THE UNCOMPENSATED CARE TRUST FUND:

ASSURING UNIVERSAL ACCESS TO HOSPITAL CARE IN NEW JERSEY

A REPORT TO THE GOVERNOR AND THE LEGISLATURE

BY

MOLLY JOEL COYE, M.D., M.P.H.
STATE COMMISSIONER OF HEALTH

November 1989

State of New Jersey

DEPARTMENT OF HEALTH
CN 360, TRENTON, N.J. 08625-0360

MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER

TO THE GOVERNOR AND THE LEGISLATURE

Thomas H. Kean
Governor

John F. Russo
Senate President

Chuck Hardwick
Assembly Speaker

Laurence S. Weiss
Senator

Harold L. Colburn
Assemblyman

Richard J. Codey
Senator

Rodney P. Frelinghuysen
Assemblyman

I am pleased to submit the enclosed report on uncompensated hospital care, entitled "Assuring Universal Access to Hospital Care in New Jersey". This report is being transmitted in accordance with the New Jersey Uncompensated Care Trust Fund Law, as amended by P.L. 1989, c. 1, which requires submission of the report by December 1, 1989.

The Act further provides that:

> The commissioner shall appear before the Senate Institutions, Health and Welfare Committee and the General Assembly Health and Human Resources Committee to discuss that report no later than December 31, 1989. (P.L. 1989, c.1, section 16).

I am therefore asking Senator Codey and Assemblyman Colburn to advise me of the date and time in December 1989 when an appearance before their respective Committees is being scheduled for the required presentation and discussion.

As indicated in the enclosed report, New Jersey's Uncompensated Care Trust Fund is the State's key system, and a national model, for assuring access to hospital care. The report presents recommendations, prepared by the statutorily created Trust Fund Advisory Committee, to stabilize the funding of this vital part of our health care system.

The report also summarizes activities performed by the Department of Health in 1989 to improve the operations of the Trust Fund. These activities include enhancements of audits of hospitals' bad debt reimbursed through the Trust Fund, the development of demonstration projects to expand insurance coverage, and exploring options for financing uncompensated care.

I am also pleased to report that Trust Fund expenditures are now projected to remain under to cap established by the Act. Vigilance is needed to contain Trust Fund expenditures in the future and to assure that the Trust Fund pays only for care appropriately charged to it, and for all care that is needed.

The root cause of uncompensated care is the lack of insurance. In order to relieve the burden of financing the Trust Fund -- a burden which now falls on people who directly or indirectly purchase their health insurance -- imaginative strategies are needed to expand insurance. Ultimately, development of those strategies will require national as well as State participation.

I look forward to discussing the report before the Senate and Assembly Health Committees in the very near future. Should you have any questions please feel free to contact me.

Sincerely,

Molly Joel Coye, M.D., M.P.H.
State Commissioner of Health

Enclosure

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Under New Jersey law (P.L. 1978, c.83), full reimbursement to hospitals for the cost of uncompensated care has been required since 1980. The payment of uncompensated care is an integral part of the State's rate setting system, and uncompensated care has been funded for nearly ten years through the rates charged to purchasers of care. During 1989, over $500 million has been paid to hospitals for uncompensated care.

Uncompensated hospital care is that provided to individuals who qualify for charity care by virtue of low income or who are classified as bad debts by virtue of failure to pay after appropriate collection efforts. Uncompensated care exists because of the many persons who lack health insurance entirely or are underinsured. In New Jersey, 11 percent of the population (843,000 persons) lacks health insurance of any kind, slightly less than the national average of 15 percent. The uninsured are those who do not qualify for Medicaid, but who for the most part cannot afford private health coverage. One-fourth of the uninsured are children, and half are under age 25. Many (41 percent) are working, and over half of the remainder are the spouses or children of working persons. Although most are connected to the work force, most of the uninsured are not financially well off; in New Jersey 45 percent of the uninsured have a family income below twice the poverty level ($24,200 for a family of four).

While it has been well documented that the uninsured suffer from lack of access to needed care in many parts of the country, patient dumping and refusal of care are not systemic problems in New Jersey. New Jersey's principal strategy for assuring access to care has been to reimburse hospitals for uncompensated care through the rate setting system, and since 1987, through the Uncompensated Care Trust Fund.

The Trust Fund improves the equity and stability of the original system of uncompensated care. Where each hospital had had its own mark-up for its own amount of uncompensated care from 1980 to 1986, the Trust Fund "leveled" the collection of uncompensated care through a single statewide mark-up and then assured proper distribution to hospitals in accordance with their actual uncompensated care cost. By eliminating the competitive disadvantage of higher mark-ups to the rates of hospitals with high levels of uncompensated care, the Trust Fund assures continued access to care for patients who do not have insurance and financial stability for hospitals that serve these low income populations.

In 1986, Federal cuts in Medicare rates began to limit Medicare contributions to uncompensated care. When the Federal waiver that allowed New Jersey's rate setting system to set Medicare payment rates ended in 1988, all of Medicare's share of uncompensated care was shifted to non-Medicare payers, thus sharply increasing their payments. Without the Trust Fund already in place the impact of this shift would have been disastrous. Nevertheless, while the Trust Fund diluted this impact, continued Federal cuts are likely and further shifts of shortfalls not related to uncompensated care may be expected to strain the rate setting system as a whole.

There is no question that access to care for uninsured people in New Jersey -- both inpatient and ambulatory care -- is significantly better than that in other states. Research surveys of actual use of services and of patient/consumer satisfaction with access show New Jersey to be consistently more successful in meeting the needs of the uninsured. The Uncompensated Care Trust Fund, therefore, has provided both access to care and financial stability for New Jersey's hospitals.

The Legislature and the Trust Fund Advisory Committee identified two major issues which became the focus of the Advisory Committee's deliberations over the past year: the financing of the uncompensated care system, and the need to increase the proportion of insured persons in the state. The principal concern regarding financing was that employers who purchase coverage for their employees are in effect penalized by having to assume the costs of uncompensated care in addition to the premiums for their own employees. In the second area, legislative mandates have been implemented and a series of new initiatives have been undertaken by the Department of Health in consultation with the Advisory Committee.

Implementation of these legislative mandates and the initiatives undertaken by the Department and its Advisory Committee will provide for the continuation of access to care provided by the Trust Fund; will make the financing of care more equitable, while introducing an appropriate incentive toward insurance; and will break new ground in projects to expand insurance coverage among working residents of the state and their families. These accomplishments are briefly summarized below.

I. Actions To Limit Growth and Enforce Appropriate Use of the Uncompensated Trust Fund Monies

- Kept growth of the Trust Fund below the legislatively-mandated "cap" of 13 percent of total hospital revenues.

- Adopted regulations to guide reimbursement if cap is exceeded in future years.

- Developed strengthened credit and collection proposals that would:

  * establish a statewide collection agency network to monitor and enforce standards of industry practice;

  * increase use of independent auditors;

  * prohibit hospital subsidiary collection agencies;

  * improve timely collection of data to monitor trends and compliance; and

  * create positive incentives for hospital improvement.

- Revised reimbursement rates for emergency room services to encourage appropriate provision and use of primary care.

- Established a mechanism for the Trust Fund to participate in the N.J. Department of Treasury's "SOIL" (set-off of individual liability) Program which permits withholding of state income tax refunds and homestead rebates in order to satisfy debts owed.

- Completed an analysis of the impact of increases in unemployment on the uncompensated care system.

II. Initiatives To Expand Insurance Coverage and Reduce the Future Burden of Uncompensated Care.

- New Jersey MOMS (Maternity Outreach & Managed Services) program redirects uncompensated care monies expended for pregnant women to more effective managed care with emphasis on early and comprehesive pre-natal services. The Department expects a significant reduction in the Uncompensated Care Trust Fund's costs for newborn care, and a major impact on low birthweight and infant mortality rates.

- Reinsurance Program to reduce insurance premiums for small businesses. The Program will permit the Uncompensated Care Trust Fund to reinsure the coverage of currently uninsured employees (who would otherwise be completely covered by uncompensated care). The level of reinsurance will be actuarially determined and result in net savings to the Trust Fund for each new person insured by the Program. It is expected that the Program will be implemented in early 1990.

- Proposal to expand dependent coverage for spouses and children of working insured persons. This program will offer cash subsidy toward the purchase of dependent coverage, using state funds set aside by the Legislature for demonstration project in 1988; implementation will require enabling legislation.

III. Recommendations for Alternative Methods of Financing the Uncompensated Care Trust Fund.

- Maintaining a system that ensures access to needed hospital care for all New Jerseyans -- regardless of their insurance status -- is integral to the State's health care system and must be preserved.

- The responsibility for health care is one that should be shared by all and therefore any financing mechanism for uncompensated care should be broadly based. Two other important criteria in evaluating funding sources of uncompensated care are equity and stability over time.

- The Uncompensated Care Trust Fund should be maintained as a mechanism to collect a portion of the statewide uncompensated care amount via a uniform statewide hospital uncompensated care mark-up, and to distribute payments, regardless of the funding source, to hospitals.

- Alternative funding should be sought for at least the Medicare share of the statewide uncompensated care amount. Funding for this

share of uncompensated care need not come from a single source; a mix of revenue sources could be used. Any alternative tax used to fund uncompensated care should be dedicated. This would protect the funds from being re-routed for other purposes during future periods of fiscal constraint. Below are suggested revenue sources for further exploration:

* Mandatory contributions from employers who do not provide insurance coverage for their employees and thus do not now contribute toward the State's uncompensated care amount. Such a mechanism would also serve as an incentive for employer-based coverage. Employees could share in this employer contribution in a way that is similar to the unemployment insurance arrangement. This funding source is particularly equitable in scenarios in which uncompensated care continues to be partially funded through the hospital mark-up (which is paid in part by employers who provide insurance for their employees as well as by employees who share in the cost of the insurance).

* State excise taxes, in particular alcohol, cigarette, and other tobacco taxes. This is especially appropriate and logical given the negative impact that alcohol and tobacco products have on health status.

* The Casino Revenue Fund -- designated for persons who are elderly or disabled/handicapped -- could support a new program to fund uncompensated hospital care provided to persons having HIV-related diseases.

- Medicaid eligibility should be expanded to the maximum permitted by the federal government. As an "indirect" funding source of uncompensated care, Medicaid expansion has the significant advantage of bringing in new federal dollars; the federal government would match every dollar New Jersey spent on Medicaid.

- Initiatives to increase the number of persons with private health insurance should continue to be studied, tested, and implemented in order to achieve a long-term solution to the issue of uncompensated care.

- Determination of the portion of uncompensated care funding raised through the hospital uncompensated care mark-up should be done in advance of each year in order to enable insurance companies to develop premium rates which will accurately reflect their contribution to uncompensated care.

- While pursuing alternative financing sources for uncompensated care, the hospital mark-up should be maintained as a safeguard. In the event that alternative financing mechanisms are not adequate to fully fund uncompensated care, the Department of Health should retain the authority to adjust the mark-up. This provision is to critical to the preservation of full reimbursement for uncompensated care.

Two of the recommendations represent important steps toward a more comprehensive and long term solution to containing uncompensated care costs by insuring people who now don't have coverage:

- Medicaid expansion to bring in maximum federal monies. Any alternative financing package would result in fairly significant savings to the State through the reduced uncompensated care mark-up. Spending for the Medicaid Program and the State Employee Health Benefits Program would be reduced. The State portion of the Medicaid expansion would be about $10 million according to the Department of Human Services; this should be more than offset by the State's savings resulting from the lowering of the hospital mark-up.

- The surcharge on employers who do not offer coverage would provide an incentive to offer insurance.

Introduction

Hospital uncompensated care and health services for the uninsured are related issues of serious and growing concern. These issues are especially important to states, because the federal government has made little headway addressing them on the national level.

New Jersey has developed and continues to refine a unique, effective, and practical approach to assuring access to care for the uninsured -- and financial solvency for the hospitals that provide the bulk of services to persons without health insurance. This report is a summary and analysis of uncompensated care and the uninsured in New Jersey. It describes recent actions to address this problem and proposals of alternative methods of financing uncompensated care and for increasing the number of insured persons.

This report is divided into three sections:

I. Context

II. Recent Actions

III. Future Agenda

I. CONTEXT

This section describes the policy issues associated with uncompensated care. Uncompensated care is defined, and a brief discussion is given of the causes and effects of uncompensated care. An overview of approaches being considered or used in other jurisdictions is provided as well as a description of the components of New Jersey's strategy. The results of research conducted on New Jersey's system are also presented, much of which has direct implications for initiatives now underway or proposed.

A. Uncompensated Care: Definition, Causes, and Impact

Uncompensated care is defined as unpaid hospital bills and is divided into two categories: charity care and bad debt. Charity care consists of care provided to persons who are "medically indigent," i.e., low income, uninsured persons who are unable to pay for their medical care. Bad debt consists of unpaid hospital bills generated by persons with incomes above the charity care level who are assumed to be able to pay. However, it is likely that many patients who are assumed to be able to pay have difficulty doing so.

In New Jersey, charity care is defined as care provided to persons who meet specific income and assets criteria and provide proof of this to the hospital. In order to qualify for full charity care an individual must have an income less than or equal to 150 percent of the federal poverty level; $18,150 represents 150% of poverty for a family of four in 1989. Charity care is provided at reduced charges to individuals with incomes greater than 150 percent of poverty but less than or equal to 250 percent of poverty.

Most uncompensated care exists simply because there are many people without third-party health insurance coverage. According to an American Hospital Association report, it is estimated that three-fourths of uncompensated care nationally arises from persons without insurance, and the rest from unpaid deductibles and co-payments of insured persons.

The growing number of people without public or private insurance coverage is a serious problem nationwide. According to the Current Population Survey (CPS) almost 37 million Americans lacked health insurance in 1986. This represents 17.6 percent of Americans under 65, compared to the 14.6 percent who lacked insurance in 1980.

New Jersey is fortunate in that it has a higher rate of insurance than the country as a whole. But lack of insurance remains a reality for 843,000 New Jerseyans. Those who do not have private or public coverage represent 14 percent of the State's under 65 population and 11 percent of the State's total population (CPS, 1986).

The Department of Health commissioned an analysis of the New Jersey subsample of the Current Population Survey (CPS) to learn more about the State's uninsured population. Selected demographic and socioeconomic characteristics of special interest are family income, age, and employment status.

Persons without insurance tend to have low incomes. About 25 percent of New Jerseyans with a family income below the federal poverty level lack insurance. **See Chart 1.** As a point of reference, the 1989 federal poverty level for a family of four is $12,100. Of all New Jersey residents without insurance, about one-fifth (20 percent) are below the federal poverty level and almost half (45 percent) have a family income less than twice the poverty level -- $24,200 represents two times poverty in 1989 for a family of four. Income of the uninsured is of special relevance when it is examined in light of the cost to purchase health coverage, which can exceed $3000 for a family of four.

More than half of the uninsured population in New Jersey are younger than 25, and children younger than 18 years account for more than 25 percent of the State's total number of uninsured.

Though most persons access health insurance coverage through their employer, employment is no guarantee of coverage. A strikingly large portion of the uninsured are working New Jerseyans; 41 percent of uninsured New Jerseyans fall into the category of employed adult. More than 150,000 children (about 69 percent of New Jersey's children without insurance) have a working parent, and many uninsured adults have a working spouse. In all, over 77 percent of New Jersey's uninsured population are working or are in a family with at least one working adult. **See Chart 2.**

National studies indicate that the uninsured working population tends to work in small business, those businesses with fewer than 20 employees. In New Jersey there are over 150,000 small businesses; the service and retail industries account for over half of these firms.

The Department of Health commissioned a study by the Eagleton Institute of New Jersey's small businesses in an effort to identify their practices and attitudes about insurance. The survey found that 40 percent of small businesses surveyed did not offer health insurance to their employees. Among those small businesses that did not offer coverage, the high cost of insurance was cited as the primary impediment in the majority of the responses.

The Uninsured Population's Utilization of Hospital Care

Hospital records of uninsured admissions to New Jersey hospitals provide useful information on the uninsured population's utilization of hospital care. In analyzing the uninsured population's utilization experience, their 90,000 admissions (1985) were grouped according to diagnosis. Maternity-related admissions accounted for 35 percent of all uninsured admissions and 19 percent of the cost of all uninsured admissions.

In reviewing charges associated with uninsured admissions, the average in 1985 was $2,533. This is lower than the $3,168 average charge of all admissions. About 75 percent of all uninsured patients had bills of $3,000 or less; these bills represented nearly 50 percent of the statewide cost of all uninsured admissions. Bills of $10,000 or more accounted for only 2 percent of all uninsured admissions and only 11 percent of the statewide cost of all uninsured admissions. Catastrophic illnesses thus represent only a small fraction of uninsured admissions in the State.

New Jersey's Uncompensated Care Costs, 1983-1988

Chart 3 displays New Jersey's uncompensated care cost and the ratio of this cost to hospital gross revenue from 1983 to 1988. Both the ratio of uncompensated care cost to hospital revenue and the uncompensated care amount have gradually increased over the past 5 years. The ratio of uncompensated care cost to hospital in 1988 was 50 percent more than that in 1983. The cost of uncompensated care has increased by an average of 17 percent per year over that time period, but approximately half of this increase is attributable to overall inflation in hospital revenue.

Other Effects of Uncompensated Care

There are also institutional and human costs due to uncompensated care. These vary by state and region. Where uncompensated care is not adequately reimbursed, hospitals that serve a large number of uninsured persons suffer operating losses that can threaten their existence. In turn, many institutions discourage uninsured admissions. As a result, in some areas of the country uninsured persons may be "dumped" on public hospitals that may not be near their homes, that may be overcrowded due to widespread dumping, and that as a result may require patients to wait long periods of time to be served. If there is no public hospital nearby, or if they are discouraged by this type of treatment, uninsured persons may defer or go without needed care.

B. Approaches to Addressing the Issues of Health Care for the Uninsured and Uncompensated Care

National Overview

States throughout the country are becoming increasingly cognizant of the need to address the problem of uncompensated care aggressively and are approaching the problem in a variety of ways, with varying degrees of comprehensiveness, and with different amounts of momentum. Some states approach the problem as a "hospital problem" or "local government problem" and develop strategies accordingly, e.g., providing subsidies to hospitals or local governments that serve medically indigent populations. Others approach it as a "people problem" and develop strategies that directly insure individuals through expansion of public and/or private insurance coverage. The National Conference of State Legislatures categorizes these approaches into three groups: 1) targeting local governments, 2) targeting providers, and 3) targeting individuals.

- Targeting Local Governments

  Many cities and counties provide care to uninsured residents by appropriating funds to their public hospitals or by providing aid through general assistance programs. Some states appropriate funds to counties for primary health care programs to serve low income and Medicaid clients, provide support to counties after the county has expended a specified percentage of its general revenue for indigent care, or allow counties to levy voter-approved taxes to fund certain hospital services for medically indigent patients. These methods serve to empower counties or local governments, instead of reserving authority on the state level.

- Targeting Providers

  Methods of targeting providers include providing direct government payment to hospitals or other health care providers, establishing mandates that hospitals provide care to the medically indigent, and giving incentives such as tax exemptions or certificate of need exemptions to hospitals which provide care to the medically indigent. Other methods involve assessing taxes to hospitals and requiring a mark-up to hospital charges in states, including New Jersey, where a rate-setting system exists.

- Targeting Individuals

  When targeting individuals, it is useful to determine which individuals are generating the greatest sums of uncompensated care, or uncompensated care that could be reduced through insurance strategies. These individuals include the employed uninsured, the unemployed uninsured, the medically

uninsurable, and uninsured dependents of insured and uninsured persons.

Strategies targeting individuals who are employed include the expansion of employer-sponsored health coverage through mandates, a tax on employers who do not provide insurance, and promotion of more affordable group health insurance plans. Finding ways to facilitate workers to purchase insurance on their own is another alternative. About 32 state and local communities have developed programs - most on a demonstration basis - to expand private coverage to the working uninsured population. An analysis by Irene Fraser, Ph.D. categorizes these strategies into five basic approaches: including more people in existing groups, forming new large groups, subsidizing coverage, changing the product or its delivery, and increasing product awareness.

Unemployed persons, if allowed to participate, could also benefit from state-sponsored programs designed to enable the employed uninsured to purchase insurance. However, it may be difficult for the unemployed uninsured to participate in these state-sponsored programs due to a lack of financial ability. The recently unemployed can be assisted by requirements to allow subscribers to continue to purchase insurance through the same group rate or at individual rates. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who sponsor insurance plans and who employ 20 or more persons to allow employees to participate in the group's policy for up to 18 months from termination or reduction of hours. Widows, divorced or separated spouses, and children of these employees must be allowed to participate for up to 36 months.

Compared to other uninsured, the "uninsurable" have the additional obstacle of a known medical condition that makes them a "poor risk" from an insurance point of view. Insurance shared risk pools can be established to help provide access to insurance for high-risk persons who otherwise would have trouble obtaining coverage. At least fifteen states have established these pools.

Another method of targeting individuals is the expansion of public insurance programs. For example, the federal government gives states some discretion in setting eligibility levels for Medicaid. States currently have the option of extending Medicaid eligibility to pregnant women and infants whose family income does not exceed 185 percent of the federal poverty level. By July 1, 1990 all states will be required to extend Medicaid eligibility to pregnant women and infants up to age one who have incomes up to 100 percent of the federal poverty level. According to the Intergovernmental Health Policy Project, forty-four states and the District of Columbia have already complied with this requirement, and of these states, six have expanded coverage

up to the range of 120 to 150 percent of poverty and fifteen have expanded coverage up to 185 percent of poverty for pregnant women and infants. Medicaid expansion has the benefit of bringing in and "leveraging" federal matching funds which in New Jersey represents 50 percent.

New Jersey's Programs to Address Uncompensated Care and the Uninsured

1. Uncompensated Care Trust Fund

New Jersey State law (P.L. 1978, c.83) maintains that the reasonable cost of uncompensated care (both charity care and bad debt), verified through audit, is a recognized element of cost which must be included in hospitals' payment rates which are charged to purchasers of hospital services. Both governmental and private payers, except for Medicare, fund this element through a mark-up of hospital rates. Medicare pays only for the bad debts and charity care of Medicare recipients.

To refine the hospital rate-setting law (P.L. 1978, c.83), a new law was enacted in January 1987 (P.L. 1986, c.204) which established the Uncompensated Care Trust Fund. At the time that P.L. 1986, c.204 was scheduled to sunset, new legislation was passed in January 1989 (P.L. 1989, c.1) which authorized the continuation of the Trust Fund.

The primary objective of the Trust Fund is to ensure universal access to hospital care and to prevent "patient dumping". To achieve this, the Trust Fund spreads the cost of uncompensated care more evenly and more equitably across hospitals in the State. Before the Trust Fund was established, all uncompensated care reimbursement was hospital-specific, i.e., each hospital collected through its own rates the funds to pay for its own uncompensated care. Prior to the inception of the Trust Fund, individual hospital uncompensated care mark-ups ranged from a low of 1 percent to a high of 25 percent. Hospitals with disproportionately high numbers of uninsured and low income patients had to add higher-than-average uncompensated care charges to the bills of their paying patients, putting these hospitals at a competitive disadvantage with hospitals that had lower numbers of uninsured patients.

Through the Trust Fund mechanism, all hospitals apply the same statewide uncompensated care mark-up to the bills of their patients. The Trust Fund neither draws any additional monies into the hospital payment system, nor represents any aggregate increase in hospital bills over the system in existence prior to the enactment of the Trust Fund.

The New Jersey reimbursement system and the Uncompensated Care Trust Fund achieve several major policy goals:

- Access - The system ensures that the uninsured poor have access to needed hospital services. This policy has been in effect since 1980 with important beneficial results. The poor, minorities, and those who lack health insurance have significantly better access to health care in New Jersey than do low income and uninsured persons in the nation as a whole, according to a nationwide study funded in part by the Robert Wood Johnson Foundation in Princeton and conducted by researchers at the University of California, Los Angeles, and the University of Illinois.

- Financial stability of hospitals - The solvency of those hospitals that provide the majority of care to the uninsured is promoted.

- Cost containment - The system has incentives for cost containment and efficiency. Due to hospital rate setting, which goes hand in hand with the Trust Fund, New Jersey hospital rates have remained low when compared to other states.

- Competitive equity - Competitive equity among hospitals is protected. No hospital under the system suffers a competitive disadvantage with other hospitals in its area or other parts of the State because it serves a disproportionately large number of the uninsured.

These goals -- access, financial stability, cost containment, and competitive equity -- must continue to be the basis for policy initiatives related to the financing and the delivery of uncompensated care. These goals define the success of our system.

2. Public Insurance Expansion

In New Jersey, public insurance programs have been expanded to decrease the number of uninsured, especially among pregnant woman, infants, and children. Targeting these groups is desired given the high proportion of maternity-related admissions. These programs include the following:

- New Jersey Care...Special Medicaid Programs - In July 1987, New Jersey took advantage of the federally-granted authority to expand Medicaid coverage to eligible pregnant women and their children under the age of two whose income is less than 100 percent of

the federal poverty level. This Medicaid expansion was authorized by P.L. 1987, c.115.

- HealthStart - The second component of the legislation (P.L. 1987, c.115) authorized the expansion and improvement in maternity and child health benefits provided through the Medicaid program. HealthStart benefits are financed through Medicaid, and planning and implementation of HealthStart are a joint effort of the Department of Health and the Department of Human Services. The comprehensive package of services is delivered by approved HealthStart providers who follow specific program standards. The package of benefits includes medical care, case management, and health support services. HealthStart served 13,000 pregnant women and 8,200 children in fiscal year 1989.

- REACH Program - "Realizing Economic Achievement" (REACH) is New Jersey's welfare reform program which began in October 1987. The goal of REACH is to enable the welfare recipient to become self-sufficient through employment, training, or education while providing the necessary supportive services such as transportation, child care, and medical benefits. Medicaid coverage is provided for up to one year after the recipient is no longer receiving welfare benefits.

- Catastrophic Illness in Children Relief Fund - This fund, which is scheduled to become operational before the end of the year, will provide financial assistance to families with out-of-pocket medical expenses for a child (under 18 years of age) which exceed 30 to 40 percent of their annual income.

3. New Jersey Blue Cross Continuous Open Enrollment and State's Insurer of Last Resort

Open enrollment, in the context of health insurance, refers to the practice of accepting all insurance applicants. The longer the open enrollment period, the easier it is for persons, especially persons with medical conditions, to purchase health coverage. New Jersey Blue Cross is unusual in that it has a continuous open enrollment period which has the fortunate result of making insurance accessible for persons who have a chronic medical condition. In addition to this continuous open enrollment policy, Blue Cross also serves as the insurer of last resort in New Jersey.

4. Private Insurance Expansion

When the recent Trust Fund law was passed the legislature, recognizing that lack of insurance is the

major cause of uncompensated care, included two provisions designed to expand insurance coverage:

- Mandated health insurance for full-time college students. According to the Current Population Survey (1986) six percent (54,000) of New Jersey's uninsured are college students. Therefore, the legislature required that all full-time college students have hospitalization coverage as a condition of enrollment.

- Insurance pilot projects. Because most of the uninsured are connected to employment, the legislature's other insurance initiative is targeted toward expansion of private coverage for employed persons and their families. The law sets aside funds for pilot insurance projects and charges the Department with the responsibility to develop the plans for these projects and return with a legislative proposal. Section II of this report details the projects the Department has developed. One of these requires legislative action.

II. RECENT ACTIONS

This section describes actions taken by the Department of Health and by three different committees working with the Department to contain the cost of uncompensated care, and to develop long run strategies to address the root causes of uncompensated care. Most of these actions were undertaken in the past year, many in direct response to the provisions of the most recent Trust Fund law (Appendix 1). This section first describes the overall objectives of all the activities pursued. It then reports on the work of three committees that were instrumental in furthering these activities: the Audit Subcommittee, the Insurance Working Group, and the Trust Fund Advisory Committee. Finally, a number of other actions taken by the Department, many in response to requirements in the law, are reported.

A. Department of Health Objectives

To carry out the letter and spirit of the Trust Fund law, the Health Department in 1989 has developed or expanded diverse initiatives, all intended to limit Trust Fund expenditures. These initiatives address several needs:

* to enhance and tighten bad debt collection practices;

* to refine and improve uncompensated care audit practices;

* to explore innovative ways of expanding health insurance coverage;

* to provide information that will allow employers, consumers, and hospitals to develop creative programs to increase access to care cost-effectively; and

* to consider alternative mechanisms for financing uncompensated care.

These initiatives were developed with the participation of the Trust Fund Advisory Committee established by section 5.a. of the law. The Advisory Committee exercised its responsibility partly through two subcommittees: the Hospital Audit and Collection Practices Subcommittee, established by section 5.c. of the law and known simply as the Audit Subcommittee; and the Insurance Working Group, which participated in the planning of two insurance pilot projects.

B. Containing Cost: Audit Subcommittee

The Health Department and Audit Subcommittee have cooperated to improve audit and collection practices and to assure the integrity of the Trust Fund (see Appendix 4 for membership). The operative principle has been to provide reimbursement for every dollar appropriately expended in delivering uncompensated care, and to prevent any inappropriate reimbursement.

The Audit Subcommittee is charged in the law to make recommendations to the Trust Fund Advisory Committee on the procedures that are used to audit uncompensated care and on procedures that are used to collect hospital bills. Along these lines a number of initiatives have been undertaken:

1. The Department has adopted, with the approval of the Health Care Administration Board (HCAB), regulations to strengthen credit and collection procedures (See Appendix 2). These regulations implement sections 9 and 10 of the law by requiring hospitals to follow a series of steps in interviewing patients and in pursuing collection of each account.

2. The Department also has proposed to the HCAB, six measures to control the costs of uncompensated care (See Appendix 3). Underlying these measures is an awareness that special controls may be in order, due to the unique character of the Uncompensated Care Trust Fund, as the recipient and distributor of moneys that assure access to care and as a state-sponsored financing mechanism.

   It is the Department's belief that every reasonable effort must be taken to assure that the Trust Fund is used only to assure access to care, and not to maximize hospitals' revenue or cash flow. We are acting now to protect the Trust Fund's integrity, and to guard against the possibility of potential exploitation of the Trust Fund.

   The Department's 1989 initiatives address:

   * Establishment of a Statewide Collection Agency Network. A procedure has been developed, with the assistance of the state Office of Management and Budget, to approve all collection agencies that assume hospitals' bad debt accounts. Agencies affiliated directly with hospitals would be prohibited from serving in this capacity. The purposes of the approval process are: (a) to ensure that collection agencies do not handle accounts that are covered by third-party payment and therefore are not yet properly classified as bad debt; and (b) to ensure that useful data and recommendations for improvement are supplied to the Department by the collection agencies. Only state-approved independent agencies, rather than hospitals' own subsidiaries, would have an incentive to respond more effectively to the interests of the State as a whole than to the interests of individual hospitals.

   * Involvement of auditing firms in scrutiny of uncompensated care. Each hospital's charity care and bad debt are examined by its own auditors, applying generally accepted accounting principles. These experts are most familiar with the hospital's practices and are in the best position to evaluate the hospital's estimates of bad debt

provision, which serve as the basis for reimbursement. A series of standards and tests are being developed to use this expertise to confirm the reasonableness of hospitals' provisions.

* Expansion of Department audits of bad debt. Although the Health Department has retained its own auditors to verify the appropriateness of classifying individual accounts as bad debt, the scope of Department audits has been narrow, and their timing and procedures thoroughly predictable. The Department is expanding these audits to include such issues as the writing off of insured accounts, and also has proposed equipping the auditors with authority to make unannounced inspections.

* Aggressive use of the Cost Reduction Plan process. Under section 7.a. of the law, the Hospital Rate-Setting Commission has authority to require implementation of cost reduction plans by selected hospitals. The Commission has approved a protocol proposed by the Department for identifying these hospitals. Criteria established by the protocol include overall increase in bad debt, apparent reasonableness of the hospital's bad debt estimates, and hospital success in helping patients to enroll in Medicaid. Applying this protocol, the Department has identified 12 hospitals as demonstrating a high priority for cost reduction and required them to submit cost reduction plans. Other hospitals will also be examined for possible cost reduction plans, on a lower priority basis. The affected hospitals will be responding to the Department and the Commission in December 1989.

* Expansion and enforcement of data submission requirements. The Department has begun and will continue to expand reporting requirements, and will analyze trend data on uncompensated care patients, aggregate uncompensated care statistics, accounts written off and referred to collection, and all collection agency/hospital transactions. Listings of accounts written off as bad debt and referred to collection agencies, and all commercial transactions between hospitals and collection agencies will come under scrutiny.

* Development of positive incentives for more effective collection. The Trust Fund law established, and the Department is implementing, several mechanisms, described elsewhere in this report, to assure that a price is paid for failure to undertake aggressive collection practices. To complement these negative sanctions, the Department and Audit Subcommittee now believe that positive incentives will help spur hospital creativity in discovering more effective methods of reducing reimbursable bad debt. Accordingly, a regulation has been proposed to authorize hospitals to submit proposals to share in savings that

result from their innovations. Demonstration projects might be useful in obtaining information about the efficacy of new approaches.

Some members of the subcommittee have expressed reservations about the need to take all these actions. For example, accountant members doubt the feasibility of complicated evaluation of bad debt provisions by the hospital's auditors. These members and Department staff are reviewing the proposed regulation, and the Department expects to simplify the regulation before submitting it to the HCAB for final adoption in January 1990.

3. Other actions also have been taken to refine Trust Fund operations. For example, in January 1989 new regulations took effect to standardize charity care standards. Prior to 1989, hospitals were permitted to set their own charity care standards, so that a patient might be eligible in one hospital but not in another, or one hospital might have inappropriately high or low income standards for charity care. The new regulations set a statewide standard of charity care that applies to all hospitals. In addition, sampling and compliance standards, used by Department auditors in reviewing hospital bad debt writeoffs, have been raised. In auditing uncompensated care, "substantial compliance" was previously defined as evidence that 70% of required steps were followed (60% for outpatient accounts). The new standard is 80% for inpatients and 70% for outpatients.

4. Reimbursement data have been tracked continually during the year, as Department staff sought to develop valid estimates of the amount of uncompensated care reimbursable through the Trust Fund. This was especially important so that we would have early warning if it were to become necessary to implement the cap on the Trust Fund add-on required in section 6.b. of the law. This cap limits the amount of money that may be raised through the mark-up to 13 percent of all governmental and non-governmental approved revenue.

   Staff of the Department and I are pleased to report that the cap will not be exceeded in either 1989 or 1990.

C. Expanding Insurance Coverage: Insurance Working Group

The Trust Fund Advisory Committee created an Insurance Working Group to guide the development of the insurance expansion pilot projects (see membership listing in Appendix 4). These projects, supported by a grant from The Robert Wood Johnson Foundation, are intended to explore ways of maximizing private insurance coverage. Fundamentally, the root cause of uncompensated care -- and the resulting costs -- is a lack of insurance coverage.

Two projects are under development with the assistance of a national expert on insurance -- Joseph Davis, Ph.D. of Medimetrix, Inc. -- who has much experience in setting up state and local demonstrations to increase the number of insured persons. Together, the Department's two projects will address the primary barrier to broader health insurance coverage among New Jerseyans -- the high cost of health coverage. These projects will address targeted populations, specifically small business employees, and dependents of low and moderate income workers who themselves are insured through their employer but cannot afford to buy family coverage at their own expense. Expanding the availability and affordability of health coverage to the working uninsured and dependents of insured workers will decrease uncompensated hospital care statewide. Below are more detailed descriptions of the two programs.

1. The Small Business Expansion Program is designed to expand employer-sponsored health coverage by making it more affordable to small businesses -- those with less than 20 employees -- which previously did not offer health insurance.

   According the the Current Population Survey, 42 percent of New Jersey's uninsured are employed adults, representing about 356,000 persons. National studies indicate that many of those who are employed yet uninsured work for small businesses. And according to an Eagleton Institute survey, 40 percent of New Jersey's 150,000 small businesses do not offer health coverage to their employees, representing roughly 60,000 businesses. The primary reason cited for not insuring is the high cost of insurance.

   To achieve the reduced-premium policies for employees of small businesses, the Department of Health is soliciting relationships with selected insurers and HMOs. In return for the premium reduction, the Department will permit a limitation on the insurers' risk via a reinsurance mechanism for hospital admissions which exceed a certain, pre-determined dollar threshold. The balance of the hospital charge which exceeds the threshold will be written off by the hospital as uncompensated care. Policies eligible for reinsurance will be pre-approved as meeting certain guidelines. The regulatory authority needed to accomplish the reinsurance mechanism was granted in November 1989 by the Health Care Administration Board. The threshold will be set at a level to ensure that the program has maximum impact on the level of uncompensated care in New Jersey. For example, a $3000 limit on insurer's liability per hospital admission would result in an estimated 20 percent premium reduction for standard insurance policies.

   In addition to favorably impacting the price of premiums, reinsurance will facilitate coverage in a secondary, though related way. By making the small business population a more attractive market -- in terms of exposure to risk -- to

insurance companies and health maintenance organizations, more companies will consider insuring small businesses. Historically, insurers, and in particular HMOs, have tended to view small groups as being more risky than large groups, a phenomenon which is evidenced by the fact that some insurance companies and HMOs will not sell policies to small businesses.

A decrease in the State's uncompensated care amount is expected to result from this program because, had the hospitalized patient had no insurance at all, a good portion of his/her bill under of the predetermined threshold would likely have not been paid and thus would have become uncompensated care.

2. The Dependent Insurance Coverage Expanion Program is designed to expand health coverage for dependents by subsidizing the cost of the family portion of insurance for low to moderate income employees whose dependents are currently uninsured. The implementation of this Program is contingent on the enactment of State legislation to authorize the release of $6 million plus interest, funds being reserved for the explicit purpose of financing a pilot insurance program.

Current research indicates that a significant number of the State's uninsured population are children (roughly 25 percent) and between 25 and 40 percent of uninsured children live in households where at least one parent is employed and receives insurance coverage through their employer. By improving the affordability of dependent coverage, it is expected that more employees will opt to purchase coverage for their children and spouses, thereby reducing the incidence of uncompensated care.

The subsidy amount will be based on a sliding scale which approximates the State's charity care income eligibility schedule. Subsidy amounts will differ in the two pilot geographic areas in an effort to assess the impact of different subsidy levels on demand for dependent coverage. In one area, subsidy amounts will be equivalent to twenty to sixty percent of the expected premium cost of a "standard" insurance product in New Jersey.

For each $1 million of available funds, it is expected that approximately 2500 dependents will receive subsidized coverage.

The target market for this pilot program will be dependents of low and moderate income employees of small businesses, with a special focus on those in the retail and service industries.

The Dependent Coverage Program will assess both the potential demand for an insurance subsidy as well as the subsidy level

necessary to encourage employees to purchase dependent coverage. Further, the pilot will test an administrative mechanism designed to support such a program.

D. Alternative Financing: Trust Fund Advisory Committee

Many of the deliberations of the Trust Fund Advisory Committee focused on the vital question of Trust Fund financing. The end of Medicare's participation in paying for uncompensated care, which has occurred gradually over the past three years, has resulted in a near doubling of the cost to other payers of uncompensated care. Without the Trust Fund this would have resulted in extreme and unmanageable increases in the mark-ups charged by many hospitals. Even with the Trust Fund, however, this increase has put an added burden on those who still pay for uncompensated care.

The Trust Fund Advisory Committee has fulfilled its charge of developing a recommendation to the Commissioner of Health on alternative financing of uncompensated care. The group developed a list of principles that it believed should be used to judge any specific financing package. It then participated in a computer-assisted modeling process to select a financing package that would 1) produce the needed sum of money and 2) be composed of individual financing elements acceptable to the group. In the end the group narrowed down the many "packages" that were modeled to two -- both of which fulfilled the agreed upon principles. Consensus could not be reached in support of either one of the two packages so the group elected to present both of them. The Committee's recommendation is discussed in Section III and is included in its entirety in Appendix 5.

E. Other Activities:

1. New Jersey MOMS (Maternity Outreach and Managed Services)

New Jersey MOMS will assure universal access to quality prenatal health support services throughout the State. The proposed program, MOMS, will build on the State's landmark HealthStart program to set a new standard of prenatal care. This standard will directly address the multifactorial causes of poor pregnancy outcomes.

Currently, approximately one-fifth of expenditures for uncompensated care in New Jersey involve maternity cases. This is an area where preventive services have clearly established a favorable twin effect: improved outcomes and reduced costs.

Behaviors of pregnant women greatly affect the birthweight and health status of newborns. Health support services, such as counseling and nutrition education, have been found to improve many of the most damaging behaviors, such as drinking, smoking, and eating an unbalanced diet.

The HealthStart program, established in 1987, provides health support services to Medicaid recipients. This is done through a system of managed care, which links the pregnant patient to a case manager and pays the same flat fee for each patient. Health support services provided under HealthStart include risk assessment, nutrition education, other health education, counseling to address social and psychological needs, and home visits when indicated. The capitated fee for these services is $350.

New Jersey MOMS will provide the same package of health support services, now available through Medicaid to women below the poverty level, to the working poor and other women whose income exceeds the poverty level. Currently, the hospital care of many of these patients is reimbursed as charity care or bad debt, through the Uncompensated Care Trust Fund. This fund assures hospitals of dollar-for-dollar reimbursement for all services rendered, but does not provide health support services which are provided through HealthStart to Medicaid patients.

Under New Jersey MOMS, women above the poverty level will be eligible to receive health support services. This group includes, for example, wives of workers whose health insurance does not cover dependents, and working women whose insurance does not provide them with maternity benefits. They will contribute to the cost of these services through a sliding fee scale based on income. The same scale now used to determine charity care will be applied to this program.

By "mainstreaming" the HealthSupport package, New Jersey MOMS will achieve several objectives:

* making available to women above the poverty level the same services now offered to Medicaid recipients;

* producing for the Uncompensated Care Trust Fund the same savings, resulting from fewer birth complications and from management of care, now being generated for the Medicaid Program;

* giving thousands of babies born every year a better chance to thrive, or even survive; and

* providing thousands of pregnant women every year with experience, health behaviors and financial responsibility for their health care.

Every dollar spend to meet prenatal care needs tends to save three dollars on expenditures caused by low birthweight and other factors associated with neonatal complications, according to the Institute of Medicine and other authoritative sources. Health Department analysts have determined that over 10,500 pregnant women with incomes

between 100 and 250 percent of poverty will be eligible for enrollment in New Jersey MOMS annually, resulting in a net savings in hospitalization costs for newborns.

Additional savings will result from other features of the program:

* contributions made by patients through the sliding fee scale, which will recoup approximately half of the $350 cost per patient;

* savings resulting from lower rates of rehospitalizations, institutionalization, demand for family support services, and other effects of preventable birth conditions;

* capitated fees, which will limit expenditures now associated with fragmented, unsystematic outpatient and emergency department visits by pregnant women seeking supportive services;

* the long-term savings associated with socialization of patients to the experiences of healthier behaviors and purchasing of health care coverage; and

* savings associated with health care for undocumented aliens, a group of patients now technically eligible for HealthStart but largely unwilling to enroll in Medicaid for fear of being reported to federal authorities.

2. Employee Education

The Trust Fund law (section 13) requires that employers that do not provide insurance coverage must provide information to employees in their options with respect to health insurance. The Department is to develop and distribute these materials. A notice regarding this was placed in a newsletter of the Department of Labor, and we have received nearly 5,000 requests from employers for the materials. The materials are nearly completed and will be mailed in the near future.

3. Student Health Coverage

The Trust Fund law requires that students at colleges in the State have health coverage. This requirement has been implemented.

4. Other Requirements

The Department has complied with the other requirements of the law:

* Two level pricing of emergency room services (section 12) will be implemented on schedule. The necessary regulations have been proposed and will be adopted prior to January, 1990.

* Regulations to implement use of the Set-Off of Individual Liability (SOIL) system will soon be adopted which will permit NJ Department of Treasury's withholding of state income tax refunds and homestead rebates for purposes of paying hospital debts. The first request for offsets will be forwarded late in 1989 or early in 1990.

* Regulations were adopted to implement the limits imposed by the cap on the Trust Fund should that become necessary (it has not).

* Staff prepared for the Trust Fund Advisory Committee an analysis of the impact on uncompensated care of an increase in the unemployment rate in New Jersey. This analysis is required in Section 5.b. of the Trust Fund Law. (See Appendix 6 for this analysis)

III. Future Agenda

Perhaps the most challenging and far reaching charge in the Trust Fund law is the charge to the Advisory Committee and to the Commissioner of Health to develop a recommendation to the Governor and the legislature on alternative funding of uncompensated care. The current funding is through hospital rate mark-ups. However, Medicare used to pay about 45 percent of this cost, and now pays virtually none. This has sharply increased the cost to remaining payers and is the basis for the need to search for alternative sources of funding. As was stated in II, this search has occupied the major part of the time and attention of the Advisory Committee over the past year, and this section of the report is devoted entirely to the critical issue of the long term financing of uncompensated care. It includes an overview of the issue, a summary of the Committee's recommendations, and the recommendations of the Commissioner of Health.

A. Overview of Uncompensated Care Alternative Financing

In enacting the most recent Trust Fund law, the legislature was very explicit in stating its interest in exploring financing options for the Trust Fund other that the current mark-up to hospital charges method. The law charges the Trust Fund Advisory Committee (see membership in Appendix 4) with this task and requires the Commissioner of Health to report on this issue by December 1989.

To assist the Committee as it developed the alternative financing recommendations, Department of Health staff projected 1990 uncompensated care in the State to be $590 million. In arriving at this gross estimate, staff trended forwared -- assumuming a 15 percent increase, the average of increases in uncompensated care in recent years -- the 1989 projected figure of $514. This crude estimate was developed only to meet the immediate need of the Committee in its deliberations.

B. Recommendations of the Trust Fund Advisory Committee

Uncompensated care is but a part of the larger issue that 11 percent of New Jerseyans lack health insurance. The long term ability to contain the growth of uncompensated care is inextricably linked to success in increasing the number of New Jerseyans with third-party coverage. This includes public coverage -- Medicaid -- as well as private coverage. Concerning the latter, a range of initiatives to accomplish this goal was discussed by the Committee over the past three years. These include voluntary efforts such as state subsidization of health insurance premiums for persons of low or moderate incomes as well as mandatory efforts to require employers to provide health insurance for their employees.

In developing alternative financing arrangements, the Committee recognized the importance of maintaining the hospital uncompensated care mark-up as a fall-back financing mechanism for any residual uncompensated care -- in the event other funding sources being implemented fall short of expectations in a given year, due to subsequent legislative action or inaccurate revenue or uncompensated care cost projections.

Below are seven principles developed by the Trust Fund Advisory Committee.

1. Maintanance system that ensures access to needed hospital care for all New Jerseyans regardless of these insurance -- is integral to the State's health care system and must be preserved.

2. The responsibility for health care is one that should be shared by all and therefore, any financing mechanism for uncompensated care should be broadly based. Two other important criteria in evaluating funding sources of uncompensated care are equity and stability over time.

3. The Uncompensated Care Trust Fund should be maintained as a mechanism to collect a portion of the statewide uncompensated care amount via a uniform statewide hospital uncompensated care mark-up, and to distribute payments, regardless of the funding source, to hospitals.

4. Alternative funding should be sought fore, at least the Medicare share of the statewide uncompensated care amount. Funding for this share of uncompensated care need not come from a single source; a mix of revenue sources could be used. Below are suggested revenue sources for further exploration:

   - Mandatory contributions from employers who do not provide insurance coverage for their employees and thus, do not now contribute towards the State's uncompensated care amount. In addition to providing revenue, such a mechanism would also serve as an incentive for employer-based coverage. Employees could share in this employer contribution in a way that is similar to the unemployment insurance arrangement. This funding source is viewed as particularly equitable in scenarios in which uncompensated care continues to be partially funded through the hospital mark-up (which is paid in part by employers who provide insurance for their employees as well as by employees who share in the cost of the insurance).

   - State excise taxes, in particular alcohol, cigarette, and other tobacco taxes. This is viewed as especially appropriate and logical given the negative impact that alcohol and tobacco products have on health status.

- The casino revenue fund -- designated for persons who are elderly or disabled/handicapped -- could support a new program to fund uncompensated hospital care provided to persons having HIV diseases, including AIDS.

- Expansion of the sales tax to some products currently excluded, such as clothing and non-prescription drugs.

5. Medicaid eligibility should be expanded to the maximum permitted by the federal government. As an "indirect" funding source of uncompensated care, Medicaid expansion has the significant advantage in bringing of new federal dollars; the federal government would match every dollar New Jersey spent on Medicaid.

6. Initiatives to increase the number of persons with private health insurance should continue to be studied, tested, and implemented in order to achieve a long-term solution to the issue of uncompensated care.

7. Determination of the portion of uncompensated care funding raised through the hospital uncompensated care mark-up should be done in advance, to the extent feasible, so as to enable insurance companies to develop premium rates which will accurately reflect their contribution towards uncompensated care.

Committee members supported one or both of the following two financing packages -- packages which flow from the Committee's principles.

Package #1

UNCOMPENSATED CARE ALTERNATIVE FINANCING

Option	AMOUNT RAISED NOW (millions)	RATE TO RAISED $10 MIL	RATE Selected	AMOUNT RAISED (millions)
T. F. MARK-UP	$590	0.37%	6.43%	$174
GEN FUND/M'CAID ($10)		$10	$10	$ 10
ALCOHOL TAX	$145	7% increase	7% increase	$ 10
OTHER TOBACCO TAX	N/A	N/A	N/A	$ 20
CASINO TAX	$235	4.5%increase	9%	$ 21
EMPL'RS W/O INS PER EMPLOYEE		$28/each	$1000	$355
ALL EMPLOYEES			$ 0	$ 0
TOTAL				$590

Package #2

UNCOMPENSATED CARE ALTERNATIVE FINANCING

Option	AMOUNT RAISED NOW (millions)	RATE TO RAISED $10 MIL	RATE Selected	AMOUNT RAISED (millions)
T. F. MARK-UP	$590	0.37%	6.51%	$176
GEN FUND/M'CAID ($10)		$10	$10	$10
ALCOHOL TAX	$145	7% increase	7%	$10
OTHER TOBACCO TAX	N/A	N/A	N/A	$20
CASINO TAX	$235	4.5increase	9%	$21
EMPL'RS W/O INS PER EMPLOYEE		$28/each	$750	$266
ALL EMPLOYEES		$2.90/each	$25	$86
TOTAL				$590

See Appendix 5 for a complete copy of the Committee's recommendations.

C. Recommendations of Commissioner of Health

Before presenting my recommendations, I would like to thank the Committee members for their dedication, long hours of hard work and cooperative spirit that allowed the Committee to move forward in this controversial area and to develop recommendations for alternative financing.

I fully support the Committee's recommendations. I would like to elaborate on two aspects of their findings. Specifically, I would recommend that we:

1. Maintain the hospital mark-up as a safeguard in the event that other financing mechanisms are not adequate to fully fund uncompensated care. This is critical to the preservation of the system's guarantee of full reimbursement for uncompensated care.

2. Dedicate any alternative tax used to fund uncompensated care. This would protect the funds from being used for other purposes during future periods of fiscal contraints.

I would like to take this opportunity to emphasize that two of the Committee's recommendations take very important steps towards a more comprehensive and long term solution to address uncompensated care costs by insuring people who do not have coverage now:

1. Expanding Medicaid to bring in maximum federal monies. Both recommended financing packages would result in fairly significant savings to the State through the reduced mark-up. These savings would be realized by reductions in spending for the Medicaid Program and the State Employee Health Benefits Program via reduced hospital charges for their beneficiaries. The State portion of the Medicaid expansion, which would be about $10 million according to the Department of Human Services, could be fully financed by the State's savings resulting from the lowering of the hospital mark-up.

2. Providing an incentive to employers to offer coverage through levying a surcharge on those employers who do not offer coverage.

These two recommendations will greatly increase the number of persons with health insurance and they will also widen the financing base for uncompensated care. Concerning the later, the recommendations would bring in additional federal contributions in the case of the Medicaid expansion and monies from employers who don't currently offer coverage for their employees in the case of the targeted employer surcharge. Further, the targeted employer surcharge addresses an inequity of the current system: employers who provide coverage for their workers currently pay for health care twice -- once for their own workers and again as the hospital costs of care for uninsured persons are factored into hospital reimbursement rates.

CONCLUDING STATEMENT OF COMMISSIONER OF HEALTH

Sufficient and controlled financing of uncompensated care has been a primary goal of the Department of Health throughout the 1980's and especially during the three years of my tenure as Commissioner. All the facts and figures presented in this report are important, but we must not let them obscure the overriding principle: the obligation to assure universal access to acute care for all people in New Jersey regardless of income, while protecting the rights of third-party payers.

When a person comes to a hospital's emergency department for needed immediate attention, or requires inpatient care, poverty or the lack of insurance should be no barrier to necessary diagnosis and treatment. But when employers or individuals who could afford to purchase insurance fail to do so, they should not thereby escape payment for the societal cost of care for those who cannot pay.

Fortunately, New Jersey is a recognized leader on uncompensated care issues. While many other states have experienced large-scale "dumping" of indigent patients to only a few hospitals that are willing to care for them, our system has guaranteed payment in full to all hospitals for the care of all patients. All New Jerseyans have reason to take pride in that achievement.

In large measure, the success of our efforts in this area reflect the contributions of many individuals who are leaders in New Jersey in their field, including persons in the hospital industry, the insurance industry, business, labor, and public life. Many of their names are listed in the appendices to this report, in the lists of committee and subcommittee members. The Department of Health has benefited greatly from their wisdom and effort.

It is vitally important, in my opinion, for state decision-makers to follow up on the recommendations of the Trust Fund Advisory Committee outlined in this report. The case for these recommendations is, I think, compelling. The seeds for future improvements will be found in initiatives to expand private and public health insurance, so that almost everyone will be covered for health care needs.

To the extent that individuals can pay for their own coverage, it's their obligation to purchase it. To the extent that employers are able to afford it, it's their obligation to offer it. To the extent that creative financing mechanisms can be found to maximize coverage cost-effectively, it's the State's obligation to promote and facilitate those mechanisms.

Our focus on acute care should not obscure the need to include ambulatory, or non-acute, care in the mix of covered services. Hospital care is the most expensive. When other settings can be used to manage a patient's care just as effectively, or more effectively, the patient should not be propelled into the hospital by an inflexible reimbursement system.

We've emphasized access throughout this report. But, in the final analysis, access is not an end in itself. Our State also must consider the question, access to what? High-quality care, care that is humanely and

efficiently provided, comprehensively structured and continuous in nature, is the real goal. Future efforts, I'm confident, will focus on the quality of care delivered to all patients regardless of income, geography, age, race, occupation, or family status.

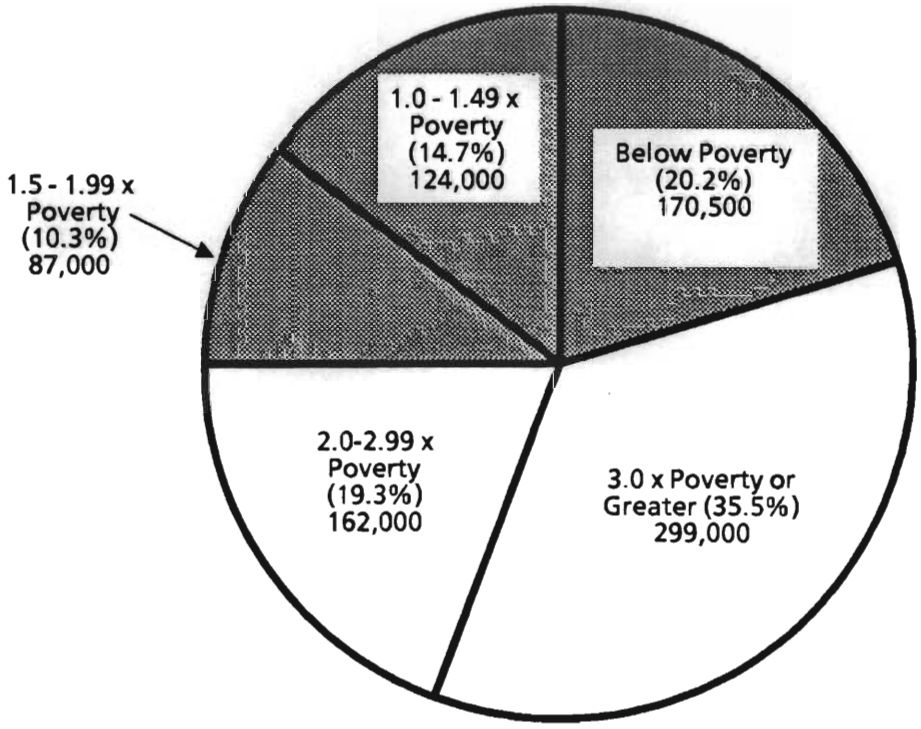
Everyone working in health policy in the United States is aware that health care for the uninsured is a national problem. As states like ours struggle to contain and manage this problem, we also must prod federal authorities to work with us and exercise greater leadership of their own. New Jersey's system can best be strengthened as the national system is strengthened.

CHARTS

CHART 1

NEW JERSEY
UNINSURED BY FAMILY INCOME RELATIVE TO THE POVERTY LEVEL (ALL AGES), 1986

Total Number Uninsured in New Jersey 843,000



NOTE:

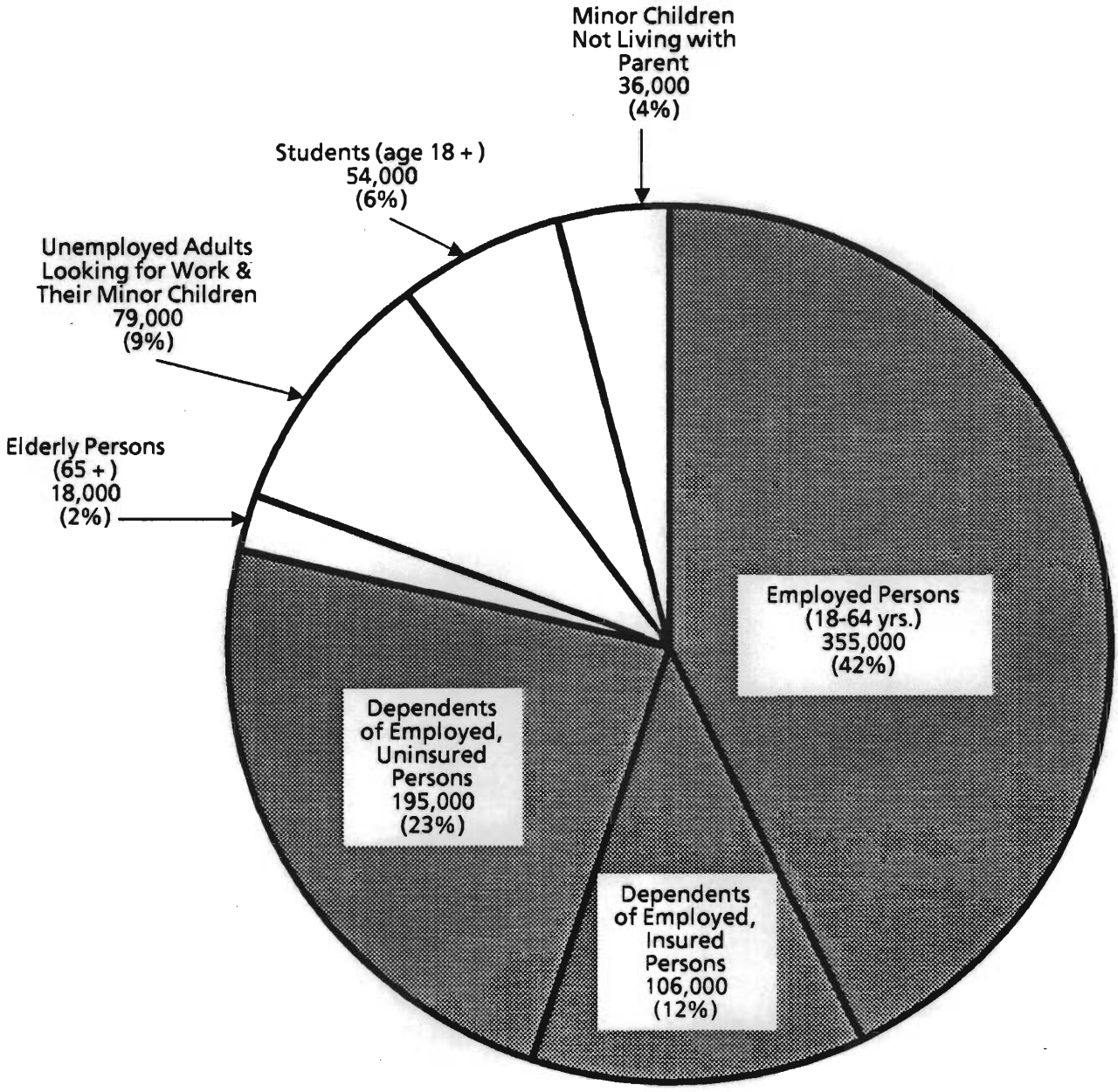
- Almost half of the uninsured (45.2%) have incomes below twice the federal poverty level.
- Almost two-thirds of the uninsured (64.5%) have incomes below three times the federal poverty level.

Source: NJ Subsample from the March 1986 Current Population Survey

CHART 2

NEW JERSEY
UNINSURED BY EMPLOYMENT STATUS
(ALL AGES), 1986

Total Number Uninsured in New Jersey 843,000



NOTE:

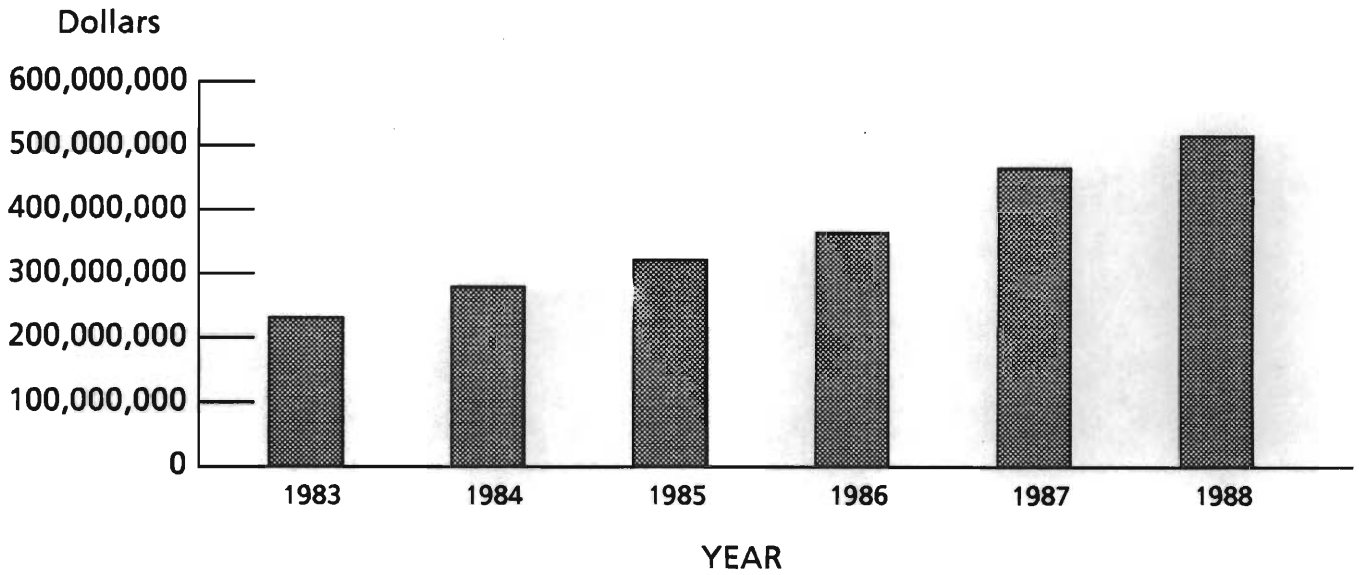
- Over three-quarters of the uninsured (77%) are employed or the dependent of an employed person.

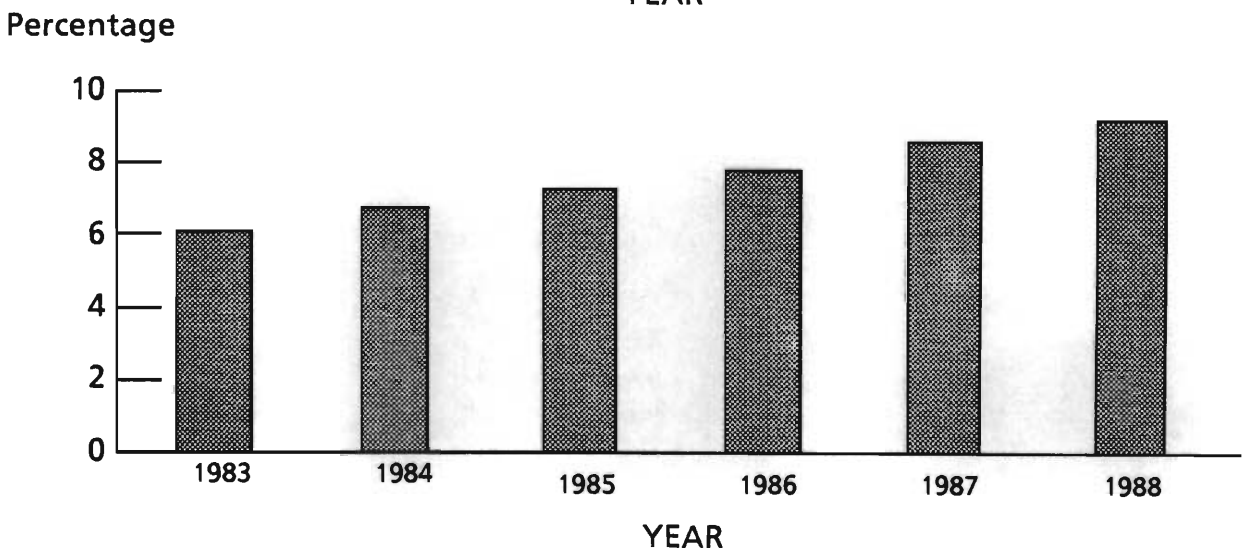
Source: NJ Subsample from the March 1986 Current Population Survey

CHART 3

NEW JERSEY UNCOMPENSATED CARE COST AND UNCOMPENSATED CARE AS A PERCENTAGE OF GROSS HOSPITAL REVENUE, 1983-1988

Year	Uncompensated Care Amount	Gross Revenue	Ratio of Uncompensated Care Cost to Gross Revenue
1983	$233 million	$3.8 billion	6.1%
1984	$282 million	$4.1 billion	6.8%
1985	$323 million	$4.4 billion	7.3%
1986	$366 million	$4.7 billion	7.8%
1987	$465 million	$5.2 billion	8.6%
1988	$513 million*	$5.6 billion*	9.2%*





*projected figure

APPENDICES

1 Trust Fund Law - P.L. 1989, c.1

2 1989 Credit and Collection Regulations

3 Proposed Measures to Further Control Uncompensated Care Cost:

- Remarks of Commissioner Coye
- Proposed Regulations

4 Lists of Committee Membership:

- Trust Fund Advisory Committee
- Audit Subcommittee
- Insurance Working Group

5 Alternative Financing Recommendation of Trust Fund Advisory Committee

6 Analysis of Possible Impact of an Increase in the Rate of Unemployment in New Jersey on the Amount of Uncompensated Care Provided by Hospitals.

[THIRD REPRINT]

SENATE, No. 2981

STATE OF NEW JERSEY

INTRODUCED OCTOBER 17, 1988

By Senator CODEY

AN ACT concerning uncompensated care in hospitals 3[and] ,3 supplementing Title 26 of the Revised Statutes and Title 18A of the New Jersey Statutes 3, and making an appropriation therefor3.

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

1. The Legislature finds and declares that:

a. Access to quality health care shall not be denied to residents of the State because of their inability to pay for the care; there are many residents of the State 3, particularly those with incomes below the federal poverty level,3 who cannot pay for needed hospital care and in order to ensure that these persons have equal access to hospital care it is necessary to maintain a mechanism which will ensure payment of uncompensated hospital care; and to protect the fiscal solvency of the State's general hospitals, as provided for in P.L.1971, c.136 (C.26:2H-1 et al.), it is necessary that all payers of health care services share 3[in] equally in the3 payment of uncompensated care on a Statewide basis.

b. The "New Jersey Uncompensated Care Trust Fund," created pursuant to P.L.1986, c.204, by which hospitals may collect their reasonable cost of 3approved3 uncompensated care, has resulted in 3[a high degree of] unobstructed3 access to health care for residents without insurance who otherwise are unable to afford care. 3[The fund has increased the stability and equity of the payment system without increasing the cost, by instituting a Statewide collection mechanism in place of the previous hospital-specific price add-ons;] It must be noted, however, that many hospitals in the State are not consistently collecting information about patients, resulting in a serious lack of demographic data on the profile of persons whose hospital care has led to spiraling uncompensated care costs, and seriously

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
1 Senate SIH committee amendments adopted December 8, 1988.
2 Senate SRF committee amendments adopted December 8, 1988.
3 Assembly floor amendments adopted January 10, 1989.

hampering hospital financial collection efforts. Bad debt collection should be one of the highest priorities of each hospital and the Department of Health.3

c. The "Uncompensated Care Trust Fund Advisory Committee," also created pursuant to P.L.1986, c.204, has 3[conducted a thorough study of all] examined at length3 alternative means of financing 3[health care for the uninsured] hospital care for those who cannot pay3, the reasons for 3[uninsurance and] a lack of insurance coverage and some3 alternative means of providing 3[coverage] health care3. The Commissioner of Health has submitted a 3[comprehensive]3 report to the Governor and the Legislature which 3[analyzes the demographics] addresses the concept3 of uncompensated care, 3[the economics of uncompensated care and alternative] its economic implications and many of the3 means by which to finance uncompensated care.

3d.3 Although New Jersey has 3[consistently]3 expanded Medicaid entitlement for 3[the lowest income New Jerseyans] certain residents of low income, to provide them with better quality health care and3 to optimize federal contributions, 3[the Department of Health found that there are still over 840,000 New Jerseyans lacking health insurance. Over 40% of these uninsured are employed, many of them by small employers who need encouragement to offer health benefits] it is clear that further State action is required. The Medicaid and medically needy programs in New Jersey should be expanded to provide the maximum coverage permitted under federal law, particularly for pregnant women and young children, in order to ensure greater access to primary, preventive health care in an appropriate setting such as a physician's office, rather than the more costly and inappropriate setting of a hospital emergency room. For every New Jersey hospital patient whose hospital care costs are charged to uncompensated care and who is eligible for Medicaid or medically needy coverage, this State loses federal dollars in an amount equal to one half of that patient's hospital bill3.

3[d.] e.3 Having received and 3thoroughly3 reviewed the report 3by the Commissioner of Health3, it is evident that 3the continuation of3 the fund is 3[still]3 necessary 3, with modifications,3 to ensure 3[the appropriate and equitable

financing of services to the uninsured. However, recognizing the burden that financing the fund places on the payers of health care,] access to hospital care for those who cannot afford to pay and the fiscal solvency of hospitals. At the same time, the State should take further actions to: provide more comprehensive Medicaid coverage for the medically indigent, ensure appropriate reimbursement for hospital emergency room services according to the level of care required by the patient, reduce the rate of increase in health insurance premiums and explore and implement various[3] initiatives [3][will be explored and implemented][3] to reduce the amount of uncompensated care in this State without impairing access to care.

2. As used in this act:

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

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

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

"Hospital" means a general acute care hospital whose schedule of rates is approved by the commission pursuant to section 11 of P.L.1978, c.83 (C.26:2H-18.1).

"Payer" means a governmental or nongovernmental third party payer or any purchaser of hospital services whose hospital reimbursement rates are established by the commission pursuant to P.L.1971, c.136 (C.26:2H-1 et al.).

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

3. The commission is authorized to approve a hospital's rates to achieve an equitable collection and distribution mechanism among hospitals in the State for payment of uncompensated care pursuant to the provisions of this act.

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

a. The fund shall be comprised of monies collected from hospitals pursuant to this act and [2]any other[2] monies appropriated [2][from the General Fund] thereto[2] to carry out the

purposes of this act.

The fund shall be a nonlapsing fund dedicated for use by the department: (1) to distribute payments for the cost of uncompensated care in the State, (2) to subsidize[1], pursuant to the provisions of section [3][16] 15[3] of this act, a[1] pilot health insurance [1][programs that are created] program[1] for small businesses, [3][and][3] (3) to fund the reasonable cost of administering the fund [3], and (4) to fund the reasonable cost of preparing and disseminating health insurance information to employers pursuant to section 13 of this act[3]; except that, monies collected from hospitals pursuant to this act shall not be used for the purpose of subsidizing pilot health insurance programs for small businesses. Interest earned on monies deposited in the fund shall be credited to the fund.

b. The fund shall be administered by a person appointed by the commissioner in consultation with the Uncompensated Care Trust Fund Advisory Committee established pursuant to section 5 of this act.

The administrator of the fund is responsible for overseeing and coordinating the collection and disbursement of fund monies. The administrator is responsible for promptly informing the commission and the commissioner if monies are not or are not reasonably expected to be collected or disbursed or if the fund's reserve as established in subsection c. of this section falls below the required level.

c. The fund shall maintain a reserve equal to 1/12 of the fund's total estimated annual payment for uncompensated care costs for the prior calendar year.

5. a. [2](1)[2] There is created in the department a [1][19-member] [3][22-member[1]] 23-member[3] Uncompensated Care Trust Fund Advisory Committee which shall be comprised of the [2]19 members of the Uncompensated Care Trust Fund Advisory Committee created pursuant to P.L.1986, c.204 which 19 members shall continue to serve the terms to which they were appointed pursuant to P.L.1986, c.204. Upon enactment of this act, the representation and manner of appointment that applied to those members shall continue to apply to reappointments to the committee as follows: the[2] Commissioners of Health, Human Services and Insurance and the Public Advocate, or their

designees who shall serve ex officio; two members of the Senate to be appointed by the President thereof, no more than one of whom shall be of the same political party, and two members of the General Assembly to be appointed by the Speaker thereof, no more than one of whom shall be of the same political party; 2[1two public members who have professional expertise in the area of health care financing, one each to be appointed by the President of the Senate and the Speaker of the General Assembly;1]2 and 1[11] 2[121] 112 members appointed by the Governor as follows: one person who represents the Office of the Governor who shall serve ex officio and 1[10] 2[111] 102 public members who include 1[two] 2[three1] two2 persons who represent payers, one to be appointed upon the recommendation of Blue Cross and Blue Shield of New Jersey, Inc., 1[and]1 2and2 one upon the recommendation of the Health Insurance Association of America 2[1and one upon the recommendation of the New Jersey Health Maintenance Organization1]2; two persons who represent hospitals in the State to be appointed upon the recommendation of the New Jersey Hospital Association; two persons who represent business and industry in this State, one to be appointed upon the recommendation of the New Jersey Business and Industry Association and one upon the recommendation of the New Jersey State Chamber of Commerce; two persons who represent organized labor in this State, to be appointed upon the recommendation of the New Jersey State AFL-CIO; and two persons who are consumers of health care.

2(2) In addition to the 19 members appointed in the manner hereinabove, there shall be appointed 3[three] four3 members as follows: two public members who have professional expertise in the area of health care financing, one each to be appointed by the President of the Senate and the Speaker of the General Assembly, and one public member who represents payers to be appointed by the Governor upon the recommendation of the New Jersey Health Maintenance Association 3and one public member who represents business and industry to be appointed by the Governor upon the recommendation of the New Jersey chapter of the National Federation of Independent Business3.2

2[The] Except for the public members continuing their term as provided hereinabove, the2 public members shall serve

for a term of [2][three] two[2] years [2][and] . Those public members continuing their term[2] are eligible for reappointment [2]by their appointing authority for a term to expire on December 31, 1990[2]. Vacancies in the advisory committee shall be filled in the same manner as the original appointments were made [2]for the unexpired term[2].

The advisory committee shall organize as soon as practicable after the appointment of its members and shall select a chairperson from among its [1]public[1] members. Members of the advisory committee shall serve without compensation but shall be reimbursed for the necessary expenses incurred in the performance of their duties as members of the advisory committee.

b. The advisory committee shall:

(1) Review the methodology and assumptions used by the department to establish the Statewide uncompensated care add-on pursuant to section 6 of this act, and advise the commissioner on its conclusions about the accuracy of the calculations;

(2) Make recommendations to the commissioner on the procedures that shall be used to audit uncompensated care at the hospitals, including methods of indigent care cost recovery and bad debt collection by the hospitals;

(3) Make recommendations to the commissioner on additional methods of funding uncompensated care that may be used to supplement funding methods already implemented;

(4) Make recommendations to the commissioner on initiatives designed to reduce uncompensated care in the State;

(5) Make recommendations to the commissioner on methods to ensure appropriate reimbursement for primary care in hospital emergency rooms;

(6) Make recommendations on initiatives to expand health insurance coverage in the State;

(7) Make recommendations to the commissioner to maximize federal, State and local participation in public assistance programs; [3][and]

(8) Analyze the possible impact of an increase in the rate of unemployment in the State on the amount of uncompensated care provided by hospitals and advise the commissioner on its

conclusions about the projected impact of the limit on the uniform Statewide uncompensated care add-on, established pursuant to subsection b. of section 6 of this act, on hospitals under those economic conditions; and[3]

[3][(8)] (9)[3] Make recommendations to the commissioner concerning any aspect of the fund.

c. There is created within the advisory committee a [1][nine-member] [3][12-member[1]] 13-member[3] subcommittee on hospital audit and collection practices.

The subcommittee shall be comprised of the Commissioners of Health and Human Services, [1]the State Treasurer[1] and the Public Advocate, or their designees, who shall serve ex officio and [1][six] [3][eight[1]] nine[3] public members. The public members shall be appointed by the commissioner and shall include: two persons who represent payers, one to be appointed upon the recommendation of the Health Insurance Association of America and one to be appointed upon the recommendation of Blue Cross and Blue Shield of New Jersey, Inc.; two persons who represent hospitals in the State to be appointed upon the recommendation of the New Jersey Hospital Association; [1]two certified public accountants who are knowledgeable about hospital audit and collection procedures, to be appointed upon the recommendation of the New Jersey chapter of the American Institute of Certified Public Accountants;[1] and [3][two] three[3] persons who represent business and industry in this State, one to be appointed upon the recommendation of the New Jersey Business and Industry Association [3][and] ,[3] one to be appointed upon the recommendation of the New Jersey State Chamber of Commerce [3]and one to be appointed upon the recommendation of the New Jersey chapter of the National Federation of Independent Business[3].

The members of the subcommittee may be members of the advisory committee. The public members of the subcommittee shall serve for a term of [2][three] two[2] years [2][and are eligible for reappointment, but of the members first appointed, [1][two] three[1] shall serve for a term of one year, [1][two] three[1] for a term of two years and two for a term of three years][2]. Vacancies in the subcommittee shall be filled in the same manner as the original appointments are made [2]for the unexpired term[2].

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

The purpose of the subcommittee is to make recommendations to the advisory committee on the procedures that are used to audit uncompensated care at the hospitals and on the procedures that are used to collect delinquent hospital bills.

6. a. For the periods beginning January or July of the hospitals' rate year, the department shall determine a uniform Statewide uncompensated care add-on. The commission shall approve the add-on before it is included in hospital rates.

The add-on shall be determined by dividing the Statewide amount of approved uncompensated care plus an amount adequate to fund the reasonable cost of administering the fund pursuant to subsection a. of section 4 of this act and to maintain the reserve pursuant to subsection c. of section 4 of this act, by the Statewide amount of approved revenue for all payers and approved revenue for medically indigent persons less the Statewide amount of approved uncompensated care.

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

b. The amount of money raised by the uniform Statewide uncompensated care add-on, as a percentage of all governmental and nongovernmental approved revenue, shall not exceed 3[by one percentage point the percentage which is in effect on January 1, 1989] 13%3.

3c. The uniform Statewide uncompensated care add-on for patients whose hospital bills are paid by a health maintenance organization or other payer which has negotiated a discounted rate of payment with the hospital shall be based on the full rate of reimbursement for the services provided by the hospital to the patient under the hospital reimbursement system established pursuant to P.L.1978, c.83, rather than on the discounted rate of payment.3

3[2c.] d.3 No provision of this section shall be construed to

preclude the commission from approving individual hospital rate increases for uncompensated care in addition to the add-on. Such increases, however, shall not be paid from the moneys in the [3][fund] Uncompensated Care Trust Fund[3].[2]

7. a. The commission shall approve each hospital's reasonable uncompensated care costs and shall ensure that uncompensated care services financed pursuant to this act are provided in the most appropriate and cost-effective manner which the commission determines hospitals can reasonably be required to achieve. The commission shall reduce a hospital's reasonable uncompensated care costs by the amount of overpayment for patient care services, if any, by the Medicare program (Pub.L.89-97, 42 U.S.C. § 1395 et seq.), the Medicaid program (P.L.1968, c.413, C.30:4D-1 et seq.), or any payer or purchaser of hospital services whose hospital reimbursement rates are not established by the commission pursuant to P.L.1971, c.136 (C.26:2H-1 et al.). For the purposes of this section, "overpayment" means [1][patient service revenue] reimbursement[1] in excess of that allowed by section 5 of P.L.1978, c.83 (C.26:2H-4.1).

The commission shall require a hospital which engages in inefficient or inappropriate provision of uncompensated care services to submit to the commission a cost reduction plan. The commission may prospectively reduce the hospital's uncompensated care payments for failure to submit or implement a cost reduction plan that has been approved by the commission.

b. The commission shall semiannually determine the amount a hospital shall pay to the fund or the fund shall pay to the hospital, as appropriate.

The hospital payment to the fund shall be funded by the uniform Statewide uncompensated care add-on determined pursuant to section 6 of this act, which is charged by the hospital to all payers.

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

the fund.

8. a. Hospitals required to remit the net difference of funds received from payers pursuant to subsection b. of section 7 of this act shall remit the funds in equal installments at the end of every month.

b. If a hospital is delinquent in its required payment to the fund, the commission may, pursuant to rules and regulations adopted by the commissioner, remove from that hospital's schedule of rates the uniform Statewide uncompensated care add-on or levy a reasonable penalty on the hospital. The penalty shall be recovered in a summary civil proceeding brought in the name of the State in the Superior Court pursuant to "the penalty enforcement law," (N.J.S.2A:58-1 et seq.). Penalties collected pursuant to this section shall be deposited in the fund established pursuant to this act.

c. Hospitals authorized to receive payments from the fund pursuant to subsection b. of section 7 of this act shall receive the payments on a monthly basis.

9. a. A hospital shall not be reimbursed for the cost of uncompensated care unless the commissioner certifies to the commission that the hospital has followed the procedures pursuant to this section and section 10 of this act. For the purposes of this section and section 10 of this act, [1]"designated hospital employee" means an employee of the hospital who has received training in the collection of patient financial data and identification of third party coverage and in assessing a patient's eligibility for public assistance; and[1] "responsible party" means any person who is responsible for paying a patient's hospital bill.

b. A [1][hospital admissions officer or appropriate] designated hospital[1] employee shall interview a patient upon the patient's initial request for care. If the emergent nature of the patient's required health care makes the immediate patient interview impractical, the [1][officer or] designated hospital[1] employee shall interview the patient's family member, responsible party or guardian, as appropriate[1][. In all instances except where it is medically inappropriate to interview the patient and where there], but if there[1] is no family member, responsible party or guardian, [1]the designated hospital employee shall interview[1] the patient[1][, family member, responsible party or guardian shall be

interviewed]1 within five working days of the patient's admission into the hospital 1or prior to discharge, whichever date is sooner1.

c. A patient interview shall, at a minimum, include the following inquiries:

(1) The 1[hospital admissions officer or]1 designated hospital employee shall obtain documentation of proper identification of the patient. Documentation of proper identification may include, but shall not be limited to, a driver's license, a voter registration card, an alien registry card, a birth certificate, an employee identification card, a union membership card, an insurance or welfare plan identification card or a Social Security card. Proper identification of the patient may also be provided by personal recognition by a person not associated with the patient. 1[Non-associated persons may include, but shall not be limited to, police officers, firefighters, members of an ambulance or rescue squad or hospital personnel.]1 For the purposes of this paragraph, "proper identification" means the patient's name; mailing address; residence telephone number; date of birth; Social Security number; and place 1and type1 of employment, employment address and employment telephone number, as applicable.

(2) The 1[hospital admissions officer or]1 designated hospital employee shall inquire of the patient, family member, responsible party or guardian, as appropriate, whether the patient is covered by health insurance, and if so, shall request documentation of the evidence of health insurance coverage. Documentation may include, but shall not be limited to, a government sponsored health plan card or number, a group sponsored or direct subscription health plan card or number, a commercial insurance identification card or claim form or a union welfare plan identification card or claim form.

(3) 1[The hospital admissions officer or] If evidence of health insurance coverage for the patient is not documented or if evidence of health insurance coverage is documented but the patient's health insurance coverage is unlikely to provide payment in full for the patient's account at the hospital, the1 designated hospital employee shall make an initial determination of whether 1[a] the1 patient is eligible for participation in a public assistance program. If the 1[officer or]1 employee

concludes that [1][a] the[1] patient may be eligible for a public assistance program, the [1][officer or][1] employee shall so advise the patient, family member, responsible party or guardian, as appropriate. The [1][officer or][1] employee, either directly or through the hospital's social services office, shall give the patient, family member, responsible party or guardian, as appropriate, the name, address and phone number of the public assistance office that can assist in enrolling the patient in the program. The [1][officer or][1] employee, or the social services office of the hospital, shall also advise the public assistance office of the patient's possible eligibility[1], including possible retroactive or presumptive eligibility,[1] for the program.

(4) [1][The hospital admissions officer or] If evidence of health insurance coverage for the patient is not documented or if evidence of health insurance coverage is documented but the patient's health insurance coverage is unlikely to provide payment in full for the patient's account at the hospital, and the patient does not appear to be eligible for public assistance, the[1] designated hospital employee shall [1]determine if the patient is eligible for charity care pursuant to regulations adopted by the commissioner. If the patient does not qualify for charity care, the designated hospital employee shall[1] request from the patient, family member, responsible party or guardian, as appropriate, the patient's or responsible party's place of employment, income, real property and durable personal property owned by the patient or responsible party and bank accounts possessed by the patient or responsible party, along with account numbers and the name and location of the bank.

10. a. If, upon the discharge of a patient from the hospital, the patient's account has not been paid in full by the patient or responsible party or by health insurance, or it is unlikely that the patient's account will be paid in full by the patient or responsible party or by health insurance, as identified pursuant to paragraphs (2) and (3) of subsection c. of section 9 of this act, and the patient or responsible party [1][has assets as] is likely to have assets such as those[1] identified pursuant to paragraph (4) of subsection c. of section 9 of this act, a hospital shall follow the collection procedure pursuant to this section if the patient's

aggregate outstanding balance exceeds the cost of collecting the account. A hospital shall comply with the collection procedure on all outstanding accounts until the point is reached where the cost of collection exceeds the patient's outstanding balance.

b. The hospital shall commence the collection procedure within two weeks after a patient's discharge from the hospital or date of service at the hospital.

The collection procedure shall include:

(1) At least three billing statements, each sent at intervals of no longer than four weeks, shall be sent to the patient's or responsible party's mailing address. [1][A hospital is not required to comply with this provision if mail sent to the patient's or responsible party's mailing address has twice been returned to the hospital, and hospital personnel, after reasonable effort, are unable to determine a new mailing address for the patient or responsible party;

(2)][1] At least two collection follow-up letters shall follow the three billing statements. The collection follow-up letters shall be sent to the patient's or responsible party's mailing address at an interval of no longer than three weeks. Each collection follow-up letter shall state the amount due and owing, the collection history on the account and the hospital's intention to proceed with legal action if the outstanding balance is not paid in full or, in the alternative, the patient or responsible party fails to enter into payment arrangements with the hospital. [3]Each collection follow-up letter shall request a partial payment of the outstanding balance in the patient's account as the minimum amount due and shall offer to establish a payment schedule for the remainder of the outstanding balance in the patient's account based upon the patient's or responsible party's ability to pay. The letter shall clearly indicate the name of a person for the patient or responsible party to contact, and a telephone number for the patient or responsible party to call, in order to arrange such a payment schedule.[3]

A hospital is not required to comply with [1][this provision] the requirements of sending a third billing statement or two collection follow-up letters[1] if mail has twice been returned to the [1][facility] hospital[1], and hospital personnel, despite reasonable efforts, are unable to determine a new mailing address

for the patient or responsible party;

[1][(3)] (2)[1] At least three attempts to reach the patient or responsible party by telephone shall be made [1][by hospital personnel,][1] if hospital personnel have determined a residence or business telephone number for the patient or responsible party. If [1]hospital personnel are not able to make[1] telephone contact with the patient or responsible party [1][is not made][1] after three attempts, the hospital shall send a collection telegram; [3][and][3]

[1][(4)] (3)[1] Legal action to collect the amount due and owing on the patient's account [1]shall be taken[1] [3][.] ;and

(4) The hospital shall request the department, on behalf of the fund, to request the Department of the Treasury to apply or cause to be applied the income tax refund or homestead rebate due the patient or responsible party, or both the income tax refund and homestead rebate, or so much of either or both as is necessary to recover the amount due and owing on the patient's account, pursuant to section 1 of P.L.1981, c.239 (C.54A:9-8.1 et seq.), for which purpose the patient's outstanding balance shall be considered a debt to the fund and the fund shall be considered an agency of State government.[3]

c. Unless the cost of completing the procedure, in part or in its entirety, exceeds the outstanding balance on a patient's account, a hospital shall complete the procedures in paragraphs (1)[1][, (2) and (3)] and (2)[1] of subsection b. of this section before submitting appropriate documentation and requesting from the commissioner that the hospital be reimbursed on a delinquent account from the fund.

If any payment on a delinquent account is received as a result of compliance with the procedures in subsection b. of this section and the hospital has already received payment from the fund, the amount of money the hospital is entitled to receive from the fund shall be adjusted pursuant to procedures established by the commission.

d. This section shall not apply to a patient who qualifies for charity care pursuant to rules and regulations adopted by the commissioner. This section also shall not apply to a patient who qualifies for care under the federal Hill-Burton program pursuant to 42 U.S.C. §291 et seq.

e. The commissioner, after review by the Uncompensated Care

Trust Fund Advisory Committee, shall adopt rules and regulations to effectuate the purposes of this section and section 9 of this act; except that nothing in this section or section 9 of this act shall be construed to prohibit the commissioner from adopting rules and regulations that are more stringent than the provisions of this section and section 9 of this act.

11. a. The department shall annually provide for an audit of each hospital's uncompensated care within a time frame established by rules and regulations adopted by the commissioner.

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

c. Upon receipt and acceptance of the final audit, the commission, within 90 calendar days, shall adjust a hospital's schedule of rates so that the rates reflect the audit adjustment.

12. The commission shall adjust a hospital's schedule of rates to ensure that services which are provided to emergency room patients who do not require those services on an emergency basis are reimbursed at a rate appropriate for primary care, according to regulations adopted by the commissioner. [3]Nothing in this section shall be construed to restrict the right of the commission to increase a hospital's schedule of rates for required emergency services, except that the increase shall not be solely to offset a reduction in hospital revenue as a result of reduced rates for primary care provided in the emergency room.[3]

Nothing in this section shall be construed to permit a hospital to refuse to provide emergency room services to a patient who does not require the services on an emergency basis.

[3][13. If the State is not eligible to receive federal matching funds to cover the cost of the uniform Statewide uncompensated care add-on for receipt of medical assistance under the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), the State is not liable for the amount of the federal matching funds. [2]The amount of the federal matching funds shall be included in the add-on for all payers except Medicaid.[2]]3

[3][14.] 13.[3] Any employer in this State who does not provide

health insurance coverage to its employees is required to provide employer assistance and to inform all of its current and prospective employees about the importance of having health insurance coverage. The employer shall also make a good faith effort to assist any employee who wishes to purchase health insurance from a health insurance carrier.

For the purposes of this section, "employer assistance" means [1][obtaining information] the dissemination to all current and prospective employees of information obtained[1] from the department on health insurance products available in the State for employees and their dependents[1][, and disseminating this information to all current and prospective employees][1].

The department shall prepare and have ready for dissemination to employers information on health insurance products available in the State, within 60 days of the [3][effective date] date of enactment[3] of this act.

[3][15.] 14.[3] a. Every student enrolled as a full-time student at a public or private institution of higher education in this State shall maintain health insurance coverage which provides basic hospital [3][and medical][3] benefits. The coverage shall be maintained throughout the period of the student's enrollment.

b. Every student enrolled as a full-time student shall present evidence of the health insurance coverage required by subsection a. of this section to the institution at least annually, in a manner prescribed by the institution.

c. The State Board of Higher Education shall require all public and private institutions of higher education in this State to offer health insurance coverage on a group or individual basis for purchase by students who are required to maintain the coverage pursuant to this section.

The State Board of Higher Education shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry [2]out[2] the purposes of [3]subsections a., b. and c. of[3] this section.

[3]d. The Student Assistance Board in the Department of Higher Education shall adopt rules and regulations to require that a public or private institution of higher education in this State consider the coverage required pursuant to this section as an educational cost for purposes of determining a student's

eligibility for financial aid.[3]

[3][d.] e.[3] Nothing in this section shall be construed to permit a hospital in this State to deny access to hospital care to a full-time student whose health insurance coverage required by this section lapses for any reason.

[3]f. The provisions of this section shall not apply to a person who is a participant in the REACH program established pursuant to P.L.1987, c.282 (C.44:10-9 et seq.).[3]

[3][16.] 15.[3] The administrator of the fund is not required to repay to the General Fund any portion of the direct appropriation of State funds made pursuant to P.L.1986, c.204 that is remaining in the fund as of December 31, 1988. [1][The State funds shall remain in the fund and shall be used for the purpose of subsidizing health insurance programs for small businesses that will be designed to reduce the amount of uncompensated care in this State and for the purpose of carrying out the provisions of section 14 of this act.]

The amounts remaining in the fund shall be credited to a special account to be known as the "Uncompensated Care Reduction- Pilot Program" account and shall be used to subsidize or otherwise provide financial assistance for a health insurance pilot program for small businesses; except that the monies, and any interest earned thereon, shall remain in the account until such time as a law is enacted which establishes the health insurance pilot program for small businesses and which appropriates the monies in the account.[1]

[3][17.] 16.[3] The commissioner shall report [2][annually] on or before December [3][31] 1[3], 1989 and on or before December 31, 1990[2] to the Governor and the Senate Institutions, Health and Welfare [2][and] Committee, the Senate Revenue, Finance and Appropriations Committee,[2] the General Assembly Health and Human Resources [2][Committees] Committee and the General Assembly Appropriations Committee[2], or their successors, on the [2]activities and accomplishments of the Uncompensated Care Trust Fund Advisory Committee, the[2] cost to the State and other payers of uncompensated hospital care in the State and the effectiveness of the New Jersey Uncompensated Care Trust Fund in ensuring access to health care services for all residents of the State, ensuring payment of uncompensated hospital care costs in

the State, and protecting the fiscal solvency of the State's general acute care hospitals. [1]The [2][report] reports[2] shall also include the names of all hospitals which have been required to submit a cost reduction plan pursuant to section 7 of this act and any actions taken by the commission against a hospital for failure to submit or implement the plan.[1]

[2]In the report issued on or before December [3][31] 1[3], 1989, the commissioner shall include a recommendation for an alternative means of funding uncompensated care.[2] [3]The commissioner shall appear before the Senate Institutions, Health and Welfare Committee and the General Assembly Health and Human Resources Committee to discuss that report no later than December 31, 1989.[3]

The commissioner shall accompany [2][the] each[2] report with any recommendations for legislative or administrative action that the commissioner deems necessary [3][, including whether an increase in the amount of money raised by the uniform Statewide uncompensated care add-on, beyond the limit established pursuant to subsection b. of section 6 of this act, is necessary]3.

[3][1[1]8.] 17.[3] A hospital shall not advertise by any means[3][,]3 the availability of uncompensated care that is provided at the hospital pursuant to this act. Nothing in this section shall be construed to prohibit a hospital from advertising its requirement to provide charity care under the federal Hill-Burton program pursuant to 42 U.S.C. §291 et seq.[1]

[3][1[1]9.] 18.[3] A hospital that does not claim any deduction for bad debt for the purpose of the department's determination of that hospital's uncompensated care factor pursuant to N.J.A.C.8:31B-4.39, is eligible for full reimbursement for charity care, as provided pursuant to N.J.A.C.8:31B-4.37, for all eligible patients regardless of a patient's state of residence; except that[3][,]3 this section shall not apply in the case of a patient who is not a resident of the United States.[1]

[3][2[2]0.] 19.[3] a. The cost of advanced life support services provided pursuant to P.L.1984, c.146 (C.26:2K-7 et seq.) to medically indigent persons incurred through a hospital's provision of advanced life support services shall be compensated pursuant to this act. The [3][commissioner] commission[3] shall, by regulation, establish a schedule of reimbursement rates for

advanced life support services. Reimbursement for mobile intensive care unit uncompensated care shall only include those uninsured patients who are classified as charity care pursuant to regulations promulgated by the commissioner. Reimbursement shall exclude bad debt, the difference in a contractual allowance, or any medical denials for a service.

b. The cost of advanced life support services provided by the University of Medicine and Dentistry of New Jersey University Hospital to uninsured patients who are classified as charity care shall be uncompensated care, except that such uncompensated care shall be exempt from any reimbursement limitations for uncompensated care that apply to University Hospital. Reimbursement for advanced life support services uncompensated care for University Hospital shall not be paid from the fund, but shall be paid through the reimbursement rates of University Hospital as established by the commission.[2]

[1][18.] [2][20.[1] Pursuant] [3][21.] 20.[3] In addition to the provisions of subsection e. of section 10 of this act, the commissioner shall, pursuant[2] to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), [2][the commissioner shall][2] adopt rules and regulations necessary to carry out the [2]other[2] provisions of this act[1]; except that all rules and regulations adopted pursuant to P.L.1986, c.204 shall remain in effect until they are amended or repealed pursuant to this act[1].

[1][19.] [2][21.[1]] [3][22.[2]] 21.[3] a. The employees, appropriations and other moneys, files, books, papers, records, equipment and other property of the "New Jersey Uncompensated Care Trust Fund" and the "Uncompensated Care Trust Fund Advisory Committee," established pursuant to P.L.1986, c.204, which law [1][expired] expires[1] on December 31, 1988, are transferred, pursuant to the "State Agency Transfer Act," P.L.1971, c.375 (C.52:14D-1 et seq.) to the "New Jersey Uncompensated Care Trust Fund" and the "Uncompensated Care Trust Fund Advisory Committee," respectively, established pursuant to this act.

b. The membership of the "Uncompensated Care Trust Fund Advisory Committee," created pursuant to P.L.1986, c.204, is continued [2][and the members appointed pursuant to that act shall continue to serve for their term of office] as provided in subsection a. of section 5 of this act[2].

3[22. There is appropriated $150,000 from the fund to the Department of the Treasury to enable that department to carry out its responsibilities as provided in section 10 of this act.]3

1[20.] 2[22.1] 23.2 This act shall take effect 1[immediately] on December 31, 1988 and if enacted after that date, this act shall be retroactive to December 31, 1988]1, except that sections 9[3[,] and]3 10[3[,]3 1[12,]1 3[14 and 15]3 shall take effect on the 90th day following enactment [3[1and] ,]3 section 12 shall take effect one year following enactment [3]and section 14 shall take effect on July 1, 1989]3. This act shall expire on December 31, 2[1992[1]] 1990]2.

HEALTH

Health Care Facilities and Providers

Establishes "New Jersey Uncompensated Care Trust Fund" and appropriates $150,000 from the fund.

HEALTH

HOSPITAL REIMBURSEMENT

Uncompensated Care

Adopted Amendment: N.J.A.C. 8:31B-4.38 through 4.40

Proposed: August 21, 1989 at 21NJR 2449(a)

Adopted By: Molly Joel Coye, M.D., M.P.H.
Commissioner
Department of Health
(with the approval of the Health Care Administration Board)

Authority: N.J.S.A. 26:2H-18.4 et seq. (P.L. 1989, c.1) and N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5b and 26:2H-18(d)

Proposal Number: PRN 1989-436

Effective Date: December 18, 1989

Operative Date: January 1, 1990

Expiration Date: October 15, 1990

Summary of Changes Between Proposal and Adoption

There are several changes being made upon adoption. The following summary describes those changes.

N.J.A.C. 8:31B-4.38(a)1 is being amended to indicate that under certain circumstances accounts may be written off prior to 120 days.

N.J.A.C. 8:1B-4.39(a)4 has been amended to indicate consistently that a hospital's bad debt provision may be used at final reconciliation.

N.J.A.C. 8:31B-4.40(b)4 was amended to indicate that hospitals may document why required information is unobtainable.

N.J.A.C. 8:31B-4.40(4)4.i. was amended to define personal recognition of a patient as a way of documentating identification; previously this was defined as being identification.

N.J.A.C. 8:31B-4.40(b)4ii. was amended to indicate that uncompensated care will not be paid if a patient has not complied with any prior authorization agreements with his or her health insurer.

N.J.A.C. 8:3B-4.40(b)4.v. was deleted. This section required hospitals to defer non-emergency treatment if the patient could, but did not, provide the required information.

N.J.A.C. 8:31B-4.40(d)1 was revised from requiring a 14 day median date for monthly outpatient bills to allowing a 31 day billing cycle.

N.J.A.C. 8:31B-4.40(d)3i was amended to clarify that hospital agents, as well as employees, may contact patient by telephone.

N.J.A.C. 8:31B-4.40(d)3ii(1) was revised to eliminate the requirement for a two color envelope for urgent notification letters.

N.J.A.C. 8:31B-4.40(e)2i was revised to specify limited collection procedures for accounts under $200.

N.J.A.C. 8:31B-4.40(g)1 changes those assets upon which a judgement may be executed. It deletes the exception for "assets necessary for daily living" because this is already covered by New Jersey creditor statutes. It also clarifies that a judgement may be executed on a primary residence when the property is sold or otherwise transferred. Currently, there is no limit on a hospital's ability to execute judgment on a patient's assets including his or her primary residence.

Full text of the adoption follows (additions to the proposal indicated in boldface *thus;* deletions from the proposal indicated in brackets *[thus]*).

8:31B-4.38 Uncompensated care

(a) Uncompensated care includes only the reasonable cost of the following:

1. Bad debts for Chapter 83 Services, provided appropriate collection procedures as defined in N.J.A.C. 8:31B-4.40 are followed*,* and the account is at least 120 days old *except as provided in N.J.A.C. 8:31B-4.40(e)*

2. Charity care for Chapter 83 Services, provided the patient is qualified as eligible pursuant to N.J.A.C. 8:31B-4.37;

3. Advanced life support (ALS) services provided pursuant to P.L. 1984, c. 146 (N.J.S.A.26:2K-7 et seq.) provided the patient is qualified as eligible for charity care pursuant to N.J.A.C. 8:31B-4.37. The Commission shall establish a schedule of reimbursement rates for advanced life support services. Reimbursement shall exclude bad debts, the difference in a contractual allowance, and any medical denials for advanced life support services. This shall apply to reimbursement for ALS services as of November 1, 1987.

4. Charity care, as defined by following N.J.A.C. 8:31B-4.37 and bad debts, provided appropriate collection procedures are followed pursuant to N.J.A.C. 8:31B-4.40, for outpatient dialysis services provided after September 1, 1987 to patients ineligible for Medicare coverage. Reasonable costs shall be limited to the lower of the hospital's charges or the prospectively determined composite rate as established by Medicare. The amount reported by the hospital as uncompensated care shall not include Medicare co-insurance amounts since Medicare will reimburse providers for that amount provided reasonable collection efforts are pursued, or if the patient is eligible for charity care pursuant to N.J.A.C. 8:31B-4.37.

(b) Uncompensated care excludes the cost of the following:

1. Medical Denials, which are services that are denied for lack of medical necessity by a utilization

review organization (URO) or peer review organization unless the denial is for days within the trim points;

2. Courtesy adjustments as defined in N.J.A.C. 8:31B-4.15(a)4;

3. Discounts provided to health maintenance organizations or other payers;

4. Patient Convenience Items as defined in N.J.A.C. 8:31B-4.65;

5. Excluded Health Services as defined in N.J.A.C. 8:31B-4.62;

6. Cosmetic surgery except where medically necessary;

7. Costs associated with procuring organs sent to foreign countries;

8. Non-health services provided by a hospital; and

9. Services not paid pursuant to Chapter 83 except as provided in sections (a) 3. and 4. above.

(c) Uncompensated care shall be determined prospectively as the cost associated with eligible services provided to persons determined to be eligible for charity care pursuant to N.J.A.C. 8:31B-4.37, net of grants and other funds available for the medically indigent, and for a hospital's Bad Debt Provision provided appropriate collection procedures have been followed.

8:31B-4.39 Determination of uncompensated care payments

(a) In order to include prospectively a factor for uncompensated care, such care shall be measured for the Current Cost Base pursuant to N.J.A.C. 8:31B-4.131 as follows:

1. The statewide uncompensated care add-on shall be determined pursuant to N.J.A.C. 8:31B-7.3(a)1.

2. A hospital's uncompensated care amount shall include the sum of a hospital's actual, reasonable charity care and a reasonable provision for bad debt. A hospital's uncompensated care amount may be adjusted by the Commission for inability to document historical charity care eligibility determination policies and practices and bad debt collection policies and practices which meet or surpass in effectiveness the appropriate collection procedures defined in N.J.A.C. 8:31B-4.37 and 8:31B-4.40, respectively.

3. In setting the Schedule of Rates for each hospital the uncompensated care factor shall be applied to the Preliminary Cost Base (determined in accordance with the Methodological and

Procedural Regulations). From the Schedule of Rates will be subtracted the Current Cost Base year amount of grants or payments from county governments, municipal governments, or others on behalf of the medically indigent.

4. At final reconciliation the uncompensated care revenue will be adjusted to the actual amount of charity care and bad *[debts]* *debt provision* .

5. Hospitals shall implement appropriate collection procedures as defined in N.J.A.C. 8:31B-4.40. Hospitals that fail to follow the appropriate collection procedures shall receive reductions in their uncompensated care amounts.

6. Hospitals that fail to meet their Hill-Burton obligation for community services (see PHS 42CFR Part 124) shall receive appropriate reductions in their uncompensated care amounts. Hospitals that fail to meet charity care requirements as defined in N.J.A.C. 8:31B-4.37 shall receive appropriate reductions in their uncompensated care amounts pursuant to N.J.A.C. 8:31B-4.39.

7. The hospital shall not pursue payment according to specified billing procedures for those patients who meet the criteria described in N.J.A.C. 8:31B-4.37.

8. Total Deductions from Gross Operating Revenue for the Current Cost Base year must agree with the hospital's financial statement for the same reporting period.

9.-10. (No change.)

8:31B-4.40 Appropriate collection procedures

(a) In determining ability to pay, the provider shall take into account a patient's total resources including, but not limited to, an analysis of assets (except those which may be necessary for the patient's daily living*[,]*)*,* liabilities, income and expenses. Although extenuating circumstances may be considered, independent verification of both the patient's financial condition and the circumstances shall be required unless totally unobtainable. Moreover, the provider shall make a continuing, diligent effort to secure payment from the patient, any legally responsible individual, or any other potential source The provider's collection effort shall be documented by copies of bills, follow-up letters, reports of phone calls, personal contact, and additional supporting documentation stored in files or on computer. Such documentation must be maintained until the Commission has approved the final audit covering the time of service. Minimum appropriate collection procedures are defined as those set forth in this section.

(b) Pre-Admission/Service Procedures: Except where an emergency medical condition dictates otherwise, prior to or upon admission or service, a patient or the patient's family member, responsible party or guardian, as appropriate, shall be interviewed by a hospital employee(s) who has been trained in the collection of patient financial data, identification of third party coverage and in assessing a patient's

eligibility for public assistance. This interview shall include the following activities.

1. Determine all existing third-party benefits.

2. Screen the patient for eligibility for medical assistance from any source ; refer the patient to that source and follow up. At such time, for any patient found to be non-eligible for existing medical assistance programs, a determination shall be made with respect to the patient's full or partial qualification for charity care pursuant to N.J.A.C. 8:31B-4.37.

3. If the patient does not qualify or qualify fully under (b) 1. and 2. above, an appropriate deposit shall be required and a reasonable payment plan negotiated prior to admission, based on the patient's ability to pay and the type of services to be rendered. A reasonable payment plan may, if necessary based on the patient's ability to pay, extend beyond a term of one year from the date of admission/service. The hospital may write-off to bad debt any amounts remaining after one year, providing all appropriate collection steps up to that point have been taken. These accounts may not be sent to a collection agency unless the patient defaults on his or her payment plan and unless the hospital first follows the required in-house collection steps to reinstate the payment plan. The monies collected by the hospital after the account has been written off shall be considered recoveries of bad debts. Necessary and appropriate treatment cannot be denied when the patient is unable to meet the financial requirements. However, upon adequate documentation and independent verification of the patient's qualifications for charity care the hospital should not pursue the collection procedures set forth herein.

4. If complete information is not provided by the patient the hospital must document the efforts made to obtain such information and the reasons why it was *[not provided. However, merely stating the reason why information was not provided does not relieve the hospital of its responsibility to obtain required information]**unobtainable*.

i. The designated hospital employee shall obtain documentation of proper identification of the patient. This shall include all of the data elements listed below as "proper identification" along with one or more of the following forms of documentation of proper identification. Documentation of proper identification may include, but shall not be limited to, a driver's license, a voter registration card, an alien registry card, a birth certificate, an employee identification card, a union membership card, an insurance or welfare plan identification card or a Social Security card. Proper identification of the patient may also be [provided]**documented* by personal recognition by a person not associated with the patient. For the purposes of this section, "proper identification" means the patient's name; mailing address; residence telephone number; date of birth; Social Security number; place and type of employment, employment address and employment telephone number, as applicable.

ii. The designated hospital employee shall inquire of the patient, family member, responsible party or guardian, as appropriate, whether the patient is covered by health insurance, and if so, shall request documentation of the evidence of health insurance coverage. Documentation

may include, but shall not be limited to, a government-sponsored health plan card or number, a group sponsored or direct subscription health plan card or number, a commercial insurance identification card or claim form or a union welfare plan identification card or claim form. The hospital shall also inquire as to whether the patient had complied with any prior authorization requirements of the patient's insurance policy. If the patient has not done so, the hospital *[shall defer the service until]* *will not be paid for uncompensated care for these services unless* prior authorization is obtained unless the patient's condition requires immediate medical attention.

iii. If evidence of health insurance coverage for the patient is not documented, or if evidence of health insurance coverage is documented but the patient's health insurance coverage is unlikely to provide payment in full for the patient's account at the hospital, the designated hospital employee shall make an initial determination of whether the patient is eligible for participation in a public assistance program. If the employee concludes that the patient may be eligible for a public assistance program, the employee shall so advise the patient, family member, responsible party or guardian, as appropriate. The employee, either directly or through the hospital's social services office shall give the patient, family member, responsible party or guardian, as appropriate, the name, address and phone number of the public assistance office that can assist in enrolling the patient in the program. The employee, or the social services office of the hospital, shall also advise the public assistance office of the patient's possible eligibility, including possible retroactive or presumptive eligibility, for the program.

iv. If evidence of health insurance coverage for the patient is not documented or if evidence of health insurance coverage is documented but the patient's health insurance coverage is unlikely to provide payment in full for the patient's account, and the patient does not appear to be eligible for public assistance, the designated hospital employee shall determine if the patient is eligible for charity care pursuant to N.J.A.C. 8:31B-4.37. If the patient does not qualify for charity care, the designated hospital employee shall request from the patient, family member, responsible party or guardian or other independent source, as appropriate, the patient's or responsible party's place of employment, income, real property and durable personal property and liquid assets owned by the patient or responsible party and bank accounts possessed by the patient or responsible party, along with account numbers and the name and location of the bank.

[v. Unless the patient's condition requires immediate medical attention, the hospital must defer the admission or service until the information required in sections i. through iv. above is provided to the hospital if the required information is available to the patient or responsible party and if the patient or responsible party fails or refuses to provide the information to the hospital. Written certification by a medical professional, or notation in the file by the designated hospital employee that verbal certification was given by a medical professional, of the patient's need for immediate medical attention shall be acceptable evidence of the same. This section does not authorize hospitals to defer necessary and appropriate treatment for failure to meet financial requirements.]

(c) Pre-discharge procedures are as follows:

1. With respect to patients admitted on an emergency basis, the interview required in (b) above shall be conducted as soon thereafter as possible but within five working days of the patient's admission into the hospital or prior to discharge, whichever is sooner. If, due to the nature of the illness, the patient cannot be interviewed, the procedure required above shall be conducted by other means including, but not limited to, direct contact by the provider with relatives, and legally responsible individuals or third parties, if any.

2. Once the information required in (b) above is obtained, the provider shall seek payment from the appropriate carrier, or follow up to obtain the medical assistance or secure the deposit agreement required in (b) above from the patient or legally responsible individual, as appropriate, on or no longer than seven days following discharge or verification of eligibility. The provider must document all cases when compliance with the aforementioned collection procedures cannot be accomplished.

(d) Post-Discharge Follow-up/In-House Efforts: The hospital shall follow up periodically with the proper carrier until the amount owing has been paid in full. Except for denials due to lack of medical necessity, the patient shall be contacted and payment requested concerning any portion of the bill declined by third party carriers. With respect to these patients, self-pay patients and legally responsible individuals, collection procedures *[must]* *shall* include but are not limited to:

1. Sending a minimum of three billing statements. The first billing statement shall be sent within an average of 14 days from the date of discharge for inpatients or the date of service for outpatients. If outpatient charges are accumulated and billed monthly, the hospital may continue to do so provided that the *[median date of the]* billing cycle for all outpatient billing *[is not more than 14 days from the billing date]**does not exceed 31 days from the date of service*. The hospital must document all cases where this schedule cannot be followed. The second and third billing statements shall be sent to the patient's or responsible party's mailing address at intervals of no less than three weeks and no more than monthly. A hospital is not required to comply with the requirements of sending a third billing statement or two collection follow-up letters if mail has twice been returned to the hospital, and hospital personnel, despite reasonable efforts, are unable to determine a new mailing address of the patient or responsible party.

2. Sending a minimum of two collection follow-up letters following the three billing statements. These letters shall be sent to the patient's or responsible party's mailing address at an interval of no less than two weeks and no more than three weeks. Each collection letter shall include the following elements:

i. the amount due and a demand for payment;

ii. the date of service;

iii. the hospital's intention to proceed with legal action if the outstanding balance is not paid in full or if the patient or responsible party fails to enter into payment arrangements; except that if the bill is too small to warrant legal action, such letter must indicate the hospital's intent to proceed with outside collection efforts. In either case the letter shall indicate that any unpaid accounts will be reported to the Department of Health and any state income tax refunds or homestead rebates up to the amount of the unpaid bill will be withheld by the Department of Treasury;

iv. A request for a partial payment and an offer to establish a payment schedule based on the patient or responsible party's ability to pay; and

v. The name of a person and a telephone number for the patient or responsible party to call in order to arrange for such a payment schedule or to discuss any aspect of the bill.

3. Making telephone contact or sending telegrams after the follow-up letters. The hospital or its agent shall make three attempts to reach the patient or responsible party by telephone if the hospital has a home or business telephone number. If hospital personnel or their agent are not able to make telephone contact with the patient or responsible party or if the hospital does not have and cannot determine a home or business telephone number for the patient or responsible party, the hospital shall send a collection telegram or comparable urgent notification letter.

i. Telephone contact means a person-to-person discussion about the bill between a hospital employee *or agent* and the patient or responsible parties via the telephone. This excludes any instance where a mechanical device is involved on either side. Such mechanical efforts may, however, be reported as an attempt to make contact.

ii. A comparable urgent notification letter must meet the following criteria.

(1) The outside envelope shall *[display at least two colors and]* include some indication that the contents are urgent;
(2) The outside envelope shall not resemble previous correspondence from the hospital;
(3) The letter shall be sent in a standard envelope, not a data mailer;
(4) Postage should be metered or use a permit number; and
(5) The letter shall convey a sense of urgency, both on the inside and the outside.

4. Documentation in each patient's file shall indicate bona fide collection efforts or adequate reasons related to the case which support the provider's decision to terminate the collection effort if such efforts are terminated prior to completing the steps listed above.

(e) Post-Discharge/Out-of-House Collection Efforts: Not less than 90 days or more than 120 days following discharge, all remaining

unpaid balances due and owing, unless subject to a payment plan pursuant to (b) 3. above, shall be reviewed and a determination made with respect to whether or not an account should be held in-house for an additional period of time if it is likely that the bill can be collected; sent to an outside collection agency; or pursued through appropriate legal action. Appropriate internal collection procedures shall be fully pursued unless and until:

1. Evidence clearly shows that there is no likelihood of recovery at any time in the future.

2. The cost of collection exceeds the amount of the bill.

i. For accounts of *[$150]**$200.00* or less, an exception shall be made and the following steps must be adhered to:

(1) Two billing statements must be mailed;

(2) One collection follow-up letter must be mailed;

(3) Two attempts at telephone contact must be made; and

(4) One collection telegram or urgent notification letter must be sent.

ii. In addition, for all accounts the hospital may use the services of outside collection agencies and must *[refer]**report* accounts not collected after following these steps, to the Department of Health who shall request the Department of Treasury to apply or cause to be applied the income tax refund or homestead rebate, or so much of either or both as is necessary to recover the amount due and owing on the patient's account, pursuant to section 1 of P.L. 1981, c.239 (N.J.S.A.54A:9-8.1 et seq.), for which purpose the patient's outstanding balance shall be considered a debt to the fund and the fund shall be considered an agency of State government.

iii. For accounts in excess of *[$150.00]**$200.00* the hospital shall complete all steps through the point of using outside collection agencies and legal action.

3. Existing evidence *shows* that further in-house collection efforts would be futile after adhering to the appropriate procedures in (d) above.

(f) While the hospital may write off accounts, or portions thereof, 120 days after discharge, this does not relieve the hospital of the obligation to continue to make reasonable efforts to obtain payment.

(g) Legal action shall be required in all cases unless legal action is not appropriate based on the patient's income and assets or unless the bill is less than the likely costs of legal action. *[If the litigation process (as distinct from the initial filing of a lawsuit) is undertaken by a law firm hired on a contingency basis, it shall be at the discretion of that law firm whether to undertake and whether to continue such

litigation.]* Legal action may not be taken for Medicaid recipients for medically necessary and appropriate services.

1. Legal action shall be defined as the filing of a lawsuit *or a lien* and shall include all subsequent steps in the litigation process up to and including the garnishment of wages*, entering a judgment* and *[the]* execution of a judgment upon the assets of the debtor *where appropriate*. Hospitals shall not execute judgement on a patient's principal residence *[or on personal property or assets needed for daily living]* *until the property is sold or otherwise transferred*.

(h) Nothing in this section precludes a hospital from taking intermediate steps after the post discharge steps in (d) and (e) above but before taking legal action. This includes, but is not limited to, sending an account to a collection agency.

SUMMARY OF REMARKS
BEFORE
AUDIT SUBCOMMITTEE OF THE UNCOMPENSATED CARE TRUST FUND
AND
HOSPITAL RATE SETTING COMMISSION

MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER OF HEALTH

SEPTEMBER 27, 1989

Today I am proposing a series of regulatory and administrative changes to contain costs of uncompensated health care in New Jersey, while at the same time protecting the integrity of the health care system and improving collection practices by some of the state's hospitals.

Uncompensated care is a trust. Through the Uncompensated Care Trust Fund hospitals are provided full reimbursement for charity care and bad debt in return for the provision of care to every citizen and for solid fiscal practices to limit bad debt.

We must ensure that all the funds provided for uncompensated care are needed and that every effort is made to collect on hospital bills from those who have the ability to pay.

New Jersey has the best health care system in the nation because it guarantees access to care for everyone. We must, however, remain vigilant to preserve the system.

In its ongoing efforts to closely monitor the Uncompensated Care Trust Fund, the Health Department has identified some disconcerting trends involving reimbursement to hospitals for bad debt. The Trust Fund reimburses hospitals for any bills which are not paid by patients. Actual writeoffs for bad debt have jumped 59 percent between 1986 and 1988, growing from $238 million to $379 million, for the 58 hospitals which have reported complete data.

Further, the costs to the Trust Fund for collection of bad debt have almost doubled in the last three years. The Trust Fund paid hospitals or collection agencies $35 million last year for the costs of collecting bad debt, up from $18 million in 1985.

The Department of Health is looking very carefully at current hospital collection practices. If we find that any hospitals have inappropriately made claims to the Trust Fund, we will ask the Hospital Rate Setting Commission to recover funds from those hospitals through their rates.

At the same time, we want to make sure that collection practices will be sufficient and responsible in the future, so we are proposing six steps to tighten controls on the collection of bad debt. They are:

+ Establish a new collections system.

  Require state certification for all agencies providing collection services for hospitals that submit claims to the Uncompensated Care Trust Fund. This move will enable the Health Department to more effectively monitor activities of collection agencies. Currently Trust Fund collection agencies are virtually unregulated.

+ Prohibit affiliated collection agencies.

  Prohibit hospitals from using their own subsidiaries or those of their parent corporations to collect bad debts from patients. Currently affiliated agencies are essentially unregulated.

+ Require auditor certification.

  Require that the hospital's own auditors certify in writing that hospital submissions to the Trust Fund for reimbursement reflect conservative accounting assumptions.

+ Toughen audit procedures.

  Outside audits of bad debt are not comprehensive. The auditors now focus on only a few issues, such as when an account was turned over to collections. A hospital now can pass the audit merely by going through rote movements on collections. Auditors lack clout to make surprise visits, review the hospital's overall collections system, or even adjust inappropriate writeoffs. A regulatory change would permit the auditors to make unannounced visits when appropriate. It would also require auditors to determine the insurance status of bad-debt accounts.

+ Make examination of collection practices more thorough.

  Hospitals' entire collection programs need to be scrutinized. The Health Department will use various screens, criteria, and data analyses to improve the situation statewide.

+ Construct an incentive for more effective collection practices by hospitals.

  Currently the system permits hospitals to obtain reimbursement for accounts of bad debt that are not energetically pursued. An incentive for effective

collections would help contain the costs of uncompensated care.

Our proposals are designed to close all possible loopholes in the uncompensated care system. We are basing our proposals not on the possibility that abuses have occurred, but rather on the fact that we need firm controls in place to guard against abuses, now and in the future.

The measures proposed today will be refined and evaluated during the next several weeks.

HEALTH

HOSPITAL REIMBURSEMENT

Financial Elements

Proposed New Rule: N.J.A.C. 8:31B-4.125

Authorized By: Thomas A. Burke, Ph.D.
Acting Commissioner
Department of Health
(with the approval of the Health
Care Administration Board)

Authority: N.J.S.A. 26:2H-18.4 et seq. and N.J.S.A. 26:2H - et seq.
specifically 26:2H-5(b) and 26:2H-18(d)

Proposal Number: PRN

Submit comments by January 4, 1990 to:

Scott Crawford, Director
Health Care for the Uninsured Program
New Jersey Department of Health
CN 360
Trenton, NJ 08625

The agency proposal follows:

Summary

This proposed new rule defines outside collection costs for the purpose of hospital rate setting. Outside collection costs include only those costs of collection paid to an unaffiliated agency for the purpose of collecting accounts after the hospital has completed all of the in-house collection steps required by N.J.A.C. 8:31B-4.40. Moreover, it bars hospitals from receiving reimbursement for outside collection costs if the collection agency has not received approval from the Department of Health to process such accounts.

Social Impact

The proposed new rule will eliminate any incentives for the inappropriate use of affiliated collection agencies and foster the controls of hospital uncompensated care required pursuant to the Uncompensated Care Trust Fund Act. This proposal will benefit consumers and payers by enhancing state scrutiny of unaffiliated outside collection agencies.

Economic Impact

This proposed new rule will eliminate payments to the affiliated collection agencies set up by a number of hospitals. It will benefit unaffiliated agencies and consumers by fostering competition for those accounts. Unaffiliated agencies that do not receive state approval will be adversely impacted.

Regulatory Flexibility Statement

The proposed amendment affects only those hospitals whose rate are set by the Hospital Rate Setting Commission. There are no hospitals subject to the amendment with fewer than 100 full-time employees. Therefore, the amendment has no impact on any institution which would quality as a small business pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows:

8:31B-4.125 Outside Collection Costs

(a) Function:

1. This center shall be used to account for outside collection costs for accounts that have already complied with all collection steps required by N.J.A.C. 8:31B-4.40. Outside collection costs that do not meet the criteria listed in this section may not be paid through the Chapter 83 rates.

2. This center may not be used to report any costs associated with outside collection activities done by an entity that is affiliated in any way with the hospital, its parent or affiliated organization(s), its directors or its management. Affiliation includes but is not limited to ownership in whole or in part, stock interest, existence of any financial transaction not stipulated in contract (for example a contribution to a related foundation), overlap of directors, management or staff, or existence of a contractual relationship for services other than collection.

3. This center may not be used to report any costs associated with outside collection activities done by an entity that has not received approval from the State Department of Health. This section shall take effect for accounts turned over 90 days after the Department of Health has instituted a system to process such approvals.

4. The Department shall institute a process for approval of entities whose collection activities may be reported in this center. The Department shall base approval on criteria including but not limited to:

i. The fee charged by the entity.
ii. The willingness and ability of the entity to provide data required by the Department.
iii. The demonstrated ability of the entity to comply with procedures required by the Department.
iv. The proposal by the agency of improvements to the collection procedures followed.

_____
Signature of Proposing Officer

_____
Date

HEALTH

HOSPITAL REIMBURSEMENT

Proposed Amendment: N.J.A.C. 8:31B-4.40

Authorized By: Thomas A. Burke, Ph.D
Acting Commissioner
Department of Health
(with the approval of the Health Care Administration Board)

Authority: N.J.S.A. 26:2H-18.4 et seq. and N.J.S.A. 26:2H et seq., specifically 26:2H-5(b) and 26:2H-18(d)

Proposal Number: PRN

Submit comments by January 4, 1990 to:

Scott Crawford, Director
New Jersey Department of Health
Health Care for the Uninsured Program
CN 360, 8th Floor
Trenton, NJ 08625

The agency proposal follows:

Summary

This proposed amendment allows hospitals additional flexibility in collection efforts by instituting a system where hospitals may submit a proposal to use alternative methods of collection. The Department will review the proposal to determine whether the alternative method meets or exceeds the effectiveness of the required steps. Approval for the use of any alternative collection efforts must be obtained from the Commission. Additional amendments to N.J.A.C. 8:31B-4.40, including new subsections (g) and (h), were proposed on August 21, 1989 at 21 N.J.R. 2449(a) and will be adopted prior to this section.

Social Impact

This amendment will afford the hospitals additional flexibility to use equally or more effective collection efforts. Moreover, this flexibility will allow the Department to evaluate alternative collection efforts and, if appropriate, spread them to other hospitals.

Economic Impact

This amendment will have a positive economic impact in that only alternative collection efforts likely to be equally or more effective will be approved. Successful innovation may be replicated throughout the system, thus decreasing uncompensated care.

Regulatory Flexibility Statement

The proposed amendment affects only those hospitals whose rate are set by the Hospital Rate Setting Commission. There are no hospitals subject to the amendment with fewer than 100 full-time employees. Therefore, the

amendment has no impact on any institution which would quality as a small business pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]).

8:31B-4.40 Appropriate Collection Procedures

(a) - (h) - (No change.)

(i) Nothing in this section shall prohibit a hospital from requesting approval to use alternative collection efforts that meet or exceed the effectiveness of the collection efforts required above. Such requests must be submitted to the Department and approved by the Commission, and must comply with the Trust Fund Law.

(j) Based on criteria to be approved by the Commission, a methodology may be used to provide incentives and disincentives to hospitals that request approval under (i) above.

_____

Signature of Proposing Officer

_____

Date

HEALTH

HOSPITAL REIMBURSEMENT

Financial elements reporting audit adjustments

Proposed Amendment: N.J.A.C. 8:31B-3.17

Authorized By: Thomas A. Burke, Ph.D.
Acting Commissioner
Department of Health
(with the approval of the Health Care Administration Board)

Authority: N.J.S.A. 26:2H-18.4 et. seq. and N.J.S.A. 26:2H-1. et seq., specifically 26:2H-5(b) and 26:2H-18(d)

Proposal Number: PRN

Submit Comments by January 4, 1990 to:

Scott Crawford, Director
Health Care for the Uninsured Program
New Jersey Department of Health
CN 360
Trenton, NJ 08625

The agency proposal follows:

Summary

This proposed amendment allows the Department to make unannounced audits of hospitals. It further eliminates the $50,000 materiality threshold for uncompensated care penalties.

Social Impact

The proposed amendment will have a positive social impact in that it will tighten the scrutiny given to hospital costs and revenues.

Economic Impact

To the extent that this proposed amendment increases the veracity of uncompensated care paid through the hospital rate setting system, this proposed amendment will have a positive economic impact for consumers. Hospitals and the Department of Health may experience marginally higher costs of auditing. Hospitals that are not in compliance with the Chapter 83 regulations may incur increased penalties. The threshold change should have little or no economic impact since most penalties exceed $50,000 and are instituted prior to the time period affected by the materiality standard.

Regulatory Flexibility Statement

The proposed amendment affects only those hospitals whose rates are set by the Hospital Rate Setting Commission. There are no hospitals subject to the amendment with fewer than 100 full-time employees. Therefore, the amendment has no impact on any institution which would qualify as a small business pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]).

8:31B-3.17 Financial elements reporting audit adjustments

(a) (No change.)

(b) All reported financial information shall be reconciled by the hospital to the hospital audited financial statement. In addition, [having given adequate notice to the hospital] at any time deemed appropriate by the Commissioner, the Department of Health may perform a cursory or detailed on-site review at the Department's discretion of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the Preliminary Cost Base (PCB). Any adjustments made subsequent to the financial review (including Medicare audit and New Jersey State Department of Health reviews) shall be brought to the attention of the Commissioner by the hospital, the Department of Health, appropriate fiscal intermediary or payor where appropriate, pursuant to N.J.A.C. 8:31B-3.63 through 3.70 or N.J.A.C. 8:31B-3.71 through 3.86, and shall be applied proportionately to the Preliminary Cost Base and Schedule of Rates (and to the extent pragmatic, applied to fixed and variable financial elements) at the time of the reconciliation to the Schedule of Rates (see N.J.A.C. 8:31B-3.71 through 3.86). All such adjustments shall be determined retroactively to the first payment on the Schedule of Rates and shall be applied prospectively. Any additional discrepancies determined beyond final reconciliation will be reflected in the hospital's current Schedule of Rates, if the net impact is greater than $50,000 or one percent of the hospital's total gross revenue. This threshold will not apply to uncompensated care penalties or other adjustments to uncompensated care amounts.

_____

Signature of Proposing Officer

_____

Date

HEALTH

HOSPITAL REIMBURSEMENT

Procedural and Methodological Regulations

Financial Elements

Proposed Amendments: N.J.A.C. 8:31B-3.3, 4.6 and 4.41

Authorized By: Thomas A. Burke, Ph.D.
Acting Commissioner, Department of Health
(with the approval of the Health Care
Administration Board)

Authority: N.J.S.A. 26:2H-18.4 et seq. and N.J.S.A. 26:2H et seq., specifically 26:2H-5(b) and 26:2H-18(d)

Proposal Number: PRN

Submit comments by January 4, 1990 to:

Scott Crawford, Director
New Jersey Department of Health
Health Care for the Uninsured Program
CN 360, 8th Floor
Trenton, NJ 08625

The agency proposal follows:

Summary

These proposed amendments require hospitals to obtain a detailed analysis of their uncompensated care policies and practices each year from their independent auditor. The proposed amendments specify the information that must be provided and a time frame for submission. It further establishes penalties for late submission and for failure to have adequate uncompensated care policies and practices.

Social Impact

These proposed amendments will add an important new element of scrutiny of hospital uncompensated care. It will benefit consumers and payers by improving the degree of protection against excessive uncompensated care costs.

Economic Impact

These proposed amendments will require hospitals to increase the work required of independent auditing firms. This will increase somewhat the cost to hospitals of independent auditing services and may have a resulting impact on hospital rates.

Regulatory Flexibility Statement

The proposed amendments affect only those hospitals whose rates are set by the Hospital Rate Setting Commission. There are no hospitals subject to the amendment with fewer than 100 full-time employees.

Therefore, the amendment has no impact on any institution which would qualify as a small business pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus].

8:31B-3.3 Uniform Reporting: Current costs

(a) (No change.)

(b) Late submission of current [cost] data, as defined in N.J.A.C. 8:31B-4.6(c), including Audited Financial Statements and Auditor's Uncompensated Care Review, may result in a penalty, payable to the Commission, of up to $200.00 per working day past the appropriate submission date. The penalty shall be levied at the discretion of the Commission.

8:31B-4.6 Reporting period

(a) - (b) (No change.)

(c) Each calendar year's Financial Elements Reporting Forms as defined in N.J.A.C. 8:31B-4.131 are due on May 31 of the following year. Each year's Audited Financial Statement is due on May 31 of the following year. Each year's Auditor's Uncompensated Care Review as defined in N.J.A.C. 8:31B-4.41(d) is due on May 31 of the following year. Failure to meet these time frames will result in penalties as stated in N.J.A.C. 8:1B-3.3.

8:31B-4.41 Uncompensated Care Audit Functions

(a)-(c) (No change.)

(d) Before a hospital's reported uncompensated care may be approved as reasonable uncompensated care and incorporated in its rates or in the Trust Fund calculation, an independent auditor retained by the hospital must review all calculations related to the hospital's reported uncompensated care and must review the hospital's practices related to the management of accounts receivable. The independent auditor must then provide a written analysis and opinion concerning the following:

1. Provision for bad debt, reserve for uncollectibles, and year end aging schedule, as related to provision for bad debt. An opinion shall be included as to whether the methods used to determine the provision for bad debt are conservative for the purpose of protecting the Trust Fund from excessive cost. The opinion shall state whether the hospital's methods are adequate to prevent, and whether they have prevented significant overstatement of provision for bad debt, given the goal of conservatism stated in this section. For purposes of this reporting an overstatement of

either 5 percent or $250,000 (whichever is greater) shall be considered a significant overstatement. Analysis of at least three years experience shall be included. A copy of the year end aging schedule shall be included with the report.

2. Write-off practices and whether they are adequate to prevent any overstatement of write-offs in the current year and a resulting high recovery rate in a future year. An opinion shall be given regarding the appropriateness of the timing of write-offs for each category of account (including but not limited to, self-pay, Blue Cross, commercial insurance, HMO, no-fault auto insurance liability insurance, Medicaid and Medicare): whether there are adequate safeguards to prevent writing off accounts where third party payment may be available; and regarding the hospital's written policy governing the transfer of accounts to bad debt status, and whether it is followed.

3. Use of collection agencies when necessary, and whether the hospital maximizes the cost/benefit to the system - generating the optimal collection rate without unreasonably increasing the cost of outside collection itself. Quantitative analysis shall be included analyzing collection agency placements, recoveries, and fees.

4. Management of accounts receivable. Quantitative analysis of changes in accounts receivable from year to year shall be provided, and an opinion given as to the reasonableness of these changes. Also included shall be an analysis and evaluation of the hospital's management of accounts receivable, including but not limited to its timeliness and aggressiveness in billing and in follow up of both insured and uninsured accounts, potential Medicaid-eligible cases, and large balance accounts. An opinion shall be given regarding the adequacy of the hospital's written formal policies and procedures to govern patient accounting activities and the extent these policies compare to industry standards in this area. An opinion shall be given regarding whether the policies are consistently followed.

(e) The report required in (d) above shall be submitted annually to the Department. The Department shall review these reports and may recommend fines to the Commission or penalties to be imposed by the Commission in amounts up to the amount by which the inappropriate or inadequate actions or failures to act are estimated to have cost the system.

_____
Signature of Proposing Officer

_____
Date

Members of Uncompensated Care Trust Fund Advisory Committee

Dorothy K. Powers, Committee Chair
Hospital Rate Setting Commission
18 Tarkington Court
Princeton, NJ 08540
(609) 921-1092

Gary L. Baker
Manager of Relocation and Reimbursement
IBM United States
2000 Purchase Street
Purchase, NY 10577
(914) 697-6688

Dennis Beatrice
Assistant Commissioner
NJ Department of Human Services
CN 700
Trenton, NJ 08625
(609) 292-8374

Judy L. Brett, Ph. D.
NJ States Nurses Association
30 Benford Drive
Princeton Junction, NJ 08550
(201) 937-8538

Dominick J. Camisi
Vice President
NJ Hospital Association
760 Alexander Road
CN-1
Princeton, NJ 08543-0001
(609) 275-4021

Kenneth M. Courey
President
St. Clare's/Riverside Medical Center
Pocono Road
Denville, NJ 07834
201) 625-6507

Roger W. Birnbaum
President
Rutgers Community Health Plan
One Worlds Fair Drive
Somerset, NJ 08873

Laura Giannotta
State Director
NJ Chapter of National Federation of Independent Business
156 West State Street
Trenton, NJ 08625
(609) 989-8777

Fred Koehler
Senior Vice President
Blue Cross and Blue Shield of New Jersey
33 Washington Street
Newark, NJ 07102
(201) 456-2217

Kenneth Merin
Commissioner
NJ Department of Insurance
20 West State Street
Trenton, NJ 08625
(609) 633-7667

Michael F. Moriarty
Assistant Counsel to the Governor
State House
Trenton, NJ 08625
(609) 292-6000 ext. 364

Clyde H. Parker
Director of Manufacturing
Personnel at Mannington Mills
Salem, NJ 08079
(609) 935-3000

Stanley B. Peck
Vice President
Health Insurance Association of America
1025 Conneticut Avenue
Washington, D.C. 20036
(202) 223-7829

Alfred Slocum
Public Advocate
NJ Department of Public Advocate
CN 850
Trenton, NJ 08625
(609) 292-0756

MEMBERS OF THE HOSPITAL AUDIT AND COLLECTION PRACTICES SUBCOMMITTEE

Steve Sylvester, Manager
Administration and Debt Collection
Office of Financial Management
1 West State Street, 3rd Floor
CN 214
Trenton, NJ 08625
(609) 292-8822

Edward Tetelman
Assistant Commissioner
NJ Department of Human Services
Capital Place One
Trenton, NJ 08625
(609) 292-1617

Fred L. Koehler, Jr.
Sr. Vice President
Blue Cross and Blue Shield of New Jersey
33 Washington Street
Newark, NJ 07102
(201) 456-2217

John V. Jacobi, Esq.
Assistant Deputy Public Advocate
NJ Department of the Public Advocate
CN 850, 2nd Floor, North Wing
Trenton, NJ 08625
(609) 292-7087

Maureen E. Lopes
Treasurer & Assistant Vice President,
Health Affairs
New Jersey Business and Industry Association
102 West State Street
Trenton, NJ 08608
(609) 393-7707

Karen Lumpp, C.P.A.
c/o Touche Ross & Co.
51 John F. Kennedy Parkway
Short Hills, NJ 07078-2708
(201) 912-4108

Eugene V. Malinowski, C.P.A.
c/o Peat Marwick Main & Co.
150 J. F. Kennedy Parkway
Short Hills, NJ 07078
(201) 467-9650

Richard Fairclough
Vice President, Finance
St. Clares/Riverside Medical Center
Pocono Road
Denville, NJ 07834
(201) 625-6503

Anthony Cottone
Senior Financial Analyst
New Jersey Hospital Association
760 Alexander Road, CN-1
Princeton, NJ 08540
(609) 275-4019

Jane Majcher
Associate Director
Consumer and Professional Relations
Health Insurance Association of America
1025 Connecticut Avenue, NW
Washington, DC 20036-3998
(202) 223-7835

Edward G. Zinser
Senior Vice President
The National State Bank
342 Westminster Avenue
Elizabeth, NJ 07208
(201) 353-7525

Sean O'Donnell
78 Lincoln Boulevard
Clark, NJ 07066
(201) 564-9191

James Petillo (Honorary Member)
Vice President
HHL Financial Services, Inc.
P.O. Box 550
Eatontown, NJ 07724
(201) 544-9161

Michael T. Kornett (Honorary Member)
Chief Executive Officer
John F. Kennedy Medical Center
James Street
Edison, NJ 08818-3059
(201) 632-1501

Membership of Pilot Insurance Working Group
New Jersey Department of Health

Melanie Willoughby, Chair
President
NJ Retail Merchants Association
332 West State Street
Trenton, NJ 08618
(609) 393-8006

Christine Grant
Deputy Commissioner
NJ Department of Health
CN 360
Trenton, NJ 08625
(609) 292-7837

Bob McLaughlin
Director of Marketing and Sales
NJ Blue Cross Blue Shield
12 Vreeland Roaad - #12128
Florham Park, NJ 07932
(201) 593-6191

Nunzio Cernero, Insurance Agent
P.O. Box 6940
Lawrenceville, NJ 08648
(609) 586-4800, ext. 291 or
(609) 896-1158 (recording)

John Jacobi
Assistant Deputy Public Advocate
Justice Complex, 2nd Floor, N Wing
CN 850
Trenton, NJ 08625
(609) 292-0756

James Morford
VP for Government Relations
NJ State Chamber of Commerce
28 West State Street, Suite 1100
Trenton, NJ 08608
(609) 989-7888

Maureen Lopes, Treasurer
NJ Business and Industry Association
102-104 West State Street
Trenton, NJ 08608
(609) 393-7707

Jeanne Sims
Special Deputy Commissioner
NJ Department of Insurance
CN 345
Trenton, NJ 08625
(609) 633-3965

Jane Majcher, Assoc. Director
Insurance, Man. Care and Prov. Rel.
Health Insurance Assoc. of America
1025 Connecticut Ave., NW #1200
Washington, DC 20036
(202) 223-7835

Kathy DeMichele
Administrative Assistant
PruCare
One Campus Drive, 1 NGO
Parsippany, NJ 07054
(201) 631-9683

Charles Bertsch, President
Marketing Communications
201 East Grove Street
Westfield, NJ 07090
(201) 789-1880

Edward Tetelman
Assistant Commissioner
NJ Deparment of Human Services
Capitol Plance One
Trenton, NJ 08625
(609) 292-1617

Anthony Ettore
Vice President
Muller & Cashin Sporting Goods
77 West Main Street
Somerville, NJ 08876
(201) 725-3150

Laura Giannotta, State Director
NJ National Fed. of Indep. Business
156 West State Street
Trenton, NJ 08608
(609) 989-8777

Roger Birnbaum, President
Rutgers Community Health Plan
One Worlds Fair Drive
Somerset, NJ 08873
(201) 560-9898

18 Tarkington Court
Princeton, NJ 08540
October 18, 1989

Molly Joel Coye, M.D., M.P.H.
Commissioner
New Jersey Department of Health
CN 360
Trenton, New Jersey 08625

Dear Commissioner Coye:

As Chair of the Uncompensated Care Trust Fund Advisory Committee, I am pleased to forward to you the Committee's recommendations vis a vis alternative financing for uncompensated care in New Jersey. These recommendations are in response to one of the Committee's legislative charges and, hopefully, will be useful to you as you prepare your recommendations to the legislature on this subject.

As you will see, the Committee's recommendations have two components. First is a set of seven principles intended as guidelines for developing an alternative financing arrangement. There was a general consensus among Committee members in support of these principles.

The second part of the recommendations consists of two specific financing packages that are in accordance with the Committee's principles. The two packages are very similar in that they both:

- rely heavily on a mandatory contribution from employers who do not offer health coverage to their employees;
- maintain the hospital mark-up to finance a portion of uncompensated care; and
- target alcohol, tobacco and casino taxes as additional financing sources.

In addition, both packages call for expanding Medicaid eligibility to the maximum level in which the federal government will participate.

The one area in which a consensus did not emerge was on the issue of whether or not an explicit employee contribution should be included in the financing package. Roughly half of the Committee believed all employees should contribute in some way and that such a contribution was an explicit acknowledgement that individuals share in the responsibility for financing health care for all members of society. The other half of the Committee opposed an employee contribution, especially given that employees are increasingly asked to participate in the cost of employer-sponsored health coverage. As a result of this lack of consensus, members agreed to disagree on this specific provision and the group opted to submit both financing packages in its recommendations to you.

After reviewing the final draft of the Committee's recommendations, members were invited to express additional comments in individual letters that would accompany the group's recommendations. Four members opted to do this -- Mr. Tetelman, Mr. Courey, Mr. Birnbaum and Mr. Peck -- and their letters are attached to the full Committee's recommendations for your review.

In submitting these recommendations to you I would like to take the opportunity to convey the sense of the Committee that hospital-based uncompensated care is but a part of our larger system for financing health care. Although members understood that the specific charge was to recommend alternative financing for uncompensated care and proceeded accordingly, the relationship of financing uncompensated care to financing health care in all settings and specifically to financing health insurance, emerged and re-emerged throughout the Committee's discussions and deliberations as an area requiring additional future attention.

I am available and would be happy to meet with you should you wish to discuss the Committee's recommendations in more detail.

Sincerely,

Dorothy Powers
Chair, Uncompensated Care Trust
Fund Advisory Committee, and
Vice Chair, Hospital Rate Setting
Commission

Enclosures

c: Members, Uncompensated Care Trust Fund Advisory Committee

Uncompensated Care Trust Fund Advisory Committee's Recommendations to Commissioner Molly Joel Coye, M.D., M.P.H.

Alternative Financing of the Uncompensated Care Trust Fund
September 1989

The Uncompensated Care Trust Fund Advisory Committee, in addressing its statutory charge to recommend alternative financing for uncompensated care respectfully submits this report to the State Commissioner of Health, Molly Joel Coye, M.D., M.P.H. This report follows almost three years of Committee deliberations on issues related to uncompensated care.

Uncompensated care is but a part of the larger issue that 11 percent of New Jerseyans lack health insurance. The long term ability to contain the growth of uncompensated care is inextricably linked to success in increasing the number of New Jerseyans with third-party coverage. This includes public coverage -- Medicaid -- as well as private coverage. Concerning the latter, a range of initiatives to accomplish this goal was discussed by the Committee over the past three years. These include voluntary efforts such as state subsidization of health insurance premiums for persons of low or moderate incomes as well as mandatory efforts to require employers to provide health insurance for their employees.

In developing alternative financing arrangements, the Committee recognized the importance of maintaining the hospital uncompensated care mark-up as a fall-back financing mechanism for any residual uncompensated care -- in the event other funding sources being implemented fall short of expectations in a given year, due to subsequent legislative action or inaccurate revenue or uncompensated care cost projections.

Below are seven principles developed by the Trust Fund Advisory Committee.

1. A system which ensures access to needed hospital care for all New Jerseyans -- those with and without insurance -- is integral to the State's health care system and must be preserved.

2. Responsibility for health care is one that should be shared by all and thus, any financing mechanism for uncompensated care should be broadly based. Two other important criteria in evaluating funding sources of uncompensated care are equity and stability over time.

3. The Uncompensated Care Trust Fund should be maintained as a mechanism to collect a portion of the statewide uncompensated care amount via a uniform statewide hospital uncompensated care mark-up, and to distribute payments, regardless of the funding source, to hospitals.

4. Alternative funding should be sought for, at a minimum, the Medicare share of the statewide uncompensated care amount. Funding for this share of uncompensated care need not come from a single source; a mix of revenue sources could be used. Below are suggested revenue sources for further exploration:

   - Mandatory contributions from employers who do not provide insurance coverage for their employees and thus, do not now contribute towards the State's uncompensated care amount. In addition to providing revenue, such a mechanism would also serve as an incentive for employer-based coverage. Employees could share in this employer contribution in a way that is similar to the unemployment insurance arrangement. This funding source is viewed as particularly equitable in scenarios in which uncompensated care continues to be partially funded through the hospital mark-up (which is paid in part by employers who provide insurance for their employees as well as by employees who share in the cost of the insurance).

   - State excise taxes, in particular alcohol, cigarette, and other tobacco taxes. This is viewed as especially appropriate and logical given the negative impact that alcohol and tobacco products have on health status.

   - The casino revenue fund -- designated for persons who are elderly or disabled/handicapped -- could support a new program to fund uncompensated hospital care provided to persons having HIV diseases, including AIDS.

   - Expansion of the sales tax to some products currently excluded, such as clothing and non-prescription drugs.

5. Medicaid eligibility should be expanded to the maximum permitted by the federal government. As an "indirect" funding source of uncompensated care, Medicaid expansion has the significant advantage in bringing of new federal dollars; the federal government would match every dollar New Jersey spent on Medicaid.

6. Initiatives to increase the number of persons with private health insurance should continue to be studied, tested, and implemented in order to achieve a long-term solution to the issue of uncompensated care.

7. Determination of the portion of uncompensated care funding raised through the hospital uncompensated care mark-up should be done in advance, to the extent feasible, so as to enable insurance companies to develop premium rates which will accurately reflect their contribution towards uncompensated care.

Committee members supported one or both of the attached two financing packages -- packages which flow from the Committee's principles.

UNCOMPENSATED CARE ALTERNATIVE FINANCING

PACKAGE #1

OPTION	AMOUNT RAISED NOW (millions)	RATE TO RAISE $10 MIL	RATE SELECTED	AMOUNT RAISED (millions)
T.F. MARK-UP	$590	0.37%	6.43%	$174
GEN FUND/M'CAID ($10)		$10	$10	$10
ALCOHOL TAX	$145	7% INCR*	7%	$10
*OTHER TOBACCO TAX**	N/A	N/A	N/A	$20
CASINO TAX	$235	4.5% INCR	9%	$21
EMPL'RS W/O INS. PER EMPLOYEE		$28.00 EA	$1,000	$355
ALL EMPLOYEES		$2.90 EA	$0	$0
			TOTAL	$590
			SHORTFALL	$0

* A 7% increase to alcohol taxes (or 7% of the existing tax) would generate $10 million.

** Expansion of sales tax to all tobacco products.

UNCOMPENSATED CARE ALTERNATIVE FINANCING

PACKAGE #2

OPTION	AMOUNT RAISED NOW (millions)	RATE TO RAISE $10 MIL	RATE SELECTED	AMOUNT RAISED (millions)
T.F. MARK-UP	$590	0.37%	6.51%	$176
GEN FUND/M'CAID ($10)		$10	$10	$10
ALCOHOL TAX	$145	7% INCR*	7%	$10
*OTHER TOBACCO TAX**	N/A	N/A	N/A	$20
CASINO TAX	$235	4.5% INCR	9%	$21
EMPL'RS W/O INS. PER EMPLOYEE		$28.00 EA	$750.00	$266
ALL EMPLOYEES		$2.90 EA	$25.00	$86
			TOTAL	$590
			SHORTFALL	$0

* A 7% increase to alcohol taxes (or 7% of the existing tax) would generate $10 million.

** Expansion of sales tax to all tobacco products.

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

WILLIAM WALDMAN
Acting Commissioner

October 5, 1989

David Knowlton, Deputy Commissioner
New Jersey Department of Health
CN 360
Trenton, New Jersey 08625

Dear Dave:

As per your request, I prefer package one over package two. Employers are already cost shifting health benefits to their employees. Thus, employees pay more in terms of co-payments and deductibles, especially lower wage employees. I don't think they should be saddled with additional costs. A more progressive tax should be looked at, rather than just taxing workers.

Additionally, I think that raising revenue to reduce the present covered employer cost won't sell very well. The legislature will probably want to do the least costly activity and use tax dollars to cover other liabilities (e.g., budget shortfall; school financing). I think we have to be practical in this area. So, I would keep the rate where it is.

Finally, I recommend that we put a funding source with the Medicaid expansion. I don't see the legislature putting general revenues behind it right now. Another revenue source, such as taxes on other tobacco products, would be a better way to go. Medicaid certainly doesn't have these funds in its budget.

Very truly yours,

Ed

Edward Tetelman
Assistant Commissioner
Quality Assurance, Auditing,
and Legal Affairs

ET:cas

ST CLARES RIVERSIDE MEDICAL CENTER

Telephone:

September 29, 1989

Mr. David L. Knowlton
Deputy Commissioner of Health
N.J. Department of Health
CN-360
Trenton, N.J. 08625-0360

Dear Dave:

I am writing you in regard to the material you sent on September 22 concerning the alternate financing for uncompensated care.

Unfortunately, I will not be able to attend the October 5 meeting, and I am using this letter to respond to the materials I received. I am discouraged that I have had to miss the last meeting and this one also, but that is what happens with busy calendars.

In reading the seven principles that are being proposed to be recommended to the Commissioner, I am in general agreement, except for one item. The minutes of the September 14 meeting incorporated the following:

> "The hospital uncompensated care mark-up should be maintained as the fall-back financing mechanism for residual uncompensated care -- in the event other funding sources being implemented fall short of expectations in a given year, due to subsequent legislative action or inaccurate revenue or uncompensated care cost projections."

I, for one, feel that should be incorporated as either an additional principle to be recommended to the Commissioner, or as part of Principle 3, which talks to maintaining the Trust Fund as a mechanism to collect a portion of, and distribute payments for, uncompensated care to hospitals. I think it is mandatory that it be cited as one of the principles, and not just take place as a preamble to any recommendation to the Commissioner.

I say this because my belief is uncompensated care reimbursement is one of the key elements in the all-payor system of New Jersey. It is a singular element which all can be proud to provide to our citizenry. It has to stand as a priority principle, in my view, in any recommendation to the Commissioner.

Pocono Road, Denville, New Jersey 07834

Having said that, however, I am in full concert with the Committee's intention to find alternate sources of funds to pay for uncompensated care in our State. In reading the materials, I am a little confused as to the intent of the alternate financings listed under Package 1 and Package 2.

In both enclosures, we list a series of options and potentially how much money can be raised from each. If our job is to provide a number of options from which the Legislature can choose, then I do not have a problem with the various packages proposed.

However, if our intention is to find a preferential option, then we should specify it and recommend it specifically as the way to go. We could add additional recommendations, but we really ought to go on line with where our preferences lie.

If the latter is our intent, I would repeat my suggestion that I think we should go for employee head taxes, similar to the disability tax in this State, which would be matched by employer and employee. I further believe that such a tax should be differentiated to those who provide insurance for their employees, versus those who do not. For those who do not, they should pay far more employer match, than those who do. In my previous letter I suggested some numbers to you, and would stand by them.

I trust this responds to your request. If you need additional information, do not hesitate to contact me.

Sincerely,

Kenneth M. Courey
President

KMC:mk

RCHP
Rutgers Community Health Plan
Administrative Offices. One Worlds Fair Drive. Somerset. NJ 08873 201 560-9898 609 989-8585

October 3, 1989

Mr. David L. Knowlton
Deputy Commissioner of Health
State of NJ Dept. of Health
CN 360
Trenton, NJ 08625-0360

Dear Dave:

While I generally concur with the statement of principles and the two alternative financing models developed by the Uncompensated Care Trust Fund Advisory Committee, I am not entirely comfortable with the priority of the seven basic principles.

It seems to me that the only meaningful way to ultimately come to grips with this issue is to move aggressively to extend health insurance coverage to the uninsured, thereby breaking the spiral of an ever increasing uncompensated care trust fund leading to higher health insurance premiums leading to an increase in the uninsured. While S2981 was given urgent consideration last year in order to fund hospitals' uncompensated care burden, the legislation makes extensive reference to the need for the state to "reduce the rate of increase in health insurance premiums and explore and implement various initiatives to reduce the amount of uncompensated care..." [Section 1.e.]; "subsidize... a pilot health insurance program for small business... and fund the reasonable cost of preparing and disseminating health insurance information to employers..." [Section 4.a.]; "make recommendations... on initiatives designed to reduce uncompensated care in the State" [Section 5.b.4]; and "make recommendations on initiatives to expand health insurance coverage in the State" [Section 5.b.6]. In addition, Sections 13 and 14 of the Act impose various obligations on employers and students to at least assist in the purchase of health insurance. Yet the principle addressing this key issue is somewhat weakly stated and is relegated to near the end of list.

In view of the fundamental importance of this insurance issue (which I recognize is under extensive review by the Department and will be considered shortly by the Committee) in ameliorating the growing uncompensated care crisis, I think principle 6, dealing with health insurance initiatives, should be strengthened and moved closer to the top of the list, perhaps second only to the first principle addressing access. Regarding that first principle, I would strongly urge that "access to needed hospital care" be replaced by "access to needed health care," reflecting the need to provide more cost-effective alternatives to the inappropriate use of hospital emergency rooms.

Finally, regarding principal number 7, which reinforces very nicely the need to enhance prospectivity and predictability in the reimbursement system, I would suggest adding the following underlined language: "Determination of the portion of uncompensated care funding raised through the hospital uncompensated care mark-up should be done in advance of each calendar year and held constant for that year, to the extent feasible..."

I have enclosed recent articles related to the insurance issues which you and the Committee might find of interest.

I recognize that coming late in the process of the Committee's deliberations limits my perspective of your earlier discussions. Nevertheless, my comments are meant to be constructive and I appreciate the opportunity to offer them.

Sincerely,

Roger W. Birnbaum
President

RWB:lc158

enclosures

HIAA

Health Insurance Association of America

Stanley B. Peck, Vice President
Insurance, Managed Care
and Provider Relations

October 13, 1989

Mr. David Knowlton, Deputy Director
State of New Jersey
Department of Health
CN 360
Trenton, New Jersey 08625-0360

Dear Dave:

The purpose of this letter is to indicate the Health Insurance Association of America's (HIAA) general support for the statement of principles and the two sets of financing mechanisms which will be recommended to the Commissioner of Health by the Uncompensated Care Trust Fund Advisory Committee.

We strongly urge, however, that the principles be reordered so they more accurately reflect the committee's deliberations and goals for the system. Specifically, the Medicaid expansions, currently principle 5 should be elevated to principle 2. It is a broad-based financing mechanism and therefore logically follows the statement made in principle 3. Further, the Medicaid expansions will increase the number of persons with coverage and thus, will preclude the use of trust fund monies to finance care for the potential enrollees. These are obviously high priorities for the Advisory Committee and should be so indicated in the recommendations.

Although we believe that the trust fund should be maintained, the recommendations to the Commissioner should emphasize that inflating the mark-up factors of the trust fund to compensate for all shortfalls is clearly a fall-back position. We encourage the Department to seek other sources of funding such as those enumerated in the principles.

A suggestion was made at our October 5 meeting to amend principle 1: "A system which ensures access to needed health care ...". We concur with this recommendation.

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7830 Telecopier 202/223-7897

HIAA is pleased to have participated in the development of the recommendations to the Commissioner. We also look forward to assisting in their implementation.

Sincerely,

Stanley B. Peck
Vice President

SBP:JM/jd

cc: Jane Majcher

Analysis of Possible Impact of an Increase in the Rate of Unemployment in New Jersey on the Amount of Uncompensated Care Provided by Hospitals

Abstract

Based on several assumptions and limitations in the use of available data, the impact of an increase in the rate of unemployment in the State of New Jersey on the Uncompensated Care Trust Fund was calculated for three 1990 unemployment rate scenarios. The rate of unemployment in the State for the first 10 months of 1989 was 4%. The three scenarios of the rate of unemployment in 1990 are 5%, 6%, and 7%. The increase in uncompensated care for 1990 has been estimated to be $13 million, $26 million, and $39 million, respectively, for the three unemployment scenarios. These increases in uncompensated care costs would result in an increase in the percentage of the uniform statewide uncompensated care add-on of approximately 0.3%, 0.6%, and 0.9%, respectively.

Introduction

This analysis has been undertaken to fulfill subsection b(8) of section 5 of the Uncompensated Care Trust Fund law (P.L. 1989, c.1). This subsection of the law states the following:

> The Uncompensated Care Trust Fund Advisory Committee shall:
>
> Analyze the possible impact of an increase in the rate of unemployment in the State on the amount of uncompensated care provided by hospitals and advise the Commissioner on its conclusions about the projected impact of the limit on the uniform statewide uncompensated care add-on, established pursuant to subsection b. of section 6 of this act, on hospitals under those economic conditions.

In order to determine the increase in uncompensated care that might result from a given increase in the rate of unemployment, there are several questions which must be answered. These questions include the following:

(1) If the rate of unemployment in New Jersey increases from the January to October 1989 rate of 4.0% to a higher rate in 1990, how many persons will become unemployed? (See Table 1, page 8, for New Jersey unemployment statistics.)

(2) Of persons who become unemployed, how many will lose existing health insurance coverage and how many dependents will be affected by the loss of health insurance of the unemployed person? (Some do not lose health insurance when they become unemployed and some did not have it when they were employed.)

(3) What will be the average cost of inpatient and outpatient hospital care for those persons who are no longer insured, and how much of it will go unpaid?

The estimates that follow were made by utilizing available State and national data. Appendix I, page 7, lists the assumptions that have been made in deriving final figures to determine the impact of an increase in the rate of unemployment on the Uncompensated Care Trust Fund.

Data Available for Analysis

1. New Jersey Labor Force and Unemployment Statistics

Table 1, page 8, displays the New Jersey civilian labor force and unemployment statistics for the years 1985 to 1990. The civilian labor force statistic for 1990 is a projected figure based upon the Economic-Demographic Model. The trend over the past five years has been a reduction in the rate of unemployment, with a high of 5.7% in 1985 to a low of 3.8% in 1988. While the unemployment rate has been remaining stable, the civilian labor force has been increasing over the same five year period. In 1985, the civilian labor force was 3,839,000 and in 1989 it was 4,002,500. The civilian labor force in 1990 is projected to be 4,029,600. The August 1989 issue of New Jersey Economic Indicators stated that the New Jersey unemployment rate is assumed to decline somewhat from its 1988 average of 3.8%, reaching a level of 3.5% by the year 2000 and 3.0% in 2015.[1] This August 1989 issue also stated that in 1989 there was an increase in the jobless rate for adult men from 3.1% to 3.5% (about 8,000 individuals) which was masked by a drop in the rate for teenagers from 12.2% to 9.3% (also about 8,000 individuals). The accuracy of these figures was substantiated by the fact that, over the same period, the weekly average of unemployment insurance claims climbed by about 10,000.[2]

The 1990 civilian labor force projection will be used in order to determine the number of persons who would become unemployed in 1990 if there is an increase in the unemployment rate when compared to 1989. Three unemployment rate scenarios will be presented in order to show the impact that an increase in the rate could possibly have on the amount which is spent on uncompensated care. The three scenarios will be:

(1) 1990 unemployment rate of 5%: 201,480 persons would be unemployed, an increase of 39,880 unemployed persons when compared to 1989;

(2) 1990 unemployment rate of 6%: 241,776 persons would be unemployed, an increase of 80,176 unemployed persons when compared to 1989; and

(3) 1990 unemployment rate of 7%: 282,072 persons would be unemployed, an increase of 120,472 unemployed persons when compared to 1989.

2. Survey of Health Insurance Coverage of New Jersey Unemployment Insurance Claimants

The New Jersey Department of Labor conducted a survey of the status of health insurance coverage of 2,135 unemployed individuals who were claiming unemployment benefits during the week ending October 25, 1986.[3] The average duration of benefits for the survey respondents was 11 weeks. The average number of insured dependents while unemployed was 2.6 (including the survey respondent). The survey found the following change in the health insurance status of the survey respondents:

- o 47% of survey respondents had health insurance coverage both when employed and unemployed.
- o 29% of survey respondents lost health insurance coverage after they became unemployed.
- o 19% of survey respondents did not have health insurance coverage when employed or unemployed.
- o 5% of survey respondents did not have health insurance coverage during employment but obtained health insurance while unemployed.

After subtracting the percentage of survey respondents (5%) who gained coverage from the percentage of survey respondents (29%) who lost coverage, there was a net increase in uninsured respondents of 24%. Table 2, page 9, is provided to give a more detailed summary of the survey sample characteristics and percentage distributions of claimants in each of the four major health insurance subpopulations.

A similar study of the change in status of health insurance coverage of the population which is ineligible for unemployment insurance benefits has not been conducted in the State of New Jersey. One would assume that this population is worse off economically than the population who is eligible for unemployment insurance benefits. In order to qualify for unemployment benefits in 1989, a person must, for the first four quarters of the last five completed calendar quarters, have worked at least 20 weeks in covered employment and earned at least $92 per week or have earned a total of $5,500 in covered employment. A person may collect unemployment for a maximum of 26 weeks. In a study conducted by the New Jersey Department of Labor of unemployment insurance recipients from 1985 to 1986, the mean number of weeks of benefits paid was 15 and the percent exhausting benefits was 35.1%.[4] In 1988, the insured unemployment rate was 2.1% while the total unemployment rate was 3.8%. Therefore, 44.7% of those who were unemployed in 1988 were not eligible for unemployment insurance benefits. The figure of 44.7% was derived from the uninsured unemployment rate of 1.7% (2.1% subtracted from 3.8%) as a percentage of the total unemployment rate of 3.8%.

In calculating the possible increase in dollars spent on uncompensated care, the figure of 24% will be used when determining

the total number of unemployed persons who have had a loss of health insurance coverage. Applying the 24% figure to all persons who are unemployed may be an overestimate of the loss of health insurance status, since many individuals without unemployment insurance may have been unemployed and without health insurance for an extended period of time prior to becoming unemployed. This figure of 24% may also be an overestimate of the number who currently lose insurance due to unemployment since COBRA legislation was not in effect at the time of the Department of Labor survey. In 1990, fewer persons may be uninsured because they will purchase health insurance through their former employers by exercising their rights under COBRA.

A factor for the number of dependents an unemployed person has will also be used when calculating the total number of persons affected by the loss of health insurance coverage. A figure of 2.6 dependents (including self) was found in the 1986 Department of Labor survey of health insurance coverage. A similar survey conducted by the Department of Labor in 1983 was consistent with the 1986 survey in the data collected regarding the number of dependents. In both surveys, a figure of 2.6 dependents (including self) was obtained. See Table 3, page 10, for a comparison of the 1983 and 1986 surveys.

The calculations of the number of persons who have lost health insurance due to an increase in unemployment in 1990 is calculated below for the three scenarios:

(1) unemployment rate of 5%: (39,880 x .24) x 2.6 = 24,885 persons

(2) unemployment rate of 6%: (80,176 x .24) x 2.6 = 50,030 persons

(3) unemployment rate of 7%: (120,472 x .24) x 2.6 = 75,175 persons

3. Number of Uninsured in New Jersey and Dollars Spent on Hospital Uncompensated Care

As of March 1986, there were 843,000 uninsured persons in the State of New Jersey.[5] This amounted to 11% of New Jersey's population. In 1990, the Department of Health estimates that uncompensated care may be as high as $590 million. This figure is based on the 1989 figure adjusted by the average percentage increase over the past several years. Of this $590 million, it is not known how much will be spent on persons who are uninsured versus persons who have insurance but cannot pay their co-payment or deductible. The American Hospital Association estimates that over 75% of total uncompensated care costs are the result of lack of insurance coverage.[6] Therefore, if 75% of $590 million in uncompensated care is spent on the uninsured, $442.5 million would be spent on the uninsured. To determine the dollars spent on each uninsured person, with the assumption that in 1990 the number of uninsured persons would be similar to the 1986 figure, the $442.5 million is divided by 843,000. This amounts to $524.91 per uninsured person for uncompensated hospital care.

Conclusion

Based on the preceding information, assumptions, and analysis, the estimates of uncompensated care cost increases due to different increases in the unemployment rate in 1990 are listed below in three scenarios:

(1) unemployment rate of 5%: $524.91 x 24,885 = $13,062,385

(2) unemployment rate of 6%: $524.91 x 50,030 = $26,261,247

(3) unemployment rate of 7%: $524.91 x 75,175 = $39,460,109

The three scenarios listed above would result in percentage increases in the uniform statewide uncompensated care add-on (percentage of all governmental and nongovernmental approved revenue) of 0.3%, 0.6%, and 0.9%, respectively, based upon the limitations of the data and assumptions that have been made (Appendix I). Although a rise in the number of unemployed persons is expected to increase the number of patients without health insurance who are being treated at New Jersey hospitals, the Uncompensated Care Trust Fund amount would not be affected for two years since hospitals are reimbursed based upon data which is two years old.

NOTES

1. New Jersey Economic Indicators. Trenton, NJ: New Jersey Department of Labor, Division of Labor Market and Demographic Research, August 1989, pp. 15, 17.

2. New Jersey Economic Indicators. Trenton, NJ: New Jersey Department of Labor, Division of Labor Market and Demographic Research, August 1989, p. 4.

3. October 1986 Health Insurance & Life Insurance Coverage of New Jersey Unemployment Insurance Claimants. Trenton, NJ: New Jersey Department of Labor, Program Analysis & Evaluation, March 1989.

4. The Duration of Unemployment Insurance Benefits in New Jersey & Characteristics of Recipients. Trenton, NJ: New Jersey Department of Labor, Program Analysis & Evaluation, December 1988.

5. New Jersey Subsample from the March 1986 Current Population Survey.

6. Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent - The Report of the Special Committee on Care for the Indigent. Chicago, IL: American Hospital Association, 1986, p. 136.

APPENDIX I

Assumptions

Assumption 1: The number of uninsured persons in New Jersey in 1990 will be similar to the number of uninsured New Jerseyans in 1986, i.e., 843,000.

Assumption 2: In 1990, the Department of Health estimates that uncompensated care may be as high as $590 million, based upon the 1989 figure adjusted by the average percentage increase over the past several years.

Assumption 3: The percentage of uncompensated care resulting from uninsured persons is equal to 75% of the uncompensated care amount, i.e., 25% of uncompensated care is spent on persons who cannot pay insurance deductibles and co-payments.

Assumption 4: The rate of loss of health benefits for those persons who become unemployed is 24%. This figure is based on the 1986 New Jersey Department of Labor survey of unemployment insurance claimants.

Assumption 5: The average number of dependents (including self) for an unemployed person is 2.6. This figure is based upon the 1983 and 1986 New Jersey Department of Labor Health Insurance Coverage Surveys.

Assumption 6: The civilian labor force projection for 1990 has been estimated by the New Jersey Department of Labor based upon the Economic-Demographic Model.

TABLE 1

New Jersey Labor Force and Unemployment Statistics

Monthly Averages 1985 to 1990[1]

	1985	1986	1987	1988	1989 Jan.-Oct.	1990[2] Projection
Civilian Labor Force (000's)	3839.0	3908.0	3967.0	3978.0	4002.5	4029.6
Resident Employment (000's)	3621.0	3712.0	3806.0	3827.0	3840.9	
Resident Unemployment (000's)	217.0	197.0	160.0	151.0	161.6	
Unemployment Rate (%)	5.7	5.0	4.0	3.8	4.0	

1989 Monthly Trends (Seasonally Adjusted 1988 Benchmark)

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.
Civilian Labor Force (000's)	4,046	4,043	4,010	3,977	3,952	3,971	3,976	3,990	4,014	4,046
Resident Employment (000's)	3,888	3,884	3,890	3,816	3,834	3,806	3,814	3,810	3,828	3,839
Resident Unemployment (000's)	158	159	120	161	118	165	162	180	186	207
Unemployment Rate (%)	3.9	3.9	3.0	4.0	3.0	4.2	4.1	4.5	4.6	5.1

[1] 1985-1989 labor force and unemployment statistics are from New Jersey Economic Indicators, Trenton, NJ: New Jersey Department of Labor, Division of Labor Market and Demographic Research, August 1989, pp. S-36 & S-37, and data provided by the New Jersey Department of Labor, Division of Labor Market and Demographic Research.

[2] 1990 projection of civilian labor force is from Population & Labor Force Projections For New Jersey: 1990 to 2030 Volume I, Trenton, NJ: New Jersey Department of Labor, Division of Labor Market and Demographic Research, February 1989, p. 31.

TABLE 2

-- New Jersey Health/Life Insurance Coverage Survey[1] --

CHARACTERISTICS AND PERCENTAGE DISTRIBUTIONS
OF CLAIMANTS IN EACH OF THE FOUR MAJOR
HEALTH INSURANCE SUBPOPULATIONS OF THE SURVEY SAMPLE

Claimant Characteristics (1)	Total Sample (2)	SUBPOPULATIONS OF SAMPLE: Had Coverage Both When Employed and Unemployed (3)	Lost Coverage (4)	Gained Coverage (5)	Not Covered Either When Employed or Unemployed (6)
Average Age	39 years	43 years	35 years	42 years	34 years
Average Base Period Wages[2]	$15,223	$18,297	$15,534	$10,450	$8,546
Average Weekly Benefit Rates[3]	$165	$179	$171	$138	$129
Average Duration of Benefits (weeks)[4]	11	11	11	10	11
Average Number of Insured Dependents while Unemployed[5]	2.6	2.6	N.A.	2.9	N.A.
Percentage Distributions (% of Total)					
Sex:					
Men	53%	51%	58%	23%	58%
Women	47	49%	42	77%	42
Race					
White, Not Hispanic	66%	76%	58%	81%	48%
Black, Not Hispanic	21	13	28	8	30
Hispanic	13	10	13	10	21
Other[6]	1	*	1	*	1

N.A. - Not Applicable.

[1] Survey of New Jersey unemployment insurance claimants; conducted during the week ending October 25, 1986.

[2] Base period wages include salary, commissions, bonuses and the cash value of any other compensation which were reported by an unemployed worker's former employers for the first four of the last five completed calendar quarters preceding the initial claim for unemployment benefits. Some survey respondents qualified for their unemployment benefits under a prior earnings eligibility criterion. Prior to July 1986, base period wages were defined as the first 52 of the 53 weeks preceding the claim for UI benefits. Differences among claimants in base period wages are affected not only by differences in wage and salary levels, but also by differential numbers of weeks and hours worked during the base period.

[3] Average weekly benefit rates on this table represent average weekly unemployment insurance entitlements of individuals who participated in the health insurance survey. Each worker's UI weekly benefit rate is determined as 60% of the worker's average weekly wage, subject to a maximum of 56 2/3% of the statewide average weekly wage in covered employment.

[4] Average duration of unemployment insurance benefits as of the end of the survey week.

[5] Average number of dependents during unemployment; includes the survey respondent. This average is derived from survey sample cases where health insurance coverage was reported in effect as of the survey week.

[6] Includes American and Alaskan natives, Asians and Pacific Islanders.

* - Less than 0.5%

NOTE: Percentage distributions may not add to 100% due to rounding.

TABLE 3

-- New Jersey Health Insurance Coverage Surveys[1] --

COMPARISON OF 1983 AND 1986
HEALTH INSURANCE SURVEYS

	1983 Survey	1986 Survey
1. Number of Valid Questionnaires	1,623	2,135
2. Survey Date(s)	March 14, 1983	October 20-24, 1986
3. New Jersey Total Unemployment Rate During Survey Month[2]	8.3%	5.2%
4. New Jersey Insured Unemployment Rate During Survey Month[2]	4.3%	2.5%
5. UI Benefit Programs Included in Survey:		
(a) Regular Unemployment Insurance Program	Yes	Yes
(b) Federal Supplemental Compensation Program	Yes	No
(c) Unemployment Compensation for Federal Employees (UCFE)	No	Yes
(d) Unemployment Compensation for Ex-Service Members (UCX)	No	Yes
6. Key Survey Findings:		
Percent without basic coverage while employed	35%	24%
Percent without basic coverage while unemployed	53%	48%
7. Claimant Characteristics:		
Average number of dependents covered by health insurance while unemployed	2.6 dependents, including self	2.6 dependents, including self
Average age of survey respondents	38 years	39 years

[1]Surveys of New Jersey unemployment insurance claimants.

G1359

[2]Seasonally adjusted.