teams with social workers, nurses, and direct care workers.

6. Schools of nursing and social work should initiate and develop educational programs about developmental disabilities.

The above recommendations are presented to initiate efforts at building capacity in the community to permit clients to live lives with caring support when it is needed. The need for medical services should never become a barrier to community living.

Opportunities for helping people with developmental disabilities should not be denied to the health care community. When the above recommendations are implemented, the mechanisms will be in place to provide the health care community with knowledge about, the skills to better help, and the support to provide adequate care for people with developmental disabilities.



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**TESTIMONY**

**ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION**

**THURSDAY, MAY 24, 1990**

The New Jersey State Nurses Association appreciates the opportunity to provide testimony relative to health care policy.

Raising the level of health coverage for the uninsured would certainly relieve the uncompensated health care fund except that much of the care required by the uninsured is inappropriately provided in high cost acute care institutions instead of private providers offices.

There are two reasons for this phenomena:

1. The emergency rooms are open 24 hours a day and are obligated to treat those who appear.

2. Preventive care that would avoid many of the unnecessary emergency room calls is not reimbursed and the providers of such care is limited to physicians.

The New Jersey State Nurses Association urges the legislature to consider the tally of reimbursement policies that ignore preventive care and licensure polices that prohibit the reimbursement needs and prescriptive needs of advanced practice nurses.

Advanced practice nurses have been developed in the past twenty years to provide the kind of care to all income levels that is now only available to those who can afford physician care. The constraints on nursing practice by the Medical establishments has been profound. Physicians within various state departments refuse to allow full practice and reimbursement and require over zealous monitoring of advanced practice nurses inappropriate to their education level. The legislature should consider those bills that have been introduced to expand nursing practice and reimbursement. Senator Lipman's A-2100 and Senator Orechio's S-2007 and 2008 are the best examples.

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In considering health procedures that should be covered by health insurance policies NJSNA supports the inclusion of preventive procedures such as mammography, pap tests, well baby assessments and immunization and especially coverage of drug and alcohol treatment.

NJSNA is not invested in the present system of health care delivery. We are actively stating a change in emphasis from tertiary care of the acutely ill to preventive care of the well. We are actively seeking a change in keeping all control invested in the physicians and allowing advanced practice nurses to join the health care team as an equal partner.

Thank you again for this opportunity to testify and I would be happy to answer any questions.

AWA/k

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Members of the Assembly Health Care Policy Study Commission, my name is Gordon Boals. I am a licensed psychologist and I am representing the New Jersey Psychological Association. We are grateful for your interest in health care and insurance matters and for the opportunity to present to you some of our concerns.

In addition to the estimated one million citizens of this State who have no health insurance at all, many more are not covered for mental or emotional problems, marital or family problems, or substance abuse problems even though they may have health insurance. And yet, we hear so much today about problems of domestic violence, child abuse, marital discord and divorce, and we are trying to wage social campaigns to fight substance abuse and academic dysfunction. One person in ten requires treatment for mental disease which, left untreated, often creates dysfunctional families.

Consequently, society has a stake in effective and affordable treatment for mental and emotional problems. But insurance companies, competing with each other to provide cheaper health insurance packages; and employers, looking for the least expensive plans they can find, often settle for health insurance plans that provide little or no coverage for mental disorders. This is unfortunate because:

1. psychotherapy prevents more serious emotional and medical problems, for the person being treated and often for others in their families;

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2. psychotherapy has been proven to reduce the number of medical visits and thus lowers medical costs; and,

3. it lowers other business costs associated with absenteeism, accidents, turnover and so forth.

And, mental health coverage adds very little to health insurance costs.

The only solution for this problem, other than finding millions of additional tax dollars to fund public treatment centers, is to mandate basic coverage for mental health treatment in all health insurance plans. We believe that this would produce great individual and social benefit at very little cost.

Consequently, we would urge your attention and support to legislation which has been introduced by Senator Codey in the Senate (S.1233 - S.1238) and Assemblywoman Ogden and Assemblyman Otlowski in the Assembly (A.2019 - A.2024). These Bills have been around for several years now and the benefit levels have been reduced (particularly in the Senate versions) to a level significantly below what we feel is needed or desirable. Still, they represent much needed health care insurance to a sizable population not now covered and we hope that you would support them.

Briefly, these Bills require health insurance policies, HMOs, and the like, to provide 60 days of inpatient care or 120 days of partial hospitalization (half that in the Senate version) and $1,000 of outpatient benefits ($650 in the Senate version) with a co-payment not to exceed 50%. Deductibles for mental illness must be consistent with those for other illnesses covered by the policy.

An additional option, which is under consideration in other States likes Pennsylvania and which would make the benefit more flexible and potentially lower health expenditures, is to allow some proportion of the inpatient benefit to be used to fund outpatient treatment which may forestall the need for hospitalization.

I thank you for your consideration.

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I am Pat Buckley, a Supervisor at MCOSS Foundation. As many of you know, MCOSS is a voluntary, non-profit home health agency which has an eighty (80) year history of providing health care in the community. Our services touch all ages; from the unborn child to the elderly.

Let me begin with the problem of access to care for women, and infants and children. Many of the working poor do not have health insurance and access to health care is limited or denied entirely. Without insurance, they cannot afford the comprehensive prenatal care and preventive child care necessary to assure good health in their children. Although they earn a low income, many of the working poor do not qualify for Medicaid, and services on a sliding fee scale become a necessity.

As you know, the Public Health Priority Funding which supports prenatal and well child clinics in New Jersey will be discontinued as of July 1. With this funding gone, Medicaid becomes the only financial access to care that many of the working poor have.

Due to federal mandate the access to Medicaid insurance will increase to 133% of the U.S. poverty level. However, there are many more women, infants and children above this 133% level of poverty who still cannot afford adequate health care.

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Many perinatal advocacy groups report the necessity to raise the eligibility level to 186% of the poverty level to meet the health needs of these women and children.

MCOSS clinic services include developmental screening, hearing and vision testing as well as parental education. Without well child clinics, an entire population of children will go unimmunized, increasing the potential for childhood epidemics and all the devastating ramifications. When we consider that there is an increased incidence of measles and tuberculosis nationwide, the importance of screening and immunization of children is heightened.

Not only children but adults across the lifespan have health care needs. For the underinsured or uninsured middle aged adult preventive health care is an impossibility. Pap smears, mammograms or colon cancer examinations are not available to many. When they are ill, this same population does not have the ability to obtain the necessary sick care services.

Health care services to the homebound mentally ill are available on a very limited basis or not available at all. Clients at the end of their lives who wish to die at home surrounded by their loved ones do not always have the ability to secure hospice benefits. Care for these most vulnerable members of our society should be available universally to all.



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Care in the home versus care in the institution is frequently not an option. Certainly not all health care programs need to be carried out in hospitals. Screening and health care can be, and is, provided in community based clinics and in the home. The Uncompensated Care Trust Fund available to hospitals should be expanded to include community health care agencies.

Also, not all care need be carried out by physicians. Nurse specialists and Nurse Practitioners can provide equally comprehensive care in a more cost effective manner.

We at MCOSS strive to provide services to all clients regardless of ability to pay. The agency provides much uncompensated care through fund raised dollars, but financial limitations exist. The state must be responsive to the health needs of all New Jersey residents. On behalf of MCOSS and the clients we serve, thank you.



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